INSURANCE LAW AMENDMENTS

2007 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Michael G. Waddoups

LONG TITLE

General Description:

This bill modifies the Insurance Code.

Highlighted Provisions:

This bill:

- addresses definitions;
- addresses examinations and costs of examinations;
- clarifies laws applicable to executive compensation;
- clarifies that certain acknowledgment forms are to be filed with the department;
- modifies certain policy and annuity examination periods;
- addresses accident and health insurance coverage related to birth or adoption;
- addresses requirements for the commissioner's adoption of a Basic Health Care Plan;
- addresses independent review organizations;
- addresses groups eligible for group or blanket insurance;
- removes certain references to a federal employer identification number;
- clarifies application of special requirements to title insurance producers which are agencies;
- allows for an insurer to provide incentives to participate in programs or activities designed to reduce claims or claims expenses;
- clarifies provisions related to sharing of commissions;
- addresses health care claims practices;
- modifies the Individual, Small Employer, and Group Health Insurance Act;

- addresses appointments to the Bail Bond Surety Oversight Board;
- addresses provisions applicable to a viatical settlement provider or viatical settlement producer;
- clarifies provisions related to examinations of captive insurance companies; and
- makes technical changes including correcting citations.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill coordinates with H.B. 340, Insurer Receivership Act, to make technical changes.

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Chapters 320 and 332, Laws of Utah 2006

31A-2-205, as last amended by Chapter 2, Laws of Utah 2004

31A-5-416, as last amended by Chapter 277, Laws of Utah 1992

31A-21-104, as last amended by Chapter 81, Laws of Utah 2003

31A-21-503, as last amended by Chapter 116, Laws of Utah 2001

31A-22-305, as last amended by Chapter 69, Laws of Utah 2006

31A-22-305.3, as enacted by Chapter 69, Laws of Utah 2006

31A-22-423, as last amended by Chapter 252, Laws of Utah 2003

31A-22-610, as last amended by Chapter 252, Laws of Utah 2003

31A-22-613.5, as last amended by Chapter 114, Laws of Utah 2002

31A-22-629, as last amended by Chapter 78, Laws of Utah 2005

31A-22-701, as last amended by Chapters 90 and 108, Laws of Utah 2004

31A-23a-104, as last amended by Chapter 173, Laws of Utah 2004

31A-23a-105, as last amended by Chapter 312, Laws of Utah 2006

31A-23a-117, as last amended by Chapter 312, Laws of Utah 2006

31A-23a-204, as last amended by Chapter 312, Laws of Utah 2006

31A-23a-401, as renumbered and amended by Chapter 298, Laws of Utah 2003
31A-23a-402, as last amended by Chapters 123 and 185, Laws of Utah 2005
31A-23a-504, as renumbered and amended by Chapter 298, Laws of Utah 2003
31A-25-202, as last amended by Chapter 90, Laws of Utah 2004
31A-26-202, as last amended by Chapter 252, Laws of Utah 2003
31A-26-301.6, as last amended by Chapter 308, Laws of Utah 2002
31A-27-331, as enacted by Chapter 242, Laws of Utah 1985
31A-30-103, as last amended by Chapters 2 and 90, Laws of Utah 2004
31A-30-107.3, as last amended by Chapter 329, Laws of Utah 2004
31A-30-107.5, as last amended by Chapter 188, Laws of Utah 2006
31A-30-112, as enacted by Chapter 321, Laws of Utah 1995
31A-35-201, as last amended by Chapter 131, Laws of Utah 1999
31A-36-102, as enacted by Chapter 81, Laws of Utah 2003
31A-36-104, as last amended by Chapter 106, Laws of Utah 2004
31A-36-105, as enacted by Chapter 81, Laws of Utah 2003
31A-36-106, as enacted by Chapter 81, Laws of Utah 2003
31A-36-107, as enacted by Chapter 81, Laws of Utah 2003
31A-36-108, as enacted by Chapter 81, Laws of Utah 2003
31A-36-109, as enacted by Chapter 81, Laws of Utah 2003
31A-36-110, as enacted by Chapter 81, Laws of Utah 2003
31A-36-111, as enacted by Chapter 81, Laws of Utah 2003
31A-36-112, as enacted by Chapter 81, Laws of Utah 2003
31A-36-113, as enacted by Chapter 81, Laws of Utah 2003
31A-36-117, as enacted by Chapter 81, Laws of Utah 2003
31A-36-119, as last amended by Chapter 106, Laws of Utah 2004
31A-37-502, as enacted by Chapter 251, Laws of Utah 2003
61-1-13, as last amended by Chapter 4, Laws of Utah 2006, Third Special Session

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) medical care expenses; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage; or

(D) loss of income coverage.

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

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection [~~(155)~~] (157).

(4) "Adult" means a natural person who has attained the age of at least 18 years.

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverages as originally offered; or

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

(B) decline to insure the risk; or

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

(11) "Articles" or "articles of incorporation" means the original articles, special laws, charters, amendments, restated articles, articles of merger or consolidation, trust instruments,

and other constitutive documents for trusts and other entities that are not corporations, and amendments to any of these.

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

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

(14) "Blanket insurance policy" means a group policy covering classes of persons without individual underwriting, where the persons insured are determined by definition of the class with or without designating the persons covered.

[~~(14)~~] (15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

[~~(15)~~] (16) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

[~~(16)~~] (17) "Business of insurance" is defined in Subsection [~~(82)~~] (84).

[~~(17)~~] (18) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections are applicable by reference under:

(a) Section 31A-7-201;

(b) Section 31A-8-205; or

(c) Subsection 31A-9-205(2).

[~~(18)~~] (19) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated and includes comparable rules for trusts and other entities that are not corporations.

[~~(19)~~] (20) "Captive insurance company" means:

(a) an insurance company:

(i) owned by another organization; and

(ii) whose exclusive purpose is to insure risks of the parent organization and affiliated companies; or

(b) in the case of groups and associations, an insurance organization:

(i) owned by the insureds; and

(ii) whose exclusive purpose is to insure risks of:

(A) member organizations;

(B) group members; and

(C) affiliates of:

(I) member organizations; or

(II) group members.

[~~(20)~~] (21) "Casualty insurance" means liability insurance as defined in Subsection [~~(94)~~] (96).

[~~(21)~~] (22) "Certificate" means evidence of insurance given to:

(a) an insured under a group insurance policy; or

(b) a third party.

[~~(22)~~] (23) "Certificate of authority" is included within the term "license."

[~~(23)~~] (24) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of benefits according to the terms of an insurance policy.

[~~(24)~~] (25) "Claims-made coverage" means an insurance contract or provision limiting coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

[~~(25)~~] (26) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection [~~(25)~~] (26)(a) apply to the equivalent supervisory official of another jurisdiction.

[~~(26)~~] (27) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following services:

(A) personal services;

(B) nursing services;

(C) medical services; or

(D) other health-related services; and

(iii) provides the coverage described in Subsection [~~(26)~~] (27)(a)(i) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as the services described in Subsection [~~(26)~~] (27)(a)(ii).

[~~(27)~~] (28) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections [~~(27)~~] (28)(a)(i) through (iii).

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

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

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

[~~(28)~~] (29) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

[~~(29)~~] (30) "Controlling person" means any person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

[~~(30)~~] (31) "Controlling producer" means a producer who directly or indirectly controls an insurer.

[~~(31)~~] (32) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a limited line producer;

(III) a consultant;

(IV) a managing general agent;

(V) a reinsurance intermediary;

(VI) a third party administrator; or

(VII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

(ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance Holding Companies.

(b) "Stock corporation" means a stock insurance corporation.

(c) "Mutual" or "mutual corporation" means a mutual insurance corporation.

[~~(32)~~] (33) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

[~~(33)~~] (34) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

[~~(34)~~] (35) (a) "Credit insurance" means insurance offered in connection with an

extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

[~~(35)~~] (36) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

[~~(36)~~] (37) "Credit property insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that protects the property until the debt is paid.

[~~(37)~~] (38) "Credit unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

[~~(38)~~] (39) "Creditor" means a person, including an insured, having any claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

[~~(39)~~] (40) (a) "Customer service representative" means a person that provides insurance services and insurance product information:

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

[~~(40)~~] (41) "Deadline" means the final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

[~~(41)~~] (42) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is deemed to have taken a specific action. If the statute so provides, the condition precedent may be the commissioner's failure to take a specific action.

[~~(42)~~] (43) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

[~~(43)~~] (44) "Department" means the Insurance Department.

[~~(44)~~] (45) "Director" means a member of the board of directors of a corporation.

[~~(45)~~] (46) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

[~~(46)~~] (47) "Disability income insurance" is defined in Subsection [~~(73)~~] (75).

[~~(47)~~] (48) "Domestic insurer" means an insurer organized under the laws of this state.

[~~(48)~~] (49) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

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

[~~(49)~~] (50) (a) "Eligible employee" means:

(i) an employee who:

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

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

(ii) a person described in Subsection [~~(49)~~] (50)(b).

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

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection [~~(49)~~] (50)(b):

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

(ii) an employer's spouse; or

(iii) a dependent of an employer.

[~~(50)~~] (51) "Employee" means any individual employed by an employer.

[~~(51)~~] (52) "Employee benefits" means one or more benefits or services provided to:

(a) employees; or

(b) dependents of employees.

[~~(52)~~] (53) (a) "Employee welfare fund" means a fund:

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

(A) one or more employers;

(B) one or more labor organizations; or

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

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund, by or on behalf of an employer doing business in this state or for the benefit of any person employed in this state.

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

[~~(53)~~] (54) "Endorsement" means a written agreement attached to a policy or certificate to modify one or more of the provisions of the policy or certificate.

[~~(54)~~] (55) "Enrollment date," with respect to a health benefit plan, means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

[~~(55)~~] (56) (a) "Escrow" means:

(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

[~~(56)~~] (57) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

(b) a person defined as an escrow agent in Section 7-22-101.

[~~(57)~~] (58) "Excludes" is not exhaustive and does not mean that other things are not also excluded. The items listed are representative examples for use in interpretation of this title.

[~~(58)~~] (59) "Expense reimbursement insurance" means insurance:

(a) written to provide payments for expenses relating to hospital confinements resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

[~~(59)~~] (60) "Fidelity insurance" means insurance guaranteeing the fidelity of persons holding positions of public or private trust.

[~~(60)~~] (61) (a) "Filed" means that a filing is:

(i) submitted to the department as required by and in accordance with any applicable statute, rule, or filing order;

(ii) received by the department within the time period provided in the applicable

statute, rule, or filing order; and

(iii) accompanied by the appropriate fee in accordance with:

(A) Section 31A-3-103; or

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(60)~~] (61)(a).

[~~(61)~~] (62) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application; or

(n) an advertisement.

[~~(62)~~] (63) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay claims submitted to it by the insured for the insured's losses.

[~~(63)~~] (64) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(64)~~] (65) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application; or

(iv) an outline of coverage.

(b) "Form" does not include a document specially prepared for use in an individual case.

[~~(65)~~] (66) "Franchise insurance" means individual insurance policies provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(66)~~] (67) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(67)~~] (68);

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

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

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

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

(iv) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

[~~(67)~~] (68) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(68)~~] (69) "Group health plan" means an employee welfare benefit plan to the extent

that the plan provides medical care:

(a) (i) to employees; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through any other method.

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

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

(ii) for the benefit of group members who are selected under procedures defined in:

(A) the policy; or

(B) agreements which are collateral to the policy.

(b) A group insurance policy may include members of the policyholder's family or dependents.

[~~(69)~~] (71) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(70)~~] (72) (a) Except as provided in Subsection [~~(70)~~] (72)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

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

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

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

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

(ii) is offered and marketed as supplemental health insurance.

[~~(71)~~] (73) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) professional services;

(b) personal services;

(c) facilities;

(d) equipment;

(e) devices;

(f) supplies; or

(g) medicine.

[~~(72)~~] (74) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) health care benefits; or

(ii) payment of incurred health care expenses.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing benefits for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) any type of accident and health insurance coverage that is a part of or attached to another type of policy.

[~~(73)~~] (75) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(74)~~] (76) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(75)~~] (77) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

[~~(76)~~] (78) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(77)~~] (79) "Individual" means a natural person.

[~~(78)~~] (80) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(79)~~] (81) "Insolvency" means that:

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

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

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

[~~(80)~~] (82) (a) "Insurance" means:

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

persons to one or more other persons; or

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

(b) "Insurance" includes:

(i) risk distributing arrangements providing for compensation or replacement for damages or loss through the provision of services or benefits in kind;

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

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

[~~(81)~~] (83) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(82)~~] (84) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection [~~(72)~~] (74), by organizations that are or should be licensed under this title;

(b) providing benefits to employees in the event of contingencies not within the control of the employees, in which the employees are entitled to the benefits as a right, which benefits may be provided either:

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

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

(c) providing annuities, including those issued in return for gifts, except those provided by persons specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of motor clubs as outlined in Subsection [~~(110)~~] (112);

(e) providing other persons with insurance as defined in Subsection [~~(80)~~] (82);

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(82)~~] (84)(a) through (g) in a manner designed to evade the provisions of this title.

[~~(83)~~] (85) "Insurance consultant" or "consultant" means a person who:

(a) advises other persons about insurance needs and coverages;

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

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

[~~(84)~~] (86) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(85)~~] (87) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) With regards to the selling, soliciting, or negotiating of an insurance product to an insurance customer or an insured:

(i) "producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating any product of that insurer; and

(ii) "producer for the insured" means a producer who:

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

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

[~~(86)~~] (88) (a) "Insured" means a person to whom or for whose benefit an insurer

makes a promise in an insurance policy and includes:

(i) policyholders;

(ii) subscribers;

(iii) members; and

(iv) beneficiaries.

(b) The definition in Subsection [~~(86)~~] (88)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in insurance policies or certificates.

[~~(87)~~] (89) (a) (i) "Insurer" means any person doing an insurance business as a principal including:

(A) fraternal benefit societies;

(B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and (3);

(C) motor clubs;

(D) employee welfare plans; and

(E) any person purporting or intending to do an insurance business as a principal on that person's own account.

(ii) "Insurer" does not include a governmental entity to the extent it is engaged in the activities described in Section 31A-12-107.

(b) "Admitted insurer" is defined in Subsection [~~(159)~~] (161)(b).

(c) "Alien insurer" is defined in Subsection (7).

(d) "Authorized insurer" is defined in Subsection [~~(159)~~] (161)(b).

(e) "Domestic insurer" is defined in Subsection [~~(47)~~] (48).

(f) "Foreign insurer" is defined in Subsection [~~(63)~~] (64).

(g) "Nonadmitted insurer" is defined in Subsection [~~(159)~~] (161)(a).

(h) "Unauthorized insurer" is defined in Subsection [~~(159)~~] (161)(a).

[~~(88)~~] (90) "Interinsurance exchange" is defined in Subsection [~~(139)~~] (141).

[~~(89)~~] (91) "Involuntary unemployment insurance" means insurance:

(a) offered in connection with an extension of credit;

(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

[~~(90)~~] (92) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and

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

[~~(91)~~] (93) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(92)~~] (94) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

(a) on the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(b) through special enrollment.

[~~(93)~~] (95) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for specified legal expenses.

(b) "Legal expense insurance" includes arrangements that create reasonable expectations of enforceable rights.

(c) "Legal expense insurance" does not include the provision of, or reimbursement for, legal services incidental to other insurance coverages.

[~~(94)~~] (96) (a) "Liability insurance" means insurance against liability:

(i) for death, injury, or disability of any human being, or for damage to property, exclusive of the coverages under:

(A) Subsection [~~(104)~~] (106) for medical malpractice insurance;

(B) Subsection [~~(131)~~] (133) for professional liability insurance; and

(C) Subsection [~~(164)~~] (166) for workers' compensation insurance;

(ii) for medical, hospital, surgical, and funeral benefits to persons other than the insured who are injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of human beings, exclusive of the coverages under:

(A) Subsection [~~(104)~~] (106) for medical malpractice insurance;

(B) Subsection [~~(131)~~] (133) for professional liability insurance; and

(C) Subsection [~~(164)~~] (166) for workers' compensation insurance;

(iii) for loss or damage to property resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus;

(iv) for loss or damage to any property caused by the breakage or leakage of sprinklers, water pipes and containers, or by water entering through leaks or openings in buildings; or

(v) for other loss or damage properly the subject of insurance not within any other kind or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection [~~(161)~~] (163);

(ii) residential dwelling liability insurance as defined in Subsection [~~(142)~~] (144); and

(iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers, machinery, and apparatus of any kind when done in connection with insurance on them.

[~~(95)~~] (97) (a) "License" means the authorization issued by the commissioner to engage in some activity that is part of or related to the insurance business.

(b) "License" includes certificates of authority issued to insurers.

[~~(96)~~] (98) (a) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting death benefits;

(ii) granting annuity benefits;

(iii) granting endowment benefits;

(iv) granting additional benefits in the event of death by accident;

(v) granting additional benefits to safeguard the policy against lapse; and

(vi) providing optional methods of settlement of proceeds.

[~~(97)~~] (99) "Limited license" means a license that:

(a) is issued for a specific product of insurance; and

(b) limits an individual or agency to transact only for that product or insurance.

[~~(98)~~] (100) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) any other form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

[~~(99)~~] (101) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

[~~(100)~~] (102) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance; and

(g) any other form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

[~~(101)~~] (103) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection [~~(100)~~] (102); and

(b) a customer service representative.

[~~(102)~~] (104) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(103)~~] (105) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(103)~~] (105)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(104)~~] (106) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of medical services other than the practice and provision of dental services.

[~~(105)~~] (107) "Member" means a person having membership rights in an insurance corporation.

[~~(106)~~] (108) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(107)~~] (109) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

[~~(108)~~] (110) "Mortgage guaranty insurance" means surety insurance under which mortgagees and other creditors are indemnified against losses caused by the default of debtors.

[~~(109)~~] (111) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(110)~~] (112) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(110)~~] (112)(b)(iii)(A) through (D); or

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

[~~(111)~~] (113) "Mutual" means a mutual insurance corporation.

[~~(112)~~] (114) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

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

[~~(113)~~] (115) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive dividends representing shares of the surplus of the insurer.

[~~(114)~~] (116) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors,

owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

[~~(115)~~] (117) "Order" means an order of the commissioner.

[~~(116)~~] (118) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(117)~~] (119) "Participating" means a plan of insurance under which the insured is entitled to receive dividends representing shares of the surplus of the insurer.

[~~(118)~~] (120) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee has other group health care insurance coverage.

[~~(119)~~] (121) "Person" includes an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, trust, limited liability company, reciprocal, syndicate, or any similar entity or combination of entities acting in concert.

[~~(120)~~] (122) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) individuals; and

(b) families.

[~~(121)~~] (123) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(122)~~] (124) "Plan year" means:

(a) the year that is designated as the plan year in:

(i) the plan document of a group health plan; or

(ii) a summary plan description of a group health plan;

(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:

(i) the year used to determine deductibles or limits;

(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;

or

(iii) the employer's taxable year if:

(A) the plan does not impose deductibles or limits on a yearly basis; and

(B) (I) the plan is not insured; or

(II) the insurance policy is not renewed on an annual basis; or

(c) in a case not described in Subsection [~~(122)~~] (124)(a) or (b), the calendar year.

[~~(123)~~] (125) (a) [~~(i)~~] "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

[~~(ii)~~] (b) "Policy" includes a service contract issued by:

[~~(A)~~] (i) a motor club under Chapter 11, Motor Clubs;

[~~(B)~~] (ii) a service contract provided under Chapter 6a, Service Contracts; and

[~~(C)~~] (iii) a corporation licensed under:

[~~(I)~~] (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or

[~~(II)~~] (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

[~~(iii)~~] (c) "Policy" does not include:

[~~(A)~~] (i) a certificate under a group insurance contract; or

[~~(B)~~] (ii) a document that does not purport to have legal effect.

[~~(b) (i) "Group insurance policy" means a policy covering a group of persons that is issued:~~]

[~~(A) to a policyholder on behalf of the group; and~~]

[~~(B) for the benefit of group members who are selected under procedures defined in:~~]

[~~(I) the policy; or~~]

[~~(II) agreements which are collateral to the policy.~~]

[~~(ii) A group insurance policy may include members of the policyholder's family or dependents.~~]

[~~(c) "Blanket insurance policy" means a group policy covering classes of persons without individual underwriting, where the persons insured are determined by definition of the~~

~~class with or without designating the persons covered.~~]

[~~(124)~~] (126) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(125)~~] (127) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(126)~~] (128) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(127)~~] (129) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; and

(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.

[~~(128)~~] (130) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) assessments;

(ii) membership fees;

(iii) required contributions; or

(iv) monetary consideration.

(c) (i) Consideration paid to third party administrators for their services is not "premium."

(ii) Amounts paid by third party administrators to insurers for insurance on the risks administered by the third party administrators are "premium."

[~~(129)~~] (131) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(130)~~] (132) "Proceedings" includes actions and special statutory proceedings.

[~~(131)~~] (133) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of any professional services.

[~~(132)~~] (134) (a) Except as provided in Subsection [~~(132)~~] (134)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance as defined in Subsection [~~(78)~~] (80); and

(ii) ocean marine insurance as defined under Subsection [~~(114)~~] (116).

[~~(133)~~] (135) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or

(b) the portion of a life insurance contract that provides long-term care insurance:

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(134)~~] (136) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

(b) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

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

(i) the commissioner by rule; or

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

[~~(135)~~] (137) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(136)~~] (138) (a) Except as provided in Subsection [~~(136)~~] (138)(b), "rate service organization" means any person who assists insurers in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

(iv) a natural person serving as an actuarial or legal consultant.

[~~(137)~~] (139) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) classifications;

(c) rate-related underwriting rules; and

(d) rating formulas that describe steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(138)~~] (140) "Received by the department" means:

(a) except as provided in Subsection [~~(138)~~] (140)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person; or

(ii) electronically; and

(b) if delivered to the department by a delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:

(i) statute;

(ii) rule; or

(iii) a specific filing order.

[~~(139)~~] (141) "Reciprocal" or "interinsurance exchange" means any unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of them; and

(b) exchanging insurance contracts with one another that provide insurance coverage on each other.

[~~(140)~~] (142) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

(a) the insurer transferring the risk as the "ceding insurer"; and

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(141)~~] (143) "Reinsurer" means any person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(142)~~] (144) "Residential dwelling liability insurance" means insurance against

liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(143)~~] (145) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part of a liability assumed under a reinsurance contract.

[~~(144)~~] (146) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(145)~~] (147) (a) "Security" means any:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in any profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(145)~~] (147)(a)(i) through (xiv); or

(xvi) other interest or instrument commonly known as a security.

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) endowment policy; or

(C) annuity contract; or

(ii) a burial certificate or burial contract.

[~~(146)~~] (148) "Self-insurance" means any arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection [~~(146)~~] (148), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(b) "Self-insurance" includes:

(i) an arrangement by which a governmental entity undertakes to indemnify its employees for liability arising out of the employees' employment; and

(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk which is related to the relationship or employment.

(c) "Self-insurance" does not include any arrangement with independent contractors.

[~~(147)~~] (149) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(148)~~] (150) "Short-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance but that provides coverage for less than 12 consecutive months for each covered person.

[~~(149)~~] (151) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have any creditable coverage.

[~~(150)~~] (152) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(151)~~] (153) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

[~~(152)~~] (154) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(153)~~] (155) Subject to Subsection [~~(80)~~] (82)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from failure of principals to pay or perform their obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(154)~~] (156) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated by the insurer as permanent.

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

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

(c) "Excess surplus" means:

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

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(157)~~] (159), that exceeds the product of:

(I) 2.5; and

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

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(157)~~] (159), that exceeds the product of:

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(155)~~] (157) "Third party administrator" or "administrator" means any person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering any:

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

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

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

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

(d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance for which the insurer holds a license in this state; or

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

[~~(156)~~] (158) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners of real or personal property or the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(157)~~] (159) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(158)~~] (160) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(159)~~] (161) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(160)~~] (162) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(161)~~] (163) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(132)~~] (134).

[~~(162)~~] (164) "Voting security" means a security with voting rights, and includes any security convertible into a security with a voting right associated with the security.

[~~(163)~~] (165) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(164)~~] (166) "Workers' compensation insurance" means:

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

(i) compensable accidental injuries; and

(ii) occupational disease disability;

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

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

Section 2. Section **31A-2-205** is amended to read:

31A-2-205. Examination costs.

(1) (a) Except as provided in Subsection (3), an examinee that is [~~an insurer, rate~~

~~service organization, or the subsidiary of either~~] one of the following shall reimburse the department for the reasonable costs of examinations made under Sections 31A-2-203 and 31A-2-204[~~.~~]:

(i) an insurer;

(ii) a rate service organization;

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

(iv) a viatical settlement provider.

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

(i) actual travel expenses;

(ii) reasonable living expense allowance;

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

(iv) the administration and supervisory expense of:

(A) the department; and

(B) the attorney general's office; and

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

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

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

(2) An insurer requesting the examination of one of its producers shall pay the cost of the examination. Otherwise, the department shall pay the cost of examining a licensee other than those specified under Subsection (1).

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

imposition of the costs would place an unreasonable burden on the examinee.

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

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

(b) The examined insurer shall, at the commissioner's direction, pay to [~~the~~] a technical [~~experts or specialists the~~] expert:

(i) (A) actual travel expenses;

[~~(ii)~~] (B) reasonable living expenses; and

[~~(iii)~~] (C) compensation [~~at customary rates~~]; and

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

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

(i) a department [~~examiners for their~~] examiner's:

(A) actual travel expenses; and

(B) reasonable living expenses; and

(ii) [~~the department for~~] the compensation of department examiners involved in the examination.

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

(ii) The examined insurer shall:

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

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

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

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

appropriation.

(5) (a) The amount payable under Subsection (1) is due ten days after the day on which the examinee [~~has been~~] is served with a detailed account of the costs.

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

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

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

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

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

Section 3. Section **31A-5-416** is amended to read:

31A-5-416. Compensation of director, officer, employee, person with investment authority, or others.

(1) Subject to this section, [~~Section 16-10a-302, except Subsection 16-10a-302(13), applies to stock and mutual corporations.~~] Subsections 16-10a-302(11) and (12) apply to:

(a) a stock corporation; and

(b) a mutual corporation.

(2) Shareholders' approval is required:

(a) of any benefit or payment to a director or officer for services rendered to a stock corporation more than 90 days before the agreement or decision to give the benefit or make the payment, unless the benefit or payment is made under a plan approved by the shareholders[~~. Shareholder approval is also required~~]; and

(b) for a new pension plan, profit-sharing plan, stock option plan, or an amendment to an existing plan which, so far as it pertains to any director or officer, substantially increases the

financial burden on the stock corporation.

(3) An action taken by the board of a mutual on the compensation of officers, directors, or employees, other than setting individual salaries or standards for salaries of classes of employees, shall be reported to the commissioner within 30 days.

(4) The annual [~~report to the commissioner~~] statement of a stock or mutual corporation shall include the amount of all direct and indirect remuneration for services, including retirement and other deferred compensation benefits and stock options[~~,~~] paid [~~or accrued~~] each year:

(a) for the benefit of each [~~director, each officer, and employee~~] of the following whose remuneration exceeds an amount established by the commissioner by rule[~~,~~]:

(i) a director;

(ii) an officer; or

(iii) an employee;

(b) for all directors and officers as a group; and

(c) (i) for the five most highly compensated officers[~~,~~];

(ii) for the five most highly compensated directors[~~,~~]; and

(iii) for the five most highly compensated employees.

(5) [~~No~~] An arrangement for compensation or other employment benefits for any director, officer, or employee with decision-making power may not be made if it would:

(a) measure the compensation or other benefits in whole or in part by any criteria that would create a financial inducement to act contrary to the best interests of the stock or mutual corporation; or

(b) have a tendency to make the stock or mutual corporation depend for continuance or soundness of operation upon the continuation of any director, officer, or employee in [~~his~~] the position of director, officer, or employee.

(6) Except for the insurer, [~~no~~] a person having any authority in the investment or disposition of the funds of a domestic insurer may not:

(a) accept any fee, brokerage, gift, or other emolument because of any investment,

loan, deposit, purchase, sale, payment, or exchange made by or for the insurer[~~, nor may that person~~]; or

(b) be financially interested in the investment or disposition of funds in any capacity.

(7) Unless the commissioner, acting in the corporation's best interests, orders otherwise, if an order of rehabilitation or liquidation is issued under Section 31A-27-303 or Section 31A-27-310, the contractual obligations of the insurer for unperformed services of any director, principal officer, or person performing similar functions or having similar powers are terminated. This Subsection (7) does not apply to obligations vested before July 1, 1986.

Section 4. Section **31A-21-104** is amended to read:

31A-21-104. Insurable interest and consent.

(1) (a) An insurer may not knowingly provide insurance to a person who does not have or expect to have an insurable interest in the subject of the insurance.

(b) A person may not knowingly procure, directly, by assignment, or otherwise, an interest in the proceeds of an insurance policy unless that person has or expects to have an insurable interest in the subject of the insurance.

(c) Except as provided in Subsections (6), (7), and (8), any insurance provided in violation of this Subsection (1) is subject to Subsection (5).

(2) As used in this chapter:

(a) (i) "Insurable interest" in a person means:

(A) for persons closely related by blood or by law, a substantial interest engendered by love and affection; or

(B) in the case of other persons, a lawful and substantial interest in having the life, health, and bodily safety of the person insured continue.

(ii) Policyholders in group insurance contracts do not need an insurable interest if certificate holders or persons other than group policyholders who are specified by the certificate holders are the recipients of the proceeds of the policies.

(iii) Each person has an unlimited insurable interest in the person's own life and health.

(iv) A shareholder or partner has an insurable interest in the life of other shareholders

or partners for purposes of insurance contracts that are an integral part of a legitimate buy-sell agreement respecting shares or a partnership interest in the business.

(v) Subject to Subsection (9), an employer or an employer sponsored trust for the benefit of the employer's employees:

(A) has an insurable interest in the lives of the employer's:

(I) directors;

(II) officers;

(III) managers;

(IV) nonmanagement employees; and

(V) retired employees; and

(B) may insure the lives listed in Subsection (2)(a)(v)(A):

(I) on an individual or group basis; and

(II) with the written consent of the insured.

(b) "Insurable interest" in property or liability means any lawful and substantial economic interest in the nonoccurrence of the event insured against.

(c) "Viatical settlement" is as defined in Section 31A-36-102.

(3) (a) Except as provided in Subsection (4), an insurer may not knowingly issue an individual life or accident and health insurance policy to a person other than the one whose life or health is at risk unless that person, who is 18 years of age or older and not under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, has given written consent to the issuance of the policy.

(b) A person shall express consent:

(i) by signing an application for the insurance with knowledge of the nature of the document; or

(ii) in any other reasonable way.

(c) Any insurance provided in violation of this Subsection (3) is subject to Subsection (5).

(4) (a) A life or accident and health insurance policy may be taken out without consent

in a circumstance described in this Subsection (4)(a).

(i) A person may obtain insurance on a dependent who does not have legal capacity.

(ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount reasonably related to the amount of the debt.

(iii) A person may obtain life and accident and health insurance on an immediate family member who is living with or dependent on the person.

(iv) A person may obtain an accident and health insurance policy on others that would merely indemnify the policyholder against expenses the person would be legally or morally obligated to pay.

(v) The commissioner may adopt rules permitting issuance of insurance for a limited term on the life or health of a person serving outside the continental United States who is in the public service of the United States, if the policyholder is related within the second degree by blood or by marriage to the person whose life or health is insured.

(b) Consent may be given by another in a circumstance described in this Subsection (4)(b).

(i) A parent, a person having legal custody of a minor, or a guardian of a person under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent to the issuance of a policy on a dependent child or on a person under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property.

(ii) A grandparent may consent to the issuance of life or accident and health insurance on a grandchild.

(iii) A court of general jurisdiction may give consent to the issuance of a life or accident and health insurance policy on an ex parte application showing facts the court considers sufficient to justify the issuance of that insurance.

(5) (a) An insurance policy is not invalid because the policyholder lacks insurable interest or because consent has not been given.

(b) Notwithstanding Subsection (5)(a), a court with appropriate jurisdiction may:

(i) order the proceeds to be paid to some person who is equitably entitled to the

proceeds, other than the one to whom the policy is designated to be payable; or

(ii) create a constructive trust in the proceeds or a part of the proceeds on behalf of such a person, subject to all the valid terms and conditions of the policy other than those relating to insurable interest or consent.

(6) This section does not prevent any organization described under 26 U.S.C. Sec. 501(c)(3), (e), or (f), as amended, and the regulations made under this section, and which is regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring, by assignment or designation as beneficiary, a gift or assignment of an interest in life insurance on the life of the donor or assignor or from enforcing payment of proceeds from that interest.

(7) An insurance policy transferred pursuant to Chapter 36, Viatical Settlements Act, is not subject to Subsection (5)(b) and nothing else in this section shall prevent:

(a) any policyholder of life insurance, whether or not the policyholder is also the subject of the insurance, from entering into a viatical settlement;

(b) any person from soliciting a person to enter into a viatical settlement;

(c) a person from enforcing payment of proceeds from the interest obtained under a viatical settlement; or

(d) a viatical settlement provider [~~of viatical settlements~~], a viatical settlement purchaser [~~of a viatical settlement~~], a financing entity, a related provider trust, or a special purpose entity from executing any of the following with respect to the death benefit or ownership of any portion of a viaticated policy as provided for in Section 31A-36-109:

(i) an assignment;

(ii) a sale;

(iii) a transfer;

(iv) a devise; or

(v) a bequest.

(8) Notwithstanding Subsection (1), an insurer authorized under this title to issue a workers' compensation policy may issue a workers' compensation policy to a sole

proprietorship, corporation, or partnership that elects not to include any owner, corporate officer, or partner as an employee under the policy even if at the time the policy is issued the sole proprietorship, corporation, or partnership has no employees.

(9) The extent of an employer's or employer sponsored trust's insurable interest for a nonmanagement and retired employee under Subsection (2)(a)(v) is limited to an amount commensurate with the employer's unfunded liabilities.

Section 5. Section **31A-21-503** is amended to read:

31A-21-503. Discrimination based on domestic violence or child abuse prohibited.

(1) Except as provided in Subsection (2), an insurer of life or accident and health insurance may not consider whether an insured or applicant is the subject of domestic abuse as a factor to:

(a) refuse to insure the applicant;

(b) refuse to continue to insure the insured;

(c) refuse to renew or reissue a policy to insure the insured or applicant;

(d) limit the amount, extent, or kind of coverage available to the insured or applicant;

(e) charge a different rate for coverage to the insured or applicant;

(f) exclude or limit benefits or coverage under an insurance policy or contract for losses incurred;

(g) deny a claim; or

(h) terminate coverage or fail to provide conversion privileges in violation of Sections 31A-22-612 and [~~31A-22-710~~] 31A-22-723 under a group accident and health policy for the insured because the coverage was issued in the name of the perpetrator of the domestic violence or abuse.

(2) (a) Notwithstanding Subsection (1), an insurer may underwrite [~~based~~] on the basis of the physical or mental condition of an insured or applicant if the underwriting is [~~based~~] on the basis of a determination that there is a correlation between the medical or mental condition and a material increase in insurance risk.

(b) For purposes of Subsection (2)(a), the fact that an insured or applicant is a subject of domestic abuse is not a mental or physical condition.

(c) The determination required by Subsection (2)(a) shall be made in conformance with sound actuarial principles.

(d) Within 30 days after receiving an oral or written request from an insured or applicant, an insurer shall disclose in writing:

(i) the basis of an action permitted under Subsection (2)(a); and

(ii) if the policy has been issued or modified, the extent the action taken will impact the amount, extent, or kind of coverage or benefits available to the insured.

Section 6. Section **31A-22-305** is amended to read:

31A-22-305. Uninsured motorist coverage.

(1) As used in this section, "covered persons" includes:

(a) the named insured;

(b) persons related to the named insured by blood, marriage, adoption, or guardianship, who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere;

(c) any person occupying or using a motor vehicle:

(i) referred to in the policy; or

(ii) owned by a self-insured; and

(d) any person who is entitled to recover damages against the owner or operator of the uninsured or underinsured motor vehicle because of bodily injury to or death of persons under Subsection (1)(a), (b), or (c).

(2) As used in this section, "uninsured motor vehicle" includes:

(a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered under a liability policy at the time of an injury-causing occurrence; or

(ii) (A) a motor vehicle covered with lower liability limits than required by Section 31A-22-304; and

(B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of

the deficiency;

(b) an unidentified motor vehicle that left the scene of an accident proximately caused by the motor vehicle operator;

(c) a motor vehicle covered by a liability policy, but coverage for an accident is disputed by the liability insurer for more than 60 days or continues to be disputed for more than 60 days; or

(d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction; and

(ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent that the claim against the insolvent insurer is not paid by a guaranty association or fund.

(3) (a) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides coverage for covered persons who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

(b) For new policies written on or after January 1, 2001, the limits of uninsured motorist coverage shall be equal to the lesser of the limits of the insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the insured's motor vehicle policy, unless the insured purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer [~~that:~~];

[~~(i)~~] (iii) waives the higher coverage;

[~~(ii)~~] (iv) reasonably explains the purpose of uninsured motorist coverage; and

[~~(iii)~~] (v) discloses the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the insured's motor vehicle policy.

(c) A self-insured, including a governmental entity, may elect to provide uninsured motorist coverage in an amount that is less than its maximum self-insured retention under

Subsections (3)(b) and (4)(a) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an uninsured motorist claim.

(d) Uninsured motorist coverage may not be sold with limits that are less than the minimum bodily injury limits for motor vehicle liability policies under Section 31A-22-304.

(e) The acknowledgment under Subsection (3)(b) continues for that issuer of the uninsured motorist coverage until the insured, in writing, requests different uninsured motorist coverage from the insurer.

(f) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of uninsured motorist coverage; and

(B) the costs associated with increasing the coverage in amounts up to and including the maximum amount available by the insurer under the insured's motor vehicle policy.

(ii) The disclosure required under this Subsection (3)(f) shall be sent to all insureds that carry uninsured motorist coverage limits in an amount less than the insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage limits available by the insurer under the insured's motor vehicle policy.

(4) (a) (i) Except as provided in Subsection (4)(b), the named insured may reject uninsured motorist coverage by an express writing to the insurer that provides liability coverage under Subsection 31A-22-302(1)(a).

(ii) This rejection shall be on a form provided by the insurer that includes a reasonable explanation of the purpose of uninsured motorist coverage.

(iii) This rejection continues for that issuer of the liability coverage until the insured in writing requests uninsured motorist coverage from that liability insurer.

(b) (i) All persons, including governmental entities, that are engaged in the business of, or that accept payment for, transporting natural persons by motor vehicle, and all school

districts that provide transportation services for their students, shall provide coverage for all motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance, uninsured motorist coverage of at least $25,000 per person and $500,000 per accident.

(ii) This coverage is secondary to any other insurance covering an injured covered person.

(c) Uninsured motorist coverage:

(i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers' Compensation Act;

(ii) may not be subrogated by the workers' compensation insurance carrier;

(iii) may not be reduced by any benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person has been made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (4)(c)(v), may be recovered:

(A) for a person under 18 years of age who is injured within the scope of Subsection (4)(c)(v) but limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(d) As used in this Subsection (4), "motor vehicle" has the same meaning as under Section 41-1a-102.

(5) When a covered person alleges that an uninsured motor vehicle under Subsection (2)(b) proximately caused an accident without touching the covered person or the motor vehicle occupied by the covered person, the covered person must show the existence of the uninsured motor vehicle by clear and convincing evidence consisting of more than the covered

person's testimony.

(6) (a) The limit of liability for uninsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(b) (i) Subsection (6)(a) applies to all persons except a covered person as defined under Subsection (7)(b)(ii).

(ii) A covered person as defined under Subsection (7)(b)(ii) is entitled to the highest limits of uninsured motorist coverage afforded for any one motor vehicle that the covered person is the named insured or an insured family member.

(iii) This coverage shall be in addition to the coverage on the motor vehicle the covered person is occupying.

(iv) Neither the primary nor the secondary coverage may be set off against the other.

(c) Coverage on a motor vehicle occupied at the time of an accident shall be primary coverage, and the coverage elected by a person described under Subsections (1)(a) and (b) shall be secondary coverage.

(7) (a) Uninsured motorist coverage under this section applies to bodily injury, sickness, disease, or death of covered persons while occupying or using a motor vehicle only if the motor vehicle is described in the policy under which a claim is made, or if the motor vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy. Except as provided in Subsection (6) or this Subsection (7), a covered person injured in a motor vehicle described in a policy that includes uninsured motorist benefits may not elect to collect uninsured motorist coverage benefits from any other motor vehicle insurance policy under which the person is a covered person.

(b) Each of the following persons may also recover uninsured motorist benefits under any one other policy in which they are described as a "covered person" as defined in Subsection (1):

(i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

(ii) except as provided in Subsection (7)(c), a covered person injured while occupying

or using a motor vehicle that is not owned, leased, or furnished:

(A) to the covered person;

(B) to the covered person's spouse; or

(C) to the covered person's resident parent or resident sibling.

(c) (i) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(A) a dependent minor of parents who reside in separate households; and

(B) injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(I) to the covered person;

(II) to the covered person's resident parent; or

(III) to the covered person's resident sibling.

(ii) Each parent's policy under this Subsection (7)(c) is liable only for the percentage of the damages that the limit of liability of each parent's policy of uninsured motorist coverage bears to the total of both parents' uninsured coverage applicable to the accident.

(d) A covered person's recovery under any available policies may not exceed the full amount of damages.

(e) A covered person in Subsection (7)(b) is not barred against making subsequent elections if recovery is unavailable under previous elections.

(f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(ii) Except to the extent permitted by Subsection (6) and this Subsection (7), interpolicy stacking is prohibited for uninsured motorist coverage.

(8) (a) When a claim is brought by a named insured or a person described in Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which uninsured benefits are claimed, the election provided in Subsection (8)(a) is available to the claimant only.

(c) Once the claimant has elected to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the uninsured motorist carrier.

(d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (8)(d)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (8)(d)(ii), the parties shall select a panel of three arbitrators.

(e) If the parties select a panel of three arbitrators under Subsection (8)(d)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (8)(e)(i) shall select one additional arbitrator to be included in the panel.

(f) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(d)(i); or

(ii) if an arbitration panel is selected under Subsection (8)(d)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(e)(ii).

(g) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78, Chapter 31a, Utah Uniform Arbitration Act.

(h) The arbitration shall be conducted in accordance with Rules 26 through 37, 54, and 68 of the Utah Rules of Civil Procedure.

(i) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

(j) A written decision by a single arbitrator or by a majority of the arbitration panel

shall constitute a final decision.

(k) (i) The amount of an arbitration award may not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies, including applicable uninsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all applicable uninsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined uninsured motorist policy limits of all applicable uninsured motorist policies.

(l) The arbitrator or arbitration panel may not decide the issues of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) any allegations or claims asserting consequential damages or bad faith liability.

(m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(n) If the arbitrator or arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(o) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (8)(l) between the parties unless:

(i) the award was procured by corruption, fraud, or other undue means; or

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (8)(o)(ii)(A).

(p) (i) Upon filing a complaint for a trial de novo under Subsection (8)(o), the claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (8)(o)(ii)(A).

(q) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (8)(o), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested under Subsection (8)(o), does not obtain a verdict that is at least 20% less than the arbitration award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (8)(q)(iv), the costs under this Subsection (8)(q) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (8)(q) may not exceed $2,500.

(r) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (8)(q), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(s) If a district court determines, upon a motion of the nonmoving party, that the moving party's use of the trial de novo process was filed in bad faith in accordance with Section 78-27-56, the district court may award reasonable attorney fees to the nonmoving party.

(t) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(u) If there are multiple uninsured motorist policies, as set forth in Subsection (7), the claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist carriers.

Section 7. Section **31A-22-305.3** is amended to read:

31A-22-305.3. Underinsured motorist coverage.

(1) As used in this section:

(a) "Covered person" has the same meaning as defined in Section 31A-22-305.

(b) (i) "Underinsured motor vehicle" includes a motor vehicle, the operation, maintenance, or use of which is covered under a liability policy at the time of an injury-causing occurrence, but which has insufficient liability coverage to compensate fully the injured party for all special and general damages.

(ii) The term "underinsured motor vehicle" does not include:

(A) a motor vehicle that is covered under the liability coverage of the same policy that also contains the underinsured motorist coverage;

(B) an uninsured motor vehicle as defined in Subsection 31A-22-305(2); or

(C) a motor vehicle owned or leased by:

(I) the named insured;

(II) the named insured's spouse; or

(III) any dependent of the named insured.

(2) (a) (i) Underinsured motorist coverage under Subsection 31A-22-302(1)(c) provides coverage for covered persons who are legally entitled to recover damages from owners or operators of underinsured motor vehicles because of bodily injury, sickness, disease, or death.

(ii) A covered person occupying or using a motor vehicle owned, leased, or furnished to the covered person, the covered person's spouse, or covered person's resident relative may recover underinsured benefits only if the motor vehicle is:

(A) described in the policy under which a claim is made; or

(B) a newly acquired or replacement motor vehicle covered under the terms of the policy.

(b) For new policies written on or after January 1, 2001, the limits of underinsured motorist coverage shall be equal to the lesser of the limits of the insured's motor vehicle

liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the insured's motor vehicle policy, unless the insured purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer [~~that:~~];

[~~(i)~~] (iii) waives the higher coverage;

[~~(ii)~~] (iv) reasonably explains the purpose of underinsured motorist coverage; and

[~~(iii)~~] (v) discloses the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the insured's motor vehicle policy.

(c) A self-insured, including a governmental entity, may elect to provide underinsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (2)(b) and (2)(g) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an underinsured motorist claim.

(d) Underinsured motorist coverage may not be sold with limits that are less than:

(i) $10,000 for one person in any one accident; and

(ii) at least $20,000 for two or more persons in any one accident.

(e) The acknowledgment under Subsection (2)(b) continues for that issuer of the underinsured motorist coverage until the insured, in writing, requests different underinsured motorist coverage from the insurer.

(f) (i) The named insured's underinsured motorist coverage, as described in Subsection (2)(a), is secondary to the liability coverage of an owner or operator of an underinsured motor vehicle, as described in Subsection (1).

(ii) Underinsured motorist coverage may not be set off against the liability coverage of the owner or operator of an underinsured motor vehicle, but shall be added to, combined with,

or stacked upon the liability coverage of the owner or operator of the underinsured motor vehicle to determine the limit of coverage available to the injured person.

(g) (i) A named insured may reject underinsured motorist coverage by an express writing to the insurer that provides liability coverage under Subsection 31A-22-302(1)(a).

(ii) This written rejection shall be on a form provided by the insurer that includes a reasonable explanation of the purpose of underinsured motorist coverage and when it would be applicable.

(iii) This rejection continues for that issuer of the liability coverage until the insured in writing requests underinsured motorist coverage from that liability insurer.

(h) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of underinsured motorist coverage; and

(B) the costs associated with increasing the coverage in amounts up to and including the maximum amount available by the insurer under the insured's motor vehicle policy.

(ii) The disclosure required by this Subsection (2)(h) shall be sent to all insureds that carry underinsured motorist coverage limits in an amount less than the insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage limits available by the insurer under the insured's motor vehicle policy.

(3) (a) (i) Except as provided in this Subsection (3), a covered person injured in a motor vehicle described in a policy that includes underinsured motorist benefits may not elect to collect underinsured motorist coverage benefits from any other motor vehicle insurance policy.

(ii) The limit of liability for underinsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(iii) Subsection (3)(a)(ii) applies to all persons except a covered person described under Subsections (3)(b)(i) and (ii).

(b) (i) Except as provided in Subsection (3)(b)(ii), a covered person injured while occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's spouse, or the covered person's resident parent or resident sibling, may also recover benefits under any one other policy under which they are a covered person.

(ii) (A) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(I) a dependent minor of parents who reside in separate households; and

(II) injured while occupying or using a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's resident parent, or the covered person's resident sibling.

(B) Each parent's policy under this Subsection (3)(b)(ii) is liable only for the percentage of the damages that the limit of liability of each parent's policy of underinsured motorist coverage bears to the total of both parents' underinsured coverage applicable to the accident.

(iii) A covered person's recovery under any available policies may not exceed the full amount of damages.

(iv) Underinsured coverage on a motor vehicle occupied at the time of an accident shall be primary coverage, and the coverage elected by a person described under Subsections 31A-22-305(1)(a) and (b) shall be secondary coverage.

(v) The primary and the secondary coverage may not be set off against the other.

(vi) A covered person as described under Subsection (3)(b)(i) is entitled to the highest limits of underinsured motorist coverage under only one additional policy per household applicable to that covered person as a named insured, spouse, or relative.

(vii) A covered injured person is not barred against making subsequent elections if recovery is unavailable under previous elections.

(viii) (A) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(B) Except to the extent permitted by this Subsection (3), interpolicy stacking is prohibited for underinsured motorist coverage.

(c) Underinsured motorist coverage:

(i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers' Compensation Act;

(ii) may not be subrogated by the workers' compensation insurance carrier;

(iii) may not be reduced by any benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person has been made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (3)(c)(v), may be recovered:

(A) for a person under 18 years of age who is injured within the scope of Subsection (3)(c)(v) but limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(4) The inception of the loss under Subsection 31A-21-313(1) for underinsured motorist claims occurs upon the date of the last liability policy payment.

(5) (a) Within five business days after notification in a manner specified by the department that all liability insurers have tendered their liability policy limits, the underinsured carrier shall either:

(i) waive any subrogation claim the underinsured carrier may have against the person liable for the injuries caused in the accident; or

(ii) pay the insured an amount equal to the policy limits tendered by the liability carrier.

(b) If neither option is exercised under Subsection (5)(a), the subrogation claim is

considered to be waived by the underinsured carrier.

(6) Except as otherwise provided in this section, a covered person may seek, subject to the terms and conditions of the policy, additional coverage under any policy:

(a) that provides coverage for damages resulting from motor vehicle accidents; and

(b) that is not required to conform to Section 31A-22-302.

(7) (a) When a claim is brought by a named insured or a person described in Subsection 31A-22-305(1) and is asserted against the covered person's underinsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which underinsured benefits are claimed, the election provided in Subsection (7)(a) is available to the claimant only.

(c) Once the claimant has elected to commence litigation under Subsection (7)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the underinsured motorist coverage carrier.

(d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (7)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (7)(d)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (7)(d)(ii), the parties shall select a panel of three arbitrators.

(e) If the parties select a panel of three arbitrators under Subsection (7)(d)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (7)(e)(i) shall select one additional arbitrator to be included in the panel.

(f) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (7)(d)(i); or

(ii) if an arbitration panel is selected under Subsection (7)(d)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (7)(e)(ii).

(g) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78, Chapter 31a, Utah Uniform Arbitration Act.

(h) The arbitration shall be conducted in accordance with Rules 26 through 37, 54, and 68 of the Utah Rules of Civil Procedure.

(i) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

(j) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(k) (i) The amount of an arbitration award may not exceed the underinsured motorist policy limits of all applicable underinsured motorist policies, including applicable underinsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the underinsured motorist policy limits of all applicable underinsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined underinsured motorist policy limits of all applicable underinsured motorist policies.

(l) The arbitrator or arbitration panel may not decide the issues of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) any allegations or claims asserting consequential damages or bad faith liability.

(m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(n) If the arbitrator or arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(o) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (7)(l) between the parties unless:

(i) the award was procured by corruption, fraud, or other undue means; or

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (7)(o)(ii)(A).

(p) (i) Upon filing a complaint for a trial de novo under Subsection (7)(o), the claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (7)(o)(ii)(A).

(q) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (7)(o), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested under Subsection (7)(o), does not obtain a verdict that is at least 20% less than the arbitration award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (7)(q)(iv), the costs under this Subsection (7)(q) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (7)(q) may not exceed $2,500.

(r) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (7)(q), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil

Procedure.

(s) If a district court determines, upon a motion of the nonmoving party, that the moving party's use of the trial de novo process was filed in bad faith in accordance with Section 78-27-56, the district court may award reasonable attorney fees to the nonmoving party.

(t) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(u) If there are multiple underinsured motorist policies, as set forth in Subsection (3), the claimant may elect to arbitrate in one hearing the claims against all the underinsured motorist carriers.

Section 8. Section **31A-22-423** is amended to read:

31A-22-423. Policy and annuity examination period.

(1) (a) Except as provided under Subsection (2), [~~all~~] a life insurance [~~policies~~] policy, life insurance [~~certificates, annuities, and annuities certificates~~] certificate, annuity contract, or annuity certificate shall contain a notice prominently printed on or attached to the cover or front page of the policy, contract, or certificate stating that the policyholder, contract holder, or certificate holder has the right to return the policy, contract, or certificate for any reason on or before:

(i) ten days after [~~delivery~~] the day on which the policy, contract, or certificate is delivered; or

(ii) in case of a replacement policy, contract, or certificate, [~~20~~] 30 days after the day on which the replacement policy, contract, or certificate is delivered.

(b) For purposes of this section, "return" means a writing that:

(i) the policy, contract, or certificate is being returned for termination of coverage;

(ii) is:

(A) a written statement on the policy, contract, or certificate; or

(B) a writing that accompanies the policy, contract, or certificate; and

(iii) is delivered to or mailed first class to the insurer or the insurer's agent.

(c) A policy, contract, or certificate returned under this section is void from the date of issuance.

(d) A policyholder, contract holder, or certificate holder returning a policy or certificate is entitled to a refund of any premium paid.

(2) This section does not apply to:

(a) group term life insurance issued under Section 31A-22-502;

(b) a group master policy;

(c) a noncontributory certificate;

(d) a credit life insurance certificate; and

(e) other classes of life insurance policies that the commissioner specifies by rule after finding that a right to return those life insurance policies would be impracticable or unnecessary to protect the policyholder's interests.

Section 9. Section **31A-22-610** is amended to read:

31A-22-610. Dependent coverage from moment of birth or adoption.

(1) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years of age as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

(2) (a) [~~If any~~] Except as provided in Subsection (5), if an accident and health insurance policy provides coverage for any members of the policyholder's or certificate holder's family, the policy shall provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis to:

(i) a newly born child from the moment of birth; and

(ii) an adopted child:

(A) beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth; or

(B) beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

(b) The coverage described in this Subsection (2):

(i) is not subject to any preexisting conditions; and

(ii) includes any injury or sickness, including the necessary care and treatment of medically diagnosed:

(A) congenital defects;

(B) birth abnormalities; or

(C) prematurity.

(c) (i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an adopted child may be denied until the child is enrolled.

(ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).

(d) If the payment of a specific premium is required to provide coverage for a child of a policyholder or certificate holder, for there to be coverage for the child, the policyholder or certificate holder shall enroll:

(i) a newly born child within 30 days after the date of birth of the child; or

(ii) an adopted child within 30 days after the day of placement of adoption.

(e) If the payment of a specific premium is not required to provide coverage for a child of a policyholder or certificate holder, for the child to receive coverage the policyholder or certificate holder shall enroll a newly born child or an adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

(3) (a) The coverage required by Subsection (2) as to children placed for the purpose of adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless:

(i) the placement is disrupted prior to legal adoption; and

(ii) the child is removed from placement.

(b) The coverage required by Subsection (2) ends if the child is removed from placement prior to being legally adopted.

(4) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

(5) If an accident and health insurance policy that is not subject to the special enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual, the insurer may choose to:

(a) provide coverage according to this section; or

(b) allow application, subject to the insurer's underwriting criteria for:

(i) a newborn;

(ii) an adopted child; or

(iii) a child placed for adoption.

Section 10. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance -- Basic Health Care Plan.

(1) This section applies generally to all health insurance policies and health maintenance organization contracts.

(2) [~~(a)~~] The commissioner shall adopt a Basic Health Care Plan consistent with this section to be offered under the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

[~~(b) (i) Before adoption of a plan under Subsection (2)(a), the commissioner shall submit the proposed Basic Health Care Plan to the Health and Human Services Interim Committee for review and recommendations.~~]

[~~(ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human Services Interim Committee:~~]

[~~(A) shall provide legislative oversight of the Basic Health Care Plan; and~~]

[~~(B) may recommend legislation to modify the Basic Health Care Plan adopted by the commissioner.~~]

(3) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer issuing health insurance policies or health maintenance organization contracts to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, written disclosure of:

(i) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution; and

(ii) coverage limits under the plan.

(b) In addition to the requirements of Subsections (3)(a) and (d), an insurer described in Subsection (3)(a) shall submit the written disclosure required by this Subsection (3) to the commissioner:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (3)(a):

(A) treatment policies;

(B) practice standards;

(C) restrictions; or

(D) coverage limits of the insurer's health benefit plan or health insurance policy.

(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (3), taking into account:

(i) business confidentiality of the insurer;

(ii) definitions of terms; and

(iii) the method of disclosure to enrollees.

(d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included; and

(iii) any conditions that exist as a precedent to coverage.

(4) The Basic Health Care Plan adopted by the commissioner under this section shall provide for:

(a) a lifetime maximum benefit per person not to exceed $1,000,000;

(b) an annual maximum benefit per person not to exceed $300,000;

(c) an out-of-pocket maximum per person not to exceed $5,000, including the deductible;

(d) in relation to its cost-sharing features:

(i) a deductible of not less than $1,500 for major medical expenses; and

(ii) (A) a copayment of not less than:

(I) $25 per visit for office services; and

(II) $150 per visit to an emergency room; or

(B) coinsurance of not less than:

(I) 20% per visit for office services; and

(II) 20% per visit for an emergency room; and

(e) in relation to cost-sharing features for prescription drugs:

(i) a deductible of not less than $500; and

(ii) (A) a copayment of not less than:

(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or $30 for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or $60 for the highest level of cost for prescription drugs; or

(B) coinsurance of not less than:

(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.

Section 11. Section **31A-22-629** is amended to read:

31A-22-629. Adverse benefit determination review process.

(1) As used in this section:

(a) (i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) with respect to individual or group health plans, and income replacement or disability income policies, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the insurer;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Independent review organization" means a person, subject to Subsection (6), who

conducts an independent external review of adverse determinations.

[~~(c)~~] (d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

[~~(d)~~] (e) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

[~~(e)~~] (f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.

(3) (a) An insured may submit an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.

(c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:

(i) payment of a claim regarding medical necessity; or

(ii) denial of a claim regarding medical necessity.

(4) [~~Before October 1, 2000, the~~] The commissioner shall adopt rules that establish minimum standards for:

(a) internal reviews;

(b) independent reviews to ensure independence and impartiality;

(c) the types of adverse benefit determinations that may be submitted to an independent review; and

(d) the timing of the review process, including an expedited review when medically necessary.

(5) Nothing in this section may be construed as:

(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;

(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;

(c) restricting the use of arbitration in connection with or subsequent to an independent review; or

(d) altering the legal rights of any party to seek court or other redress in connection with:

(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable [~~attorneys'~~] attorney fees of the insured related to the action and court costs; or

(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.

(6) (a) An independent review organization in relation to the insurer may not be:

(i) the insurer;

(ii) the health plan;

(iii) the health plan's fiduciary;

(iv) the employer; or

(v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).

(b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:

(i) the health plan;

(ii) an officer, director, or management employee of the health plan;

(iii) the enrollee;

(iv) the enrollee's health care provider;

(v) the health care provider's medical group or independent practice association;

(vi) a health care facility where service would be provided; or

(vii) the developer or manufacturer of the service that would be provided.

Section 12. Section **31A-22-701** is amended to read:

31A-22-701. Groups eligible for group or blanket insurance.

(1) A group or blanket accident and health insurance policy may be issued to:

(a) any group:

(i) to which a group life insurance policy may be issued under Sections 31A-22-502 through 31A-22-507; and

(ii) that is formed for a reason other than the purchase of insurance; or

(b) [~~a~~] any group specifically authorized by the commissioner under Section 31A-22-509, upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the proposed group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in administrative, marketing, and brokerage costs; [~~and~~]

(iv) the health insurance policy, certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to policies that are otherwise available to similar groups[~~.~~]; and

[~~(2) Blanket policies~~]

(v) the proposed group is formed for a reason other than the purchase of insurance.

(2) A blanket policy may also be issued to:

(a) any common carrier or any operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to their travel status;

(b) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(c) an institution of learning, including a school district, school jurisdictional units, or the head, principal, or governing board of any of those units, as policyholder, covering

students, teachers, or employees;

(d) any religious, charitable, recreational, educational, or civic organization, or branch of those organizations, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(e) a sports team, camp, or sponsor of the team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(f) any volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(g) a newspaper or other publisher, as policyholder, covering its carriers;

(h) an association, including a labor union, which has a constitution and bylaws and which has been organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;

(i) a health insurance purchasing association, as defined in Section 31A-34-103, organized and controlled solely by participating employers [~~as defined in Section 31A-34-103~~]; and

(j) any other class of risks which, in the judgment of the commissioner, may be properly eligible for blanket accident and health insurance.

(3) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) class of risks; or

(c) both Subsections (3)(a) and (b).

Section 13. Section **31A-23a-104** is amended to read:

31A-23a-104. Application for individual license -- Application for agency license.

(1) [~~Subject to Subsection (2), an application for~~] This section applies to an initial or renewal [~~individual~~] license as a:

(a) producer[~~,~~];

(b) limited line producer[~~,~~];

(c) customer service representative[~~,~~];

(d) consultant[~~,~~];

(e) managing general agent[~~,~~]; or

(f) reinsurance intermediary.

(2) (a) Subject to Subsection (2)(b), an initial or renewal individual license shall be:

[~~(a)~~] (i) made to the commissioner on forms and in a manner the commissioner prescribes; and

[~~(b)~~] (ii) accompanied by a license fee that is not refunded if the application:

[~~(i)~~] (A) is denied; or

[~~(ii)~~] (B) if incomplete, is never completed by the applicant.

[~~(2)~~] (b) An application described in this Subsection [~~(1)~~] (2) shall provide:

[~~(a)~~] (i) information about the applicant's identity;

[~~(b)~~] (ii) the applicant's Social Security number;

[~~(c)~~] (iii) the applicant's personal history, experience, education, and business record;

[~~(d)~~] (iv) whether the applicant is 18 years of age or older;

[~~(e)~~] (v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and

[~~(f)~~] (vi) any other information the commissioner reasonably requires.

(3) The commissioner may require any documents reasonably necessary to verify the information contained in an application filed under this section.

(4) [~~The following information~~] An applicant's Social Security number contained in an application filed under this section is a private record under [~~Title 63, Chapter 2, Government Records Access and Management Act.~~] Section 63-2-302.

[~~(a) an applicant's Social Security number; or~~]

[~~(b) an applicant's federal employer identification number.~~]

(5) (a) Subject to Subsection (5)(b), an application for an initial or renewal agency license [~~as a producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary~~] shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes; and

(ii) accompanied by a license fee that is not refunded if the application:

(A) is denied; or

(B) if incomplete, is never completed by the applicant.

(b) An application described in Subsection (5)(a) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's federal employer identification number;

(iii) the designated responsible licensed producer;

(iv) the identity of all owners, partners, officers, and directors;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and

(vi) any other information the commissioner reasonably requires.

Section 14. Section **31A-23a-105** is amended to read:

31A-23a-105. General requirements for individual and agency license issuance and renewal.

(1) The commissioner shall issue or renew a license to act as a producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary to any person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(a) has satisfied the application requirements under Section 31A-23a-104;

(b) has satisfied the character requirements under Section 31A-23a-107;

(c) has satisfied any applicable continuing education requirements under Section 31A-23a-202;

(d) has satisfied any applicable examination requirements under Section 31A-23a-108;

(e) has satisfied any applicable training period requirements under Section 31A-23a-203;

(f) if a nonresident:

(i) has complied with Section 31A-23a-109; and

(ii) holds an active similar license in that person's state of residence;

(g) if an applicant for a title insurance producer license, has satisfied the requirements of Sections 31A-23a-203 and 31A-23a-204;

(h) if an applicant for a license to act as a viatical settlement provider or viatical settlement producer [~~of viatical settlements~~], has satisfied the requirements of Section 31A-23a-117; and

(i) has paid the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending:

(A) individual or agency producer license;

(B) limited line producer license;

(C) customer service representative license;

(D) consultant license;

(E) managing general agent license; or

(F) reinsurance intermediary license; or

(ii) a licensed:

(A) individual or agency producer;

(B) limited line producer;

(C) customer service representative;

(D) consultant;

(E) managing general agent; or

(F) reinsurance intermediary.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) any administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) any criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person files the application for an individual or agency license; and

(B) for an action or prosecution that occurs on or after the day on which the person files the application:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial pretrial hearing date; 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 request:

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

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

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

(i) determining if a person satisfies the character requirements under Section 31A-23a-107 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23a-107; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

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

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

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

(iii) charge the person applying for a license or for renewal of a license a fee equal to the aggregate of Subsections (3)(c)(i) and (ii).

(4) To become a resident licensee in accordance with Section 31A-23a-104 and this section, a person licensed as one of the following in another state who moves to this state shall apply within 90 days of establishing legal residence in this state:

(a) insurance producer;

(b) limited line producer;

(c) customer service representative;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(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 line of authority only with the concurrence of the Title and Escrow Commission; and

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

Section 15. Section **31A-23a-117** is amended to read:

31A-23a-117. Special requirements for viatical settlement providers and producers.

(1) A viatical settlement provider or viatical settlement producer [~~of viatical~~

~~settlements~~] shall be licensed in accordance with this title, with the additional requirements listed in this section.

(2) A viatical settlement provider [~~of viatical settlements~~] shall provide to the commissioner:

(a) a detailed plan of operation with the viatical settlement provider's:

(i) initial license application; and

(ii) renewal application;

(b) a copy of the viatical settlement provider's most current audited financial statement; and

(c) an antifraud plan that meets the requirements of Section 31A-36-117.

(3) A viatical settlement provider [~~or producer of viatical settlements~~] shall provide with the viatical settlement provider's [~~or producer's~~] initial license application information describing the viatical settlement provider's [~~or producer's~~] viatical settlement experience, training, and education.

(4) A viatical settlement provider [~~or producer of viatical settlements~~] shall provide to the commissioner, within 30 days after a change occurs, new or revised information concerning any of the following:

(a) officers;

(b) holders of more than 10% of its stock;

(c) partners;

(d) directors;

(e) members; and

(f) designated employees.

Section 16. Section **31A-23a-204** is amended to read:

31A-23a-204. Special requirements for title insurance producers including agencies.

Title insurance producers, including agencies, shall be licensed in accordance with this chapter, with the additional requirements listed in this section.

(1) (a) A person that receives a new license under this title on or after July 1, 2007 as a title insurance agency, shall at the time of licensure be owned or managed by one or more natural persons who are licensed with the following lines of authority for at least three of the five years immediately proceeding the date on which the title insurance agency applies for a license:

(i) both a:

(A) search line of authority; and

(B) escrow line of authority; or

(ii) a search and escrow line of authority.

(b) A title insurance agency subject to Subsection (1)(a) may comply with Subsection (1)(a) by having the title insurance agency owned or managed by:

(i) one or more natural persons who are licensed with the search line of authority for the time period provided in Subsection (1)(a); and

(ii) one or more natural persons who are licensed with the escrow line of authority for the time period provided in Subsection (1)(a).

(c) The Title and Escrow Commission may by rule made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, exempt an attorney with real estate experience from the experience requirements in Subsection (1)(a).

(2) (a) Every title insurance agency or producer appointed by an insurer shall maintain:

(i) a fidelity bond;

(ii) a professional liability insurance policy; or

(iii) a financial protection:

(A) equivalent to that described in Subsection (2)(a)(i) or (ii); and

(B) that the commissioner considers adequate.

(b) The bond [~~or~~], insurance, or financial protection required by this Subsection (2):

(i) shall be supplied under a contract approved by the commissioner to provide protection against the improper performance of any service in conjunction with the issuance of a contract or policy of title insurance; and

(ii) be in a face amount no less than $50,000.

(c) The Title and Escrow Commission may by rule made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, exempt title insurance producers from the requirements of this Subsection (2) upon a finding that, and only so long as, the required policy or bond is generally unavailable at reasonable rates.

(3) (a) (i) Every title insurance agency or producer appointed by an insurer shall maintain a reserve fund.

(ii) The reserve fund required by this Subsection (3) shall be:

(A) (I) composed of assets approved by the commissioner and the Title and Escrow Commission;

(II) maintained as a separate trust account; and

(III) charged as a reserve liability of the title insurance producer in determining the producer's financial condition; and

(B) accumulated by segregating 1% of all gross income received from the title insurance business.

(iii) The reserve fund shall contain the accumulated assets for the immediately preceding ten years as defined in Subsection (3)(a)(ii).

(iv) That portion of the assets held in the reserve fund over ten years may be:

(A) withdrawn from the reserve fund; and

(B) restored to the income of the title insurance producer.

(v) The title insurance producer may withdraw interest from the reserve fund related to the principal amount as it accrues.

(b) (i) A disbursement may not be made from the reserve fund except as provided in Subsection (3)(a) unless the title insurance producer ceases doing business as a result of:

(A) sale of assets;

(B) merger of the producer with another producer;

(C) termination of the producer's license;

(D) insolvency; or

(E) any cessation of business by the producer.

(ii) Any disbursements from the reserve fund may be made only to settle claims arising from the improper performance of the title insurance producer in providing services defined in Section 31A-23a-406.

(iii) The commissioner shall be notified ten days before any disbursements from the reserve fund.

(iv) The notice required by this Subsection (3)(b) shall contain:

(A) the amount of claim;

(B) the nature of the claim; and

(C) the name of the payee.

(c) (i) The reserve fund shall be maintained by the title insurance producer or the title insurance producer's representative for a period of two years after the day on which the title insurance producer ceases doing business.

(ii) Any assets remaining in the reserve fund at the end of the two years specified in Subsection (3)(c)(i) may be withdrawn and restored to the former title insurance producer.

(4) Any examination for licensure shall include questions regarding the search and examination of title to real property.

(5) A title insurance producer may not perform the functions of escrow unless the title insurance producer has been examined on the fiduciary duties and procedures involved in those functions.

(6) The Title and Escrow Commission shall adopt rules, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, after consulting with the department and the department's test administrator, establishing an examination for a license that will satisfy this section.

(7) A license may be issued to a title insurance producer who has qualified:

(a) to perform only searches and examinations of title as specified in Subsection (4);

(b) to handle only escrow arrangements as specified in Subsection (5); or

(c) to act as a title marketing representative.

(8) (a) A person licensed to practice law in Utah is exempt from the requirements of Subsections (2) and (3) if that person issues 12 or less policies in any 12-month period.

(b) In determining the number of policies issued by a person licensed to practice law in Utah for purposes of Subsection (8)(a), if the person licensed to practice law in Utah issues a policy to more than one party to the same closing, the person is considered to have issued only one policy.

(9) A person licensed to practice law in Utah, whether exempt under Subsection (8) or not, shall maintain a trust account separate from a law firm trust account for all title and real estate escrow transactions.

Section 17. Section **31A-23a-401** is amended to read:

31A-23a-401. Disclosure of conflicting interests.

(1) (a) Except as provided under Subsection (1)(b)[~~, no~~]:

(i) a licensee under this chapter may not act in the same or any directly related transaction as:

(A) a producer for the insured or consultant; and

(B) producer for the insurer; [~~nor may~~] and

(ii) a producer for the insured or consultant may not recommend or encourage the purchase of insurance from or through an insurer or other producer:

(A) of which the producer for the insured or consultant or producer for the insured's or consultant's spouse is an owner, executive, or employee; or

(B) to which [~~he~~] the producer for the insured or consultant has the type of relation that a material benefit would accrue to the producer for the insured or consultant or spouse as a result of the purchase.

(b) Subsection (1)(a) does not apply if the following three conditions are met:

(i) Prior to performing the consulting services, the producer for the insured or consultant [~~discloses~~] shall disclose to the client, prominently, in writing[~~,~~]:

(A) the producer for the insured's or consultant's interest as a producer for the insurer, or the relationship to an insurer or other producer[~~,~~]; and

(B) that as a result of those interests, the producer for the insured's or the consultant's recommendations should be given appropriate scrutiny.

(ii) The producer for the insured's or consultant's fee [~~is~~] shall be agreed upon, in writing, after the disclosure required under Subsection (1)(b)(i), but [~~prior to~~] before performing the requested services.

(iii) Any report resulting from requested services [~~contains~~] shall contain a copy of the disclosure made under Subsection (1)(b)(i).

(2) [~~No~~] A licensee under this chapter may not act as to the same client as both a producer for the insurer and a producer for the insured without the client's prior written consent based on full disclosure.

(3) Whenever a person applies for insurance coverage through a producer for the insured, the producer for the insured shall disclose to the applicant, in writing, that the producer for the insured is not the producer for the insurer [~~of~~] or the potential insurer. This disclosure shall also inform the applicant that the applicant likely does not have the benefit of an insurer being financially responsible for the conduct of the producer for the [~~insured's conduct~~] insured.

Section 18. Section **31A-23a-402** is amended to read:

31A-23a-402. Unfair marketing practices -- Communication -- Inducement -- Unfair discrimination -- Coercion or intimidation -- Restriction on choice.

(1) (a) (i) Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance product or contract, any insurer, or any licensee under this title, including information that is false or misleading because it is incomplete:

(A) a person who is or should be licensed under this title;

(B) an employee or producer of a person described in Subsection (1)(a)(i)(A);

(C) a person whose primary interest is as a competitor of a person licensed under this title; and

(D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

(ii) As used in this Subsection (1), "false or misleading information" includes:

(A) assuring the nonobligatory payment of future dividends or refunds of unused premiums in any specific or approximate amounts, but reporting fully and accurately past experience is not false or misleading information; and

(B) with intent to deceive a person examining it:

(I) filing a report;

(II) making a false entry in a record; or

(III) wilfully refraining from making a proper entry in a record.

(iii) A licensee under this title may not:

(A) use any business name, slogan, emblem, or related device that is misleading or likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee already in business; or

(B) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency:

(I) is responsible for the insurance sales activities of the person;

(II) stands behind the credit of the person;

(III) guarantees any returns on insurance products of or sold by the person; or

(IV) is a source of payment of any insurance obligation of or sold by the person.

(iv) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that person is an insurer.

(v) A person other than persons licensed as health maintenance organizations under Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to itself.

(b) A licensee's violation creates a rebuttable presumption that the violation was also committed by the insurer if:

(i) the licensee under this title distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1)(a), with reference to a particular insurer:

(A) that the licensee represents; or

(B) for whom the licensee processes claims; and

(ii) the cards, documents, signs, or advertisements are supplied or approved by that insurer.

(2) (a) (i) A licensee under this title, or an officer or employee of a licensee may not induce any person to enter into or continue an insurance contract or to terminate an existing insurance contract by offering benefits not specified in the policy to be issued or continued, including premium or commission rebates.

(ii) An insurer may not make or knowingly allow any agreement of insurance that is not clearly expressed in the policy to be issued or renewed.

(iii) This Subsection (2)(a) does not preclude:

(A) [~~insurers~~] an insurer from reducing premiums because of expense savings;

(B) an insurer from providing to a policyholder or insured one or more incentives to participate in programs or activities designed to reduce claims or claim expenses;

[~~(B)~~] (C) the usual kinds of social courtesies not related to particular transactions; or

[~~(C)~~] (D) an insurer from receiving premiums under an installment payment plan.

(iv) The commissioner may adopt rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to define what constitutes an incentive described in Subsection (2)(a)(iii)(B).

(b) A licensee under this title may not absorb the tax under Section 31A-3-301.

(c) (i) A title insurer or producer or any officer or employee of either may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business:

(A) any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the title insurance;

(B) any special favor or advantage not generally available to others; or

(C) any money or other consideration or material inducement.

(ii) "Charge made incident to the issuance of the title insurance" includes escrow

charges, and any other services that are prescribed in rule by the Title and Escrow Commission after consultation with the commissioner.

(iii) An insured or any other person connected, directly or indirectly, with the transaction, including a mortgage lender, real estate broker, builder, attorney, or any officer, employee, or agent of any of them, may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(c)(i).

(3) (a) An insurer may not unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage, except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved.

(b) Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly discriminatory merely because they are more favorable than in similar individual policies.

(4) (a) This Subsection (4) applies to:

(i) a person who is or should be licensed under this title;

(ii) an employee of that licensee or person who should be licensed;

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) one acting on behalf of any person described in Subsections (4)(a)(i) through (iii).

(b) A person described in Subsection (4)(a) may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that:

(i) tends to produce:

(A) an unreasonable restraint of the business of insurance; or

(B) a monopoly in that business; or

(ii) results in an applicant purchasing or replacing an insurance contract.

(5) (a) (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an insurer or licensee under this chapter, another person who is required to pay for insurance as a condition for the conclusion of a contract or other transaction or for the exercise of any right

under a contract.

(ii) A person requiring coverage may reserve the right to disapprove the insurer or the coverage selected on reasonable grounds.

(b) The form of corporate organization of an insurer authorized to do business in this state is not a reasonable ground for disapproval, and the commissioner may by rule specify additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an application for insurance.

(6) A person may not make any charge other than insurance premiums and premium financing charges for the protection of property or of a security interest in property, as a condition for obtaining, renewing, or continuing the financing of a purchase of the property or the lending of money on the security of an interest in the property.

(7) (a) A licensee under this title may not refuse or fail to return promptly all indicia of agency to the principal on demand.

(b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308, 31A-23a-111, or 31A-23a-112 may not refuse or fail to return the license to the commissioner on demand.

(8) (a) A person may not engage in any other unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that they:

(i) are misleading;

(ii) are deceptive;

(iii) are unfairly discriminatory;

(iv) provide an unfair inducement; or

(v) unreasonably restrain competition.

(b) Notwithstanding Subsection (8)(a), for purpose of the title insurance industry, the Title and Escrow Commission shall make rules, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, that define any other unfair method of competition or any other unfair or deceptive act or practice after a finding that they:

(i) are misleading;

(ii) are deceptive;

(iii) are unfairly discriminatory;

(iv) provide an unfair inducement; or

(v) unreasonably restrain competition.

Section 19. Section **31A-23a-504** is amended to read:

31A-23a-504. Sharing commissions.

(1) (a) Except as provided in Subsection 31A-15-103(3), a licensee under this chapter or an insurer may only pay consideration or reimburse out-of-pocket expenses to a person if the licensee knows that the person is licensed under this chapter as to the particular type of insurance to act in Utah as:

(i) a producer[~~,~~];

(ii) a limited line producer[~~,~~];

(iii) a customer service representative[~~,~~];

(iv) a consultant[~~,~~];

(v) a managing general agent[~~,~~]; or

(vi) a reinsurance intermediary [~~in Utah as to the particular type of insurance~~].

(b) A person may only accept commission compensation or other compensation as [~~a producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary~~] a person described in Subsections (1)(a)(i) through (vi) that is directly or indirectly the result of any insurance transaction if that person is licensed under this chapter to act [~~as a producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary as to the particular type of insurance~~] as described in Subsection (1)(a).

(2) (a) Except as provided in Section 31A-23a-501, a consultant may not pay or receive any commission or other compensation that is directly or indirectly the result of any insurance transaction.

(b) A consultant may share a consultant fee or other compensation received for

consulting services performed within Utah only:

(i) with another consultant licensed under this chapter[~~,~~]; and [~~only~~]

(ii) to the extent that the other consultant contributed to the services performed.

(3) This section does not prohibit the payment of renewal commissions to former licensees under this chapter, former Title 31, Chapter 17, or their successors in interest under a deferred compensation or agency sales agreement.

(4) This section does not prohibit compensation paid to or received by a person for referral of a potential customer that seeks to purchase or obtain an opinion or advice on an insurance product if:

(a) the person is not licensed to sell insurance;

(b) the person [~~sells or provides~~] does not sell or provide opinions or advice on the product; and

(c) the compensation does not depend on whether the referral results in a purchase or sale.

(5) (a) In selling [~~any~~] a policy of title insurance, [~~no~~] sharing of commissions under Subsection (1) may not occur if it will result in:

(i) an unlawful rebate[~~, or in~~];

(ii) compensation in connection with controlled business[~~,~~]; or [~~in~~]

(iii) payment of a forwarding fee or finder's fee.

(b) A person may share compensation for the issuance of a title insurance policy only to the extent that [~~he~~] the person contributed to the search and examination of the title or other services connected with [~~it~~] the title insurance policy.

(6) This section does not apply to bail bond producers or bail enforcement agents as defined in Section 31A-35-102.

Section 20. Section **31A-25-202** is amended to read:

31A-25-202. Application for license.

(1) (a) An application for a license as a third party administrator shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes;

and

(ii) accompanied by the applicable fee, which is not refundable if the application is denied.

(b) The application for a license as a third party administrator shall:

(i) state the applicant's:

(A) Social Security number; or

(B) federal employer identification number;

(ii) provide information about:

(A) the applicant's identity;

(B) the applicant's personal history, experience, education, and business record;

(C) if the applicant is a natural person, whether the applicant is 18 years of age or older; and

(D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

(iii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

[~~(3) The following are private records under Subsection 63-2-302(1)(h):~~]

[~~(a) an applicant's Social Security number; and~~]

[~~(b) an applicant's federal employer identification number.~~]

(3) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63-2-302.

Section 21. Section **31A-26-202** is amended to read:

31A-26-202. Application for license.

(1) (a) The application for a license as an independent adjuster or public adjuster shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes; and

(ii) accompanied by the applicable fee, which is not refunded if the application is denied.

(b) The application shall provide:

(i) information about the applicant's identity, including:

(A) the applicant's:

(I) Social Security number; or

(II) federal employer identification number;

(B) the applicant's personal history, experience, education, and business record;

(C) if the applicant is a natural person, whether the applicant is 18 years of age or older; and

(D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

(ii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

(3) [~~The following information~~] An applicant's Social Security number contained in an application filed under this section is a private record under [~~Title 63, Chapter 2, Government Records Access and Management Act:~~] Section 63-2-302.

[~~(a) an applicant's Social Security number; or~~]

[~~(b) an applicant's federal employer identification number.~~]

Section 22. Section **31A-26-301.6** is amended to read:

31A-26-301.6. Health care claims practices.

(1) As used in this section:

(a) "Articulable reason" may include a determination regarding:

(i) eligibility for coverage;

(ii) preexisting conditions;

(iii) applicability of other public or private insurance;

(iv) medical necessity; and

(v) any other reason that would justify an extension of the time to investigate a claim.

(b) "Health care provider" means a person licensed to provide health care under:

(i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(ii) Title 58, Occupations and Professions.

(c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a [~~third-party~~] third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(d) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) a health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) [~~Within~~] Except as provided in Subsection (4), within 30 days of [~~receiving~~] the day on which the insurer receives a written claim, an insurer shall [~~do one of the following~~]:

(i) pay the claim [~~unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies~~]; or

(ii) deny the claim and provide a written explanation [~~if the claim is denied;~~] for the denial.

[~~(iii) specifically describe and request any additional information from the provider that is necessary to process the claim;~~]

[~~(iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the insurer's investigation of the claim; or~~]

[~~(v) request additional information and inform the provider of the 30-day extension if~~

~~both Subsections (3)(a)(iii) and (iv) apply.~~]

[~~(b) A provider shall respond to each request by an insurer for additional necessary information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by providing the requested information that is in the possession of the provider, unless:~~]

[~~(i) the provider has requested and received the permission of the insurer to extend the 30-day period; or~~]

[~~(ii) the provider explains to the insurer in writing that additional time, which may not exceed 30 days, is necessary to comply with the request for information.~~]

[~~(c) Subsection (7) shall apply after an insurer has received the information requested.~~]

[~~(4) The time to investigate a claim may be extended by the insurer for an additional 30-days if:~~]

[~~(a) the investigation of the claim cannot reasonably be completed within the initial 30-day period of Subsection (3)(a);~~]

[~~(b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the provider in writing of the reason for the payment delay, the nature of the investigation, the timelines for investigations established in this section, and the anticipated completion date.~~]

[~~(5) Notwithstanding Subsection (4), the time to investigate a claim may be extended beyond the initial 30-day period and the extended 30-day period if:~~]

[~~(a) due to matters beyond the control of the insurer, the investigation cannot reasonably be completed within 60 days as to some part or all of the claim;~~]

[~~(b) before the end of the combined 60-day period, the insurer makes a written request to the commissioner for an extension, including the reason for the delay, the nature of the investigation, the anticipated completion date, and the amount of any partial payment of the claim made pursuant to Subsection (5)(d);~~]

[~~(c) before the end of the combined 60-day period, the commissioner informs the insurer that the request for an extension has been granted, based on a finding that:~~]

[~~(i) there is a good faith and articulable reason to believe that the insurer is not obligated to pay some part or all of the claim; and~~]

[~~(ii) the investigation cannot reasonably be completed within 60 days; and~~]

[~~(d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim and which are not subject to the extension requested under this Subsection (5).~~]

[~~(6) An extension granted by the commissioner under Subsection (5)(c) shall include the completion date for the investigation.~~]

(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.

[~~(7) (a)~~] (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[~~: (i)~~] receiving the information requested under Subsection (3)[~~(a)(iii);~~](b), (4)(b), or (4)(c).

[~~(ii) completing an investigation under Subsection (4) or (5); or~~]

[~~(iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.~~]

[~~(b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request for additional information within the 20-day time period in Subsection (7)(a) if the previous response of the provider was not sufficient for the insurer to make a decision on the claim.~~]

[~~(ii) A follow-up request for additional necessary information shall state with specificity:~~]

[~~(A) the reason why the previous response was insufficient;~~]

[~~(B) the information that is necessary to comply with the request for information; and~~]

[~~(C) the reason why the requested information is necessary to process the claim.~~]

[~~(c) Unless an insurer has an extension for an investigation pursuant to Subsection (4) or (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written explanation of any part of the claim that is denied within 20 days of receiving a notice from the provider that the provider has submitted all requested information in the provider's possession that is related to the claim.~~]

[~~(8)~~] (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 [~~(8)~~] (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or federal law.

[~~(9)~~] (8) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together:

(i) the total amount of the claim;

(ii) the total number of days the response or the payment is late; and

(iii) .1%.

(c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together:

(i) the late fee for a 90-day period under Subsection [~~(9)~~] (8)(b); and

(ii) the following multiplied together:

(A) the total amount of the claim;

(B) the total number of days the response or payment was late beyond the initial 90-day period; and

(C) the rate of interest set in accordance with Section 15-1-1.

(d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.

(e) For purposes of this Subsection [~~(9)~~] (8), "late fee" does not include an amount that is less than $1.

[~~(10)~~] (9) Each insurer shall establish a review process to resolve claims-related

disputes between the insurer and providers.

[~~(11) No~~] (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 [~~(9)~~] (8) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for [~~availing himself of the provisions of~~] 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.

[~~(12)~~] (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 [~~(12)~~] (11)(a), this section may not be the basis for a

bad faith insurance claim.

(c) Nothing in Subsection [~~(12)~~] (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.

[~~(13)~~] (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) [~~After December 31, 2002, the~~] The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding [~~the provisions of~~] Subsection [~~(13)~~] (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection [~~(10)~~] (9).

[~~(14)~~] (13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

[~~(15)~~] (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 36 months for a coordination of benefits error; or

(iii) within 18 months for any other reason not identified in Subsection [~~(15)~~] (14)(a)(i) or (ii);

(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.

Section 23. Section **31A-27-331** is amended to read:

31A-27-331. Special provisions for third party claims.

(1) This section does not apply to a claim that is or may be covered by one of the Utah insurance guaranty associations or a corresponding association or fund of another state.

(2) Whenever any third party asserts a cause of action against an insured of an insurer which is in liquidation for which the insurance might indemnify the insured, the third party may file a claim with the liquidator.

(3) Whether or not the third party files a claim, the insured may file a claim on [~~his~~] the insured's own behalf in the liquidation. An insured who fails to file a claim by the date for filing claims specified in the order of liquidation or within 60 days after mailing of the notice required by Subsection 31A-27-315 (1) (b), whichever is later, is an unexcused late filer.

(4) (a) The liquidator shall make recommendations to the court under Section 31A-27-336 for the allowance of an insured's claim under Subsection (3) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense.

(b) After allowance of the claim by the court, the liquidator shall withhold any distributions payable on the claim, pending the outcome of the litigation and negotiation with the insured.

(c) Whenever it seems appropriate, the liquidator may reconsider the claim on the basis of additional information and amend the recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination.

(d) The court may amend [~~its~~] the court's allowance as it determines is appropriate.

(e) (i) As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage distribution as was paid on other claims of like priority, based on the lesser of:

[~~(a)~~] (A) the amount actually recovered from the insured by the action or paid by the

agreement, plus the reasonable costs and expenses of defense; and

[~~(b)~~] (B) the amount allowed on the claims by the court.

(ii) After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection is not a reason for unreasonable delay of final distribution and discharge of the liquidator.

(5) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured are evaluated as in Subsection (4). If any insured's claim is subsequently reduced under Subsection (4), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this Subsection (5).

Section 24. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under Subsection 31A-22-613.5(2).

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" [~~does~~] do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds established under Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if

there is not a plan document, the plan year is:

(a) the deductible or limit year used under the plan;

(b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

(c) if the plan does not impose a deductible or limit on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer's taxable year; or

(d) in any case not described in Subsections (20)(a) through (c), the calendar year.

[~~(20)~~] (21) "Preexisting condition" is as defined in Section 31A-1-301.

[~~(21)~~] (22) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

[~~(22)~~] (23) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

[~~(23)~~] (24) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

[~~(24)~~] (25) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

[~~(25)~~] (26) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

[~~(26)~~] (27) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

[~~(27)~~] (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Section 25. Section **31A-30-107.3** is amended to read:

31A-30-107.3. Discontinuance and nonrenewal limitations and conditions.

(1) (a) A carrier that elects to discontinue offering a health benefit plan under Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e) is prohibited from writing new business:

(i) in the small employer and individual market in this state; and

(ii) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The prohibition described in Subsection (1)(a) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(2) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A,

Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier:

(i) may elect to discontinue offering new individual health benefit plans, except to HIPAA eligibles, but must keep existing individual health benefit plans in effect, except those individual plans that are not renewed under the provisions of Subsection 31A-30-107(2) or 31A-30-107.1(2);

(ii) may elect to continue to offer new individual and small employer health benefit plans; or

(iii) may elect to discontinue all of the covered carrier's health benefit plans in the individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e).

(b) A carrier that makes an election under Subsection (2)(a)(i):

(i) is prohibited from writing new business:

(A) in the individual market in this state; and

(B) for a period of five years beginning on the date of discontinuation;

(ii) may continue to write new business in the small employer market; and

(iii) must provide written notice of the election under Subsection (2)(a)(i) within two calendar days of the election to the Utah Insurance Department.

(c) The prohibition described in Subsection (2)(b)(i) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(d) A carrier that makes an election under Subsection (2)(a)(iii) is subject to the provisions of Subsection (1).

(3) If a carrier is doing business in one established geographic service area of the state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that geographic service area.

(4) If a small employer employs less than two <u>eligible</u> employees, a carrier may not

discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that the employer no longer has at least two current employees.

Section 26. Section **31A-30-107.5** is amended to read:

31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.

(1) A health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).

(2) (a) In accordance with Subsection (2)(b), an individual carrier:

(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:

(A) a specific physical condition;

(B) a specific disease or disorder; and

(C) any specific or class of prescription drugs; and

(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).

(b) (i) Except as provided in Section 31A-22-630 and [~~except for the treatment of asthma or when the condition is due to cancer~~] Subsection (2)(b)(ii), the following may be the subject of a condition-specific exclusion rider:

(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;

(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius,

interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;

(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and sinus related conditions, diseases, and disorders;

(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;

(E) goiter and other thyroid related conditions, diseases, or disorders;

(F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;

(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;

(H) Baker's cyst, ganglion cyst;

(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;

(J) sleep disorders and speech disorders; and

(K) any specific or class of prescription drugs.

(ii) Subsection (2)(b)(i) does not apply:

(A) for the treatment of asthma; or

(B) when the condition is due to cancer.

[~~(ii)~~] (iii) A condition-specific exclusion rider:

(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;

(B) may not extend to any secondary medical condition; and

(C) must include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition, disease, or disorder."

(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.

(d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6[~~(9)~~](7).

(3) Notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:

(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation period;

(b) the limitation period does not exceed 12 months;

(c) the limitation period is applied uniformly; and

(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).

Section 27. Section **31A-30-112** is amended to read:

31A-30-112. Employee participation levels.

(1) Except as provided in Subsection (2), requirements used by a covered carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier. In addition to applying Subsection 31A-1-301(120), a covered carrier may require that a small employer have a minimum of two eligible employees to meet participation requirements.

(2) A covered carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

Section 28. Section **31A-35-201** is amended to read:

31A-35-201. Bail Bond Surety Oversight Board.

(1) There is created a Bail Bond Surety Oversight Board within the department, consisting of:

(a) the following seven voting members to be appointed by the commissioner:

(i) one representative each from four licensed bail bond surety companies;

(ii) two members of the general public who do not have any financial interest in or professional affiliation with any bail bond surety company; and

(iii) one attorney in good standing licensed to practice law in Utah; and

(b) a nonvoting member who is a staff member of the insurance department appointed by the commissioner.

(2) (a) The appointments are for terms of four years. A board member may not serve more than two consecutive terms.

[~~(b) Except as required by Subsection (2)(c), the members as of May 5, 1998, of the Bail Bond Surety Licensing Board created under Section 77-20-11 shall serve the remainder of their terms as members of the board. Upon expiration of their terms they are eligible for appointment to another term.~~]

[~~(c)~~] (b) The insurance commissioner shall, at the time of [~~initial appointments~~] appointment or reappointment of a board member described in Subsection (1)(a), adjust the length of terms to ensure that the terms of board members are staggered so approximately half of the board is appointed every two years.

(3) A board member serves until:

(a) removed by the insurance commissioner;

(b) the member's resignation; or

(c) for a member described in Subsection (1)(a), the expiration of the member's term and the appointment of a successor.

(4) When a vacancy occurs in the membership of a board member described in Subsection (1)(a) for any reason, the replacement shall be appointed for the remainder of the unexpired term.

(5) The board shall annually elect one of its members as chair.

(6) Four voting members constitute a quorum for the transaction of business.

(7) (a) [~~Members do~~] A member described in Subsection (1)(a) does not receive compensation or benefits for [~~their~~] the member's services, but may receive per diem and expenses incurred in the performance of official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(b) [~~Members~~] A member described in Subsection (1)(a) may decline to receive per diem and expenses for [~~their~~] the member's services.

(8) (a) The commissioner, with a majority vote of the board, may remove any member of the board described in Subsection (1)(a) for misconduct, incompetency, or neglect of duty.

(b) The board shall conduct a hearing if requested by the board member described in Subsection (1)(a) that is to be removed.

(9) Members of the board are immune from suit with respect to all acts done and actions taken in good faith in carrying out the purposes of this chapter.

Section 29. Section **31A-36-102** is amended to read:

31A-36-102. Definitions.

As used in this chapter:

(1) (a) "Advertising" means any communication placed before the public to:

(i) create an interest in viatical settlements; or

(ii) induce a person to sell a policy or an interest in a policy pursuant to a viatical settlement.

(b) "Advertising" includes the following, if the requirements of Subsection (1)(a) are met:

(i) any written, electronic, or printed communication;

(ii) any communication by means of recorded telephone messages;

(iii) any communication transmitted on radio, television, the Internet, or similar communications media; and

(iv) film strips, motion pictures, and videos.

(2) "Business of viatical settlements" includes the following:

(a) offering a viatical settlement;

(b) [~~solicitation of~~] soliciting a viatical settlement;

(c) [~~negotiation of~~] negotiating a viatical settlement;

(d) [~~procurement of~~] procuring a viatical settlement;

(e) [~~effectuation of~~] effectuating a viatical settlement;

(f) purchasing a viatical settlement;

(g) investing in a viatical settlement;

(h) financing a viatical settlement;

(i) monitoring a viatical settlement;

(j) tracking a viatical settlement;

(k) underwriting a viatical settlement;

(l) selling a viatical settlement;

(m) transferring a viatical settlement;

(n) assigning a viatical settlement;

(o) pledging a viatical settlement; and

(p) otherwise hypothecating a viatical [~~settlements~~] settlement.

(3) "Chronically ill" means:

(a) being unable to perform at least two activities of daily living, such as eating, toileting, moving from one place to another, bathing, dressing, or continence;

(b) requiring substantial supervision for protection from threats to health and safety because of severe cognitive impairment; or

(c) having a level of disability similar to that described in Subsection (3)(a).

(4) (a) "Financing entity" means a person:

(i) [~~that~~] who has direct ownership in a policy that is the subject of [~~the~~] a viatical settlement;

(ii) whose principal activity related to [~~the transaction~~] a viatical settlement is providing money to effect the viatical settlement; and

(iii) [~~that~~] who has an agreement in writing with one or more licensed viatical

settlement providers [~~of viatical settlements~~] to finance the acquisition of one or more viatical settlements.

(b) "Financing entity" includes, if the requirements of Subsection (4)(a) are met, the following:

(i) an underwriter;

(ii) a placement agent;

(iii) an enhancer of credit;

(iv) a lender;

(v) a purchaser of securities; and

(vi) a purchaser of a policy from a viatical settlement provider [~~of viatical settlements~~].

(c) "Financing entity" does not include:

(i) a nonaccredited investor [~~or a purchaser of~~]; or

(ii) a viatical [~~settlements~~] settlement purchaser.

(5) "Form" means, in addition to a form as defined in Section 31A-1-301:

(a) a viatical settlement;

(b) a disclosure to a viator;

(c) a notice of intent to viaticate; or

(d) a verification of coverage.

[~~(5)~~] (6) "Policy" means:

(a) an individual or group policy;

(b) a group certificate; or

(c) a contract or arrangement of life insurance, whether or not delivered or issued for delivery in Utah:

(i) affecting the rights of a resident of Utah; or

(ii) bearing a reasonable relation to Utah.

[~~(6) (a) "Producer of viatical settlements" means a person that on behalf of a viator and for consideration offers or attempts to negotiate a viatical settlement between the viator and one or more providers of viatical settlements.~~]

[~~(b) "Producer of viatical settlements" does not include an attorney licensed to practice law in any state, certified public accountant, or financial planner accredited by a nationally recognized accrediting agency:~~]

[~~(i) that is retained by the viator; and~~]

[~~(ii) whose compensation is not paid directly or indirectly by a provider or purchaser of viatical settlements.~~]

[~~(7) (a) "Provider of viatical settlements" means a person other than a viator that enters into or effectuates a viatical settlement.~~]

[~~(b) "Provider of viatical settlements" does not include:~~]

[~~(i) a licensed lender that takes an assignment of a policy as security for a loan, including a:~~]

[~~(A) bank;~~]

[~~(B) savings bank;~~]

[~~(C) savings and loan association;~~]

[~~(D) credit union; or~~]

[~~(E) other licensed lender;~~]

[~~(ii) the issuer of a policy providing accelerated benefits pursuant to the policy;~~]

[~~(iii) an authorized or eligible insurer that provides stop-loss coverage to:~~]

[~~(A) a provider of viatical settlements;~~]

[~~(B) a purchaser of viatical settlements;~~]

[~~(C) a financing entity;~~]

[~~(D) a special purpose entity; or~~]

[~~(E) a related provider trust;~~]

[~~(iv) a natural person that enters or effectuates no more than one agreement in a calendar year for the transfer of policies for a value less than the expected death benefit;~~]

[~~(v) a financing entity;~~]

[~~(vi) a special purpose entity;~~]

[~~(vii) a related provider trust;~~]

[~~(viii) a purchaser of viatical settlements; or~~]

[~~(ix) any of the following that purchases a viaticated policy from a provider of viatical settlements:~~]

[~~(A) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501; or~~]

[~~(B) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A.~~]

[~~(8) (a) "Purchaser of viatical settlements" means a person that, to derive an economic benefit:~~]

[~~(i) gives a sum of money as consideration for a policy or an interest in the death benefits of a policy; or~~]

[~~(ii) owns, acquires, or is entitled to a beneficial interest in a trust that:~~]

[~~(A) owns a viatical settlement contract; or~~]

[~~(B) is the beneficiary of a policy that has been or will be the subject of a viatical settlement.~~]

[~~(b) "Purchaser of viatical settlements" does not include:~~]

[~~(i) a licensee under this chapter;~~]

[~~(ii) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501;~~]

[~~(iii) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;~~]

[~~(iv) a financing entity;~~]

[~~(v) a special purpose entity; or~~]

[~~(vi) a related provider trust.~~]

[~~(9)~~] (7) "Related provider trust" means a trust established by a licensed viatical settlement provider [~~of viatical settlements~~] or a financing entity solely to hold the ownership of or beneficial interests in purchased policies in connection with financing.

[~~(10)~~] (8) "Special purpose entity" means an organization formed by a licensed viatical settlement provider [~~of viatical settlements~~] solely to enable the provider to gain access to

institutional markets for capital.

[~~(11)~~] (9) "Terminally ill" means having a condition that reasonably may be expected to result in death within 24 months.

[~~(13)~~] (10) "Viaticated policy" means a policy that has been acquired by a viatical settlement provider [~~of viatical settlements~~] pursuant to a viatical settlement.

[~~(12)~~] (11) (a) "Viatical settlement" means a written agreement for the payment of anything of value, which is less than the expected death benefit of the policy, in exchange for the viator's assignment, sale, transfer, devise, or bequest of the death benefit or ownership of any portion of a policy.

(b) "Viatical settlement" includes:

(i) an agreement with a viator for a loan or other financing secured primarily by a policy; and

(ii) an agreement with a viator to transfer ownership or change the beneficiary in the future, regardless of the date of payment to the viator.

(c) "Viatical settlement" does not include:

(i) a loan by an insurer pursuant to the terms of a policy; or

(ii) a loan secured by the cash value of a policy.

(12) (a) "Viatical settlement producer" means a person that on behalf of a viator and for consideration offers or attempts to negotiate a viatical settlement between the viator and one or more viatical settlement providers.

(b) "Viatical settlement producer" does not include an attorney licensed to practice law in any state, a certified public accountant, or a financial planner accredited by a nationally recognized accrediting agency:

(i) that is retained by the viator; and

(ii) whose compensation is not paid directly or indirectly by:

(A) a viatical settlement provider; or

(B) a viatical settlement purchaser.

(13) (a) "Viatical settlement provider" means a person other than a viator that enters

into or effectuates a viatical settlement.

(b) "Viatical settlement provider" does not include:

(i) a licensed lender that takes an assignment of a policy as security for a loan, including a:

(A) bank;

(B) savings bank;

(C) savings and loan association;

(D) credit union; or

(E) other licensed lender;

(ii) the issuer of a policy providing accelerated benefits pursuant to the policy;

(iii) an authorized or eligible insurer that provides stop-loss coverage to:

(A) a viatical settlement provider;

(B) a viatical settlement purchaser;

(C) a financing entity;

(D) a special purpose entity; or

(E) a related provider trust;

(iv) a natural person that enters or effectuates no more than one agreement in a calendar year for the transfer of policies for a value less than the expected death benefit;

(v) a financing entity;

(vi) a special purpose entity;

(vii) a related provider trust;

(viii) a viatical settlement purchaser; or

(ix) any of the following that purchases a viaticated policy from a viatical settlement provider:

(A) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501; or

(B) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A.

(14) (a) "Viatical settlement purchaser" means a person that, to derive an economic

benefit:

(i) gives a sum of money as consideration for a policy or an interest in the death benefits of a policy; or

(ii) owns, acquires, or is entitled to a beneficial interest in a trust that:

(A) owns a viatical settlement contract; or

(B) is the beneficiary of a policy that has been or will be the subject of a viatical settlement.

(b) "Viatical settlement purchaser" does not include:

(i) a viatical settlement provider;

(ii) a viatical settlement producer;

(iii) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501;

(iv) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;

(v) a financing entity;

(vi) a special purpose entity; or

(vii) a related provider trust.

[~~(14)~~] (15) (a) "Viator" means any of the following that seeks to enter into a viatical settlement:

(i) the owner of a policy; or

(ii) the holder of a certificate of insurance under a policy of group insurance.

(b) "Viator" is not limited to a person that is terminally ill or chronically ill except where that limitation is expressly provided.

(c) "Viator" does not include:

[~~(i) a licensee under this chapter;~~]

(i) a viatical settlement provider;

(ii) a viatical settlement producer;

[~~(ii)~~] (iii) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501;

[~~(iii)~~] (iv) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;

[~~(iv)~~] (v) a financing entity;

[~~(v)~~] (vi) a special purpose entity; or

[~~(vi)~~] (vii) a related provider trust.

Section 30. Section **31A-36-104** is amended to read:

31A-36-104. License requirements, revocation, and denial.

(1) (a) A person may not, without first obtaining a license from the commissioner, operate in or from this state as:

(i) a viatical settlement provider [~~of viatical settlements~~]; or

(ii) a viatical settlement producer [~~of viatical settlements~~].

(b) Viatical settlements are included within the scope of the life insurance producer line of authority.

(2) (a) To obtain a license as a viatical settlement provider [~~of viatical settlements~~], an applicant shall:

(i) comply with Section 31A-23a-117;

(ii) file an application; and

(iii) pay the license fee.

(b) If an applicant complies with Subsection (2)(a), the commissioner shall investigate the applicant and issue a license if the commissioner finds that the applicant is competent and trustworthy to engage in the business of providing viatical settlements by experience, training, or education.

(3) In addition to the requirements in Sections 31A-23a-111, 31A-23a-112 and 31A-23a-113, the commissioner may refuse to issue, suspend, revoke, or refuse to renew the license of a viatical settlement provider [~~of viatical settlements~~] or viatical settlement producer [~~of viatical settlements~~] if the commissioner finds that:

(a) a viatical settlement provider [~~of viatical settlements~~] demonstrates a pattern of unreasonable payments to viators;

(b) the applicant [~~or~~], the licensee, [~~or~~] an officer, partner, or member, or key management personnel:

(i) has, whether or not a judgment of conviction has been entered by the court, been found guilty of, or pleaded guilty or nolo contendere to:

(A) a felony; or

(B) a misdemeanor involving fraud or moral turpitude;

(ii) violated any provision of this chapter; or

(iii) has been subject to a final administrative action by another state or federal jurisdiction.

(c) a viatical settlement provider [~~of viatical settlements~~] has entered into a viatical settlement not approved under this chapter;

(d) a viatical settlement provider [~~of viatical settlements~~] has failed to honor obligations of a viatical settlement;

(e) a viatical settlement provider [~~of viatical settlements~~] has assigned, transferred, or pledged a viaticated policy to a person other than:

(i) a viatical settlement provider [~~of viatical settlements~~] licensed under this chapter;

(ii) a viatical settlement purchaser [~~of the viatical settlement~~];

(iii) an accredited investor as defined in Regulation D, Rule 501, 17 C.F.R. Sec. 230.501;

(iv) a qualified institutional buyer as defined in Rule 144A, 17 C.F.R. Sec. 230.144A;

(v) a financing entity;

(vi) a special purpose entity; or

(vii) a related provider trust; or

(f) a viatical settlement provider [~~of viatical settlements~~] has failed to maintain a standard set forth in Subsection (2)(b).

(4) If the commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider [~~of viatical settlements~~] or viatical settlement producer [~~of viatical settlements~~], the commissioner shall conduct an adjudicative proceeding

under Title 63, Chapter 46b, Administrative Procedures Act.

Section 31. Section **31A-36-105** is amended to read:

31A-36-105. Filing and use of forms for viatical settlement and disclosure.

(1) [~~Unless~~] A person may not use a form unless the form has been filed with the commissioner under Subsection 31A-21-201(1)[~~, a person may not use a form for a:~~].

[~~(a) viatical settlement;~~]

[~~(b) disclosure to the viator;~~]

[~~(c) notice of intent to viaticate;~~]

[~~(d) verification of coverage; or~~]

[~~(e) application.~~]

(2) The commissioner may prohibit the use of a form submitted under Subsection (1) pursuant to Subsection 31A-21-201(3).

(3) The commissioner may require the submission of advertising material before its use.

Section 32. Section **31A-36-106** is amended to read:

31A-36-106. Reporting requirements and privacy.

(1) (a) [~~Each licensee under this chapter~~] Subject to Subsection (1)(b), each viatical settlement provider shall file with the commissioner on or before March 1 of each year an annual statement containing [~~such~~] the information [~~as~~] the commissioner prescribes under Section 31A-36-119[~~, provided, however, that~~].

(b) Notwithstanding Subsection (1)(a), the commissioner shall only require the information [~~shall be limited to~~] for those transactions where the viator is a resident of Utah.

(2) Except as otherwise allowed or required by law, the following may not disclose the identity, financial information, or medical information of an insured to any other person:

(a) a viatical settlement provider [~~of viatical settlements~~];

(b) a viatical settlement producer [~~of viatical settlements~~];

(c) a producer of insurance;

(d) an information bureau;

(e) a rating agency or company; or

(f) any other person knowing the identity of an insured.

(3) Notwithstanding Subsection (2), a person may disclose the identity of an insured if the disclosure is:

(a) necessary to effect a viatical settlement between the viator and a viatical settlement provider [~~of viatical settlements~~] and both the viator and the insured have given prior written consent to the disclosure;

(b) furnished in response to an investigation or examination by the commissioner or another governmental officer or agency;

(c) furnished pursuant to Section 31A-36-114;

(d) a term of or condition to the transfer of a policy by one viatical settlement provider [~~of viatical settlements~~] to another viatical settlement provider;

(e) necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of a policy by a viatical settlement provider [~~of viatical settlements~~] and the insured has given prior written consent to the disclosure;

(f) necessary to allow the viatical settlement provider or viatical settlement producer [~~of viatical settlements~~] or [~~their~~] the viatical settlement provider's or viatical settlement producer's authorized representatives to make contacts to determine the health status of the viator; or

(g) required to purchase stop-loss coverage.

Section 33. Section **31A-36-107** is amended to read:

31A-36-107. Examinations and retention of records.

(1) The commissioner may conduct an examination of a [~~licensee under this chapter~~] viatical settlement provider or viatical settlement producer in accordance with Sections 31A-2-203, 31A-2-203.5, 31A-2-204, and 31A-2-205.

(2) A [~~person required to be licensed under this chapter~~] viatical settlement provider or viatical settlement producer shall retain for five years copies of all:

(a) the following records, whether proposed, offered, or executed, from the later of the

date of the proposal, offer, or execution[~~, whichever is later~~]:

(i) contracts;

(ii) purchase agreements;

(iii) underwriting documents;

(iv) policy forms; and

(v) applications;

(b) checks, drafts, and other evidence or documentation relating to the payment, transfer, or release of money, from the date of the transaction; and

(c) records and documents related to the requirements of this chapter.

(3) This section does not relieve a person of the obligation to produce a document described in Subsection (2) to the commissioner after the expiration of the relevant period if the person has retained the document.

(4) Records required by this section to be retained must be legible and complete. They may be retained in any form or by any process that accurately reproduces or is a durable medium for the reproduction of the record.

(5) An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This [~~section~~] Subsection (5) does not automatically preclude an examiner from being:

(a) a viator;

(b) an insured in a viaticated policy; or

(c) a beneficiary in a policy that is proposed to be viaticated.

(6) (a) Examinees under this section shall reimburse the cost of any examination to the department consistent with Section 31A-2-205.

(b) Notwithstanding Subsection (6)(a), an individual [~~producers of viatical settlements are~~] viatical settlement producer is not subject to Section 31A-2-205.

Section 34. Section **31A-36-108** is amended to read:

31A-36-108. Required disclosures.

(1) With each application for a viatical settlement, a viatical settlement provider or viatical settlement producer [~~of viatical settlements~~] shall furnish to the viator any disclosures the commissioner may require under Section 31A-36-119, in a separate document signed by the viator and the viatical settlement provider or viatical settlement producer, no later than the time the application for the viatical settlement is signed by all the parties.

(2) A viatical settlement provider [~~of viatical settlements~~] shall furnish to the viator any disclosures the commissioner may require under Section 31A-36-119, conspicuously displayed in the viatical settlement or in a separate document signed by the viator and the viatical settlement provider [~~of viatical settlements~~], no later than the time the viatical settlement is signed by all parties.

Section 35. Section **31A-36-109** is amended to read:

31A-36-109. General requirements.

(1) If a viatical settlement provider [~~of viatical settlements~~] transfers ownership or changes the beneficiary of a viaticated policy, the viatical settlement provider shall inform the insured of the transfer or change within 20 calendar days.

(2) A viatical settlement provider [~~of viatical settlements~~] that enters a viatical settlement shall first obtain:

(a) if the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter a viatical settlement;

(b) a witnessed document in which the viator represents that:

(i) the viator has a full and complete understanding of the viatical settlement and the benefits of the policy;

(ii) the viator has entered the viatical settlement freely and voluntarily; and

(iii) if applicable, the insured is terminally ill or chronically ill and that the illness was diagnosed after the policy was issued; and

(c) a document in which the insured consents to the release of the insured's medical records to:

(i) a viatical settlement provider [~~of viatical settlements~~];

(ii) a viatical settlement producer [~~of viatical settlements~~]; and

(iii) the insurer that issued the policy covering the insured.

(3) Within 20 calendar days after a viator executes documents necessary to transfer rights under a policy, or enters into an agreement in any form, express or implied, to viaticate the policy, the viatical settlement provider [~~of viatical settlements~~] shall give written notice to the issuer of the policy that the policy has or will become viaticated. The notice must be accompanied by a copy of the documents required by Subsection (4).

(4) The viatical settlement provider [~~of viatical settlements~~] shall deliver a copy of the following to the insurer that issued the policy that is the subject of the viatical settlement:

(a) the medical release required under Subsection (2)(c);

(b) a copy of the viator's application for the viatical settlement; and

(c) the notice required under Subsection (3).

(5) The insurer shall complete and return a request for verification of coverage not later than 30 calendar days after the date the request is received. In its response, the insurer shall indicate whether the insurer intends to pursue an investigation regarding the validity of the insurance contract.

(6) All medical information solicited or obtained by a [~~licensee under this chapter~~] viatical settlement provider or viatical settlement producer is subject to:

(a) other laws of this state relating to the confidentiality of the information; and

(b) a rule relating to privacy of medical or personal information promulgated by the commissioner under Title V, Section 505 of the Gramm-Leach-Bliley Act of 1999, 15 U.S.C. Sec. 6805.

(7) A viatical settlement entered into in this state must reserve to the viator an unconditional right to terminate the viatical settlement within 15 calendar days after the viator receives the proceeds of the viatical settlement. If the insured dies during that period, the viatical settlement is terminated and all proceeds, premiums, loans, and loan interest that have been paid by the viatical settlement provider or viatical settlement purchaser [~~of the viatical~~

~~settlement~~] must be repaid to the viatical settlement provider or viatical settlement purchaser [~~of the viatical settlement~~].

(8) (a) Contact with an insured to determine the health status of the insured after a viatical settlement may be made only by a viatical settlement provider or viatical settlement producer [~~of viatical settlements~~] that is licensed in this state, or its authorized representative, and no more than:

(i) once every three months if the insured has a life expectancy of one year or more; or

(ii) once every month if the insured has a life expectancy of less than one year.

(b) The viatical settlement provider or viatical settlement producer [~~of viatical settlements~~] shall explain the procedure for the contacts allowed under this Subsection (8) to the viator when the application for the viatical settlement is signed by all parties.

(c) The limitations of this Subsection (8) do not apply to contacts for purposes other than determining health status.

(d) A viatical settlement provider or viatical settlement producer [~~of viatical settlements~~] is responsible for the acts of its authorized representative in violation of this Subsection (8).

(9) The trustee of a related provider trust must agree in writing with the viatical settlement provider [~~of viatical settlements~~] that:

(a) the viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements; and

(b) the trustee will make all records and files related to viatical settlements available to the commissioner as if those records and files were maintained directly by the viatical settlement provider.

(10) Regardless of the method of compensation, a viatical settlement producer [~~of viatical settlements~~]:

(a) represents only the viator; and

(b) owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

Section 36. Section **31A-36-110** is amended to read:

31A-36-110. Payment and document requirements.

(1) (a) A viatical settlement provider [~~of viatical settlements~~] shall instruct the viator to send the executed documents required to effect the change in ownership or assignment or change of beneficiary of the affected policy to a designated independent escrow agent.

(b) Within three business days after the [~~date~~] day on which the escrow agent receives the documents, or within three business days after the day on which the viatical settlement provider [~~of viatical settlements~~] receives the documents if by mistake they are sent directly to the viatical settlement provider [~~of viatical settlements~~], the escrow agent shall deposit the proceeds of the settlement into an escrow or trust account maintained in a regulated financial institution whose deposits are insured by a federal deposit insurer.

(2) (a) Upon completion of the requirements of Subsection (1), the escrow agent shall deliver to the viatical settlement provider [~~of viatical settlements~~] the original documents executed by the viator.

(b) Upon the viatical settlement provider's receipt from the insurer of an acknowledgment of the change in ownership or assignment or change of beneficiary of the affected policy, the viatical settlement provider [~~of viatical settlements~~] shall instruct the escrow agent to pay the proceeds of the settlement to the viator.

(3) Payment to the viator must be made within three business days after the [~~date~~] day on which the viatical settlement provider [~~of viatical settlements received~~] receives the acknowledgment from the insurer. Failure to make the payment within that time makes the viatical settlement voidable by the viator for lack of consideration until payment is tendered to and accepted by the viator.

Section 37. Section **31A-36-111** is amended to read:

31A-36-111. Prohibited acts.

(1) A viator may not enter into a viatical settlement within two years after the date of issuance of the policy to which the settlement relates unless the viator certifies to the viatical settlement provider [~~of viatical settlements~~] that one of the following is satisfied:

(a) the policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided:

(i) the total time covered under the conversion policy plus the time covered under the prior policy is at least 24 months; and

(ii) the time covered under a group policy, calculated without regard to any change in insurance carriers, has been continuous and under the same group sponsorship;

(b) the viator is a charitable organization exempt from taxation under 26 U.S.C. Sec. 501(c)(3);

(c) the viator is not a natural person; or

(d) the viator submits to the viatical settlement provider [~~of viatical settlements~~] independent evidence that within the two-year period:

(i) the viator or insured is terminally ill;

(ii) the viator or insured is chronically ill;

(iii) the spouse of the viator has died;

(iv) the viator has divorced the viator's spouse;

(v) the viator has retired from full-time employment;

(vi) the viator has become physically or mentally disabled and a physician determines that the disability precludes the viator from maintaining full-time employment;

(vii) (A) the viator was the employer of the insured when the policy or certificate was issued; and

(B) the employment relationship has terminated;

(viii) a final judgment or order has been entered or issued by a court of competent jurisdiction, on the application of a creditor of the viator:

(A) adjudging the viator bankrupt or insolvent;

(B) approving a petition for reorganization of the viator; or

(C) appointing a receiver, trustee, or liquidator for all or a substantial part of the viator's assets;

(ix) the viator experiences a significant decrease in income that is unexpected and

impairs the viator's reasonable ability to pay the policy premium;

(x) the viator disposes of the viator's ownership in a closely held corporation; or

(xi) the insured disposes of the insured's ownership in a closely held corporation.

(2) When the viatical settlement provider [~~of viatical settlements~~] submits a request to the insurer to verify coverage, the viatical settlement provider [~~of viatical settlements~~] shall submit to the insurer the following:

(a) copies of the independent evidence required under Subsection (1)(d); and

(b) documents required under Subsection 31A-36-109(2).

(3) If a viatical settlement provider [~~of viatical settlements~~] submits to an insurer a copy of the owner's or insured's certification that one of the events described in Subsection (1)(d) has occurred, the certification conclusively establishes that the viatical settlement satisfies the requirements of this section, and the insurer shall timely respond to the viatical settlement provider's request to effect a transfer of the policy.

Section 38. Section **31A-36-112** is amended to read:

31A-36-112. Advertising regulations.

(1) (a) Each [~~licensee under this chapter~~] viatical settlement provider or viatical settlement producer shall establish and continuously maintain a system of control over the content, form, and method of dissemination of all advertisements of [~~its~~] the viatical settlement provider's or viatical settlement producer's contracts and services.

(b) Each advertisement is the responsibility of the [~~licensee~~] viatical settlement provider or viatical settlement producer as well as the person that creates or presents [~~it~~] the advertisement.

(c) A system of control must include at least annual notification to persons authorized by the [~~licensee~~] viatical settlement provider or viatical settlement producer that disseminate advertisements of the requirements and procedures for approval before use of any advertisements not furnished by the [~~licensee~~] viatical settlement provider or viatical settlement producer.

(2) An advertisement must be truthful and not misleading in fact or by implication, as

determined by the commissioner from the overall impression it may reasonably be expected to create upon a person of average education or intelligence in the segment of the public to which it is directed.

(3) False or misleading statements are not remedied by:

(a) making a viatical settlement available for inspection before it is consummated; or

(b) offering to refund payment if the viator is not satisfied within the period prescribed in Subsection 31A-36-109(7).

Section 39. Section **31A-36-113** is amended to read:

31A-36-113. Fraud.

(1) As used in this section, "recklessly" means engaging in conduct:

(a) where a person knows or should have known of a substantial likelihood of the existence of the relevant facts or risks; and

(b) involving a significant deviation from acceptable standards of conduct.

(2) A person may not, knowingly or with intent to defraud, to deprive another of property or for pecuniary gain, do or permit its employees or agents to engage in any of the following acts:

(a) present, cause to be presented or prepare with knowledge or belief that it will be presented, false information to or by a viatical settlement provider or viatical settlement producer [~~of viatical settlements~~], a financing entity, an insurer, a provider of insurance or any other person, or to conceal information, as part of, in support of or concerning a fact material to:

(i) an application for the issuance of a policy or viatical settlement;

(ii) the underwriting of a policy or viatical settlement;

(iii) a claim for payment or other benefit under a policy or viatical settlement;

(iv) a premium paid on a policy;

(v) a payment or change of beneficiary or ownership pursuant to a policy or viatical settlement;

(vi) the reinstatement or conversion of a policy;

(vii) the solicitation, offer, effectuation, or sale of a policy or viatical settlement;

(viii) the issuance of written evidence of a policy or viatical settlement; or

(ix) a financing transaction;

(b) in furtherance of a fraud or to prevent detection of a fraud:

(i) remove, conceal, alter, destroy, or sequester from the commissioner assets or records of a [~~licensee under this chapter or other~~] person engaged in the business of viatical settlements;

(ii) misrepresent or conceal the financial condition of a licensee, a financing entity, an insurer, or other person;

(iii) transact the business of viatical settlements in violation of this chapter; or

(iv) file with the commissioner or analogous officer of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the commissioner or analogous officer;

(c) embezzle, steal, misappropriate, or convert money, premiums, credits, or other property of a viatical settlement provider [~~of viatical settlements~~], a viator, an insurer, an insured, an owner of a policy, or other person engaged in the business of viatical settlements or insurance;

(d) recklessly enter into, negotiate, or otherwise deal in a viatical settlement, the subject of which is a policy obtained where the viator or the viator's agent intended to defraud the policy's issuer by:

(i) presenting false information concerning any fact material to the policy; or

(ii) concealing, to mislead another, information concerning any fact material to the policy; or

(e) attempt to commit, assist, aid, abet, or conspire to commit an act or omission described in this Subsection (2).

(3) A person may not knowingly or intentionally interfere with the enforcement of [~~the provisions of~~] this chapter or an investigation of a possible violation of this chapter.

(4) A person engaged in the business of viatical settlements may not knowingly or

intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

(5) (a) An application or contract for a viatical settlement, however transmitted, shall contain the following or a substantially similar statement: "A person that knowingly presents false information in an application for insurance or a viatical settlement is guilty of a crime and may be subject to fines and confinement in prison."

(b) The lack of [~~such a~~] the statement described in Subsection (5)(a) is not a defense in a prosecution for violation of this section.

Section 40. Section **31A-36-117** is amended to read:

31A-36-117. Antifraud initiatives.

(1) The following shall establish and maintain antifraud initiatives which are reasonably calculated to prevent, detect, and assist in the prosecution of violations of Section 31A-36-113:

(a) a viatical settlement provider [~~of viatical settlements~~]; and

(b) an agency that is a viatical settlement producer [~~of viatical settlements~~].

(2) The commissioner may order, or a licensee may request and the commissioner may approve, modifications of the measures otherwise required under this section, more or less restrictive than those measures, as necessary to protect against fraud.

(3) Antifraud initiatives shall include:

(a) fraud investigators, that may be either:

(i) employees of a viatical settlement provider or viatical settlement producer [~~of viatical settlements~~]; or

(ii) independent contractors;

(b) an antifraud plan submitted to the commissioner, which shall include:

(i) a description of the procedures for:

(A) detecting and investigating possible violations of Section 31A-36-113; and

(B) resolving material inconsistencies between medical records and applications for insurance;

(ii) a description of the procedures for reporting possible violations to the commissioner;

(iii) a description of the plan for educating and training underwriters and other personnel against fraud; and

(iv) a description or chart of the organizational arrangement of the personnel responsible for detecting and investigating possible violations of Section 31A-36-113 and for resolving material inconsistencies between medical records and applications for insurance.

(4) A plan submitted to the commissioner shall be classified as a protected record under Title 63, Chapter 2, Government Records Access and Management Act.

Section 41. Section **31A-36-119** is amended to read:

31A-36-119. Authority to make rules.

In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner may adopt rules to:

(1) establish the requirements for the annual statement required under Section 31A-36-106;

(2) establish standards for evaluating the reasonableness of payments under viatical settlements;

(3) establish appropriate licensing requirements, fees, and standards for continued licensure for:

(a) [~~providers of~~] a viatical [~~settlements~~] settlement provider; and

(b) [~~producers of~~] a viatical [~~settlements~~] settlement producer;

(4) require a bond or otherwise ensure financial accountability of:

(a) [~~providers of~~] a viatical [~~settlements~~] settlement provider; and

(b) [~~producers of~~] a viatical [~~settlements~~] settlement producer;

(5) govern the relationship of insurers with [~~providers of viatical settlements and producers of viatical settlements~~] a viatical settlement provider or viatical settlement producer during the viatication of a policy;

(6) determine the specific disclosures required under Section 31A-36-108;

(7) determine whether advertising for viatical settlements violates Section 31A-36-112;

(8) determine the information to be provided to the commissioner under Section 31A-36-114 and the manner of providing the information;

(9) determine additional acts or practices that are prohibited under Section 31A-36-111;

(10) establish payment requirements for the payments in Section 31A-36-110; and

(11) establish the filing procedure for the forms listed in Subsection 31A-36-105(1).

Section 42. Section **31A-37-502** is amended to read:

31A-37-502. Examination.

(1) (a) [~~At least once in three years, and whenever the commissioner determines it to be prudent, the department,~~] As provided in this section, the commissioner or a person appointed by the commissioner, shall [~~visit~~] examine each captive insurance company [~~and~~] in each three-year period.

(b) The three-year period described in Subsection (1)(a) shall be determined on the basis of three full annual accounting periods of operation.

(c) The examination is to be made as of:

(i) December 31 of the full three-year period; or

(ii) the last day of the month of an annual accounting period authorized for a captive insurance company under this section.

(d) In addition to an examination required under this Subsection (1), the commissioner, or a person appointed by the commissioner may examine a captive insurance company whenever the commissioner determines it to be prudent.

(2) During an examination under this section the commissioner, or a person appointed by the commissioner, shall thoroughly inspect and examine the affairs of the captive insurance company to ascertain:

(a) the financial condition of the captive insurance company;

(b) the ability of the captive insurance company to fulfill the obligations of the captive insurance company; and

(c) whether the captive insurance company has complied with this chapter.

[~~(2)~~] (3) The commissioner upon application may enlarge the three-year period described in Subsection (1) to five years, if a captive insurance company is subject to a comprehensive annual audit during that period:

(a) of a scope satisfactory to the commissioner; and

(b) performed by independent auditors approved by the commissioner.

[~~(3)~~] (4) A captive insurance company that is inspected and examined under this section shall pay, as provided in Subsection 31A-37-202(5)(b), the expenses and charges of an inspection and examination.

Section 43. Section **61-1-13** is amended to read:

61-1-13. Definitions.

(1) As used in this chapter:

(a) "Affiliate" means a person that, directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with a person specified.

(b) (i) "Agent" means any individual other than a broker-dealer who represents a broker-dealer or issuer in effecting or attempting to effect purchases or sales of securities.

(ii) "Agent" does not include an individual who represents:

(A) an issuer, who receives no commission or other remuneration, directly or indirectly, for effecting or attempting to effect purchases or sales of securities in this state, and who effects transactions:

(I) in securities exempted by Subsection 61-1-14(1)(a), (b), (c), (i), or (j);

(II) exempted by Subsection 61-1-14(2);

(III) in a covered security as described in Sections 18(b)(3) and 18(b)(4)(D) of the Securities Act of 1933; or

(IV) with existing employees, partners, officers, or directors of the issuer; or

(B) a broker-dealer in effecting transactions in this state limited to those transactions described in Section 15(h)(2) of the Securities Exchange Act of 1934.

(iii) A partner, officer, or director of a broker-dealer or issuer, or a person occupying a similar status or performing similar functions, is an agent only if the partner, officer, director, or person otherwise comes within the definition of "agent."

(iv) "Agent" does not include a person described in Subsection (3).

(c) (i) "Broker-dealer" means any person engaged in the business of effecting transactions in securities for the account of others or for the person's own account.

(ii) "Broker-dealer" does not include:

(A) an agent;

(B) an issuer;

(C) a bank, savings institution, or trust company;

(D) a person who has no place of business in this state if:

(I) the person effects transactions in this state exclusively with or through:

(Aa) the issuers of the securities involved in the transactions;

(Bb) other broker-dealers; or

(Cc) banks, savings institutions, trust companies, insurance companies, investment companies as defined in the Investment Company Act of 1940, pension or profit-sharing trusts, or other financial institutions or institutional buyers, whether acting for themselves or as trustees; or

(II) during any period of 12 consecutive months the person does not direct more than 15 offers to sell or buy into this state in any manner to persons other than those specified in Subsection (1)(c)(ii)(D)(I), whether or not the offeror or any of the offerees is then present in this state;

(E) a general partner who organizes and effects transactions in securities of three or fewer limited partnerships, of which the person is the general partner, in any period of 12 consecutive months;

(F) a person whose participation in transactions in securities is confined to those transactions made by or through a broker-dealer licensed in this state;

(G) a person who is a real estate broker licensed in this state and who effects

transactions in a bond or other evidence of indebtedness secured by a real or chattel mortgage or deed of trust, or by an agreement for the sale of real estate or chattels, if the entire mortgage, deed or trust, or agreement, together with all the bonds or other evidences of indebtedness secured thereby, is offered and sold as a unit;

(H) a person effecting transactions in commodity contracts or commodity options;

(I) a person described in Subsection (3); or

(J) other persons as the division, by rule or order, may designate, consistent with the public interest and protection of investors, as not within the intent of this Subsection (1)(c).

(d) "Buy" or "purchase" means every contract for purchase of, contract to buy, or acquisition of a security or interest in a security for value.

(e) "Commodity" means, except as otherwise specified by the division by rule:

(i) any agricultural, grain, or livestock product or byproduct, except real property or any timber, agricultural, or livestock product grown or raised on real property and offered or sold by the owner or lessee of the real property;

(ii) any metal or mineral, including a precious metal, except a numismatic coin whose fair market value is at least 15% greater than the value of the metal it contains;

(iii) any gem or gemstone, whether characterized as precious, semi-precious, or otherwise;

(iv) any fuel, whether liquid, gaseous, or otherwise;

(v) any foreign currency; and

(vi) all other goods, articles, products, or items of any kind, except any work of art offered or sold by art dealers, at public auction or offered or sold through a private sale by the owner of the work.

(f) (i) "Commodity contract" means any account, agreement, or contract for the purchase or sale, primarily for speculation or investment purposes and not for use or consumption by the offeree or purchaser, of one or more commodities, whether for immediate or subsequent delivery or whether delivery is intended by the parties, and whether characterized as a cash contract, deferred shipment or deferred delivery contract, forward contract, futures

contract, installment or margin contract, leverage contract, or otherwise.

(ii) Any commodity contract offered or sold shall, in the absence of evidence to the contrary, be presumed to be offered or sold for speculation or investment purposes.

(iii) (A) A commodity contract shall not include any contract or agreement which requires, and under which the purchaser receives, within 28 calendar days from the payment in good funds any portion of the purchase price, physical delivery of the total amount of each commodity to be purchased under the contract or agreement.

(B) The purchaser is not considered to have received physical delivery of the total amount of each commodity to be purchased under the contract or agreement when the commodity or commodities are held as collateral for a loan or are subject to a lien of any person when the loan or lien arises in connection with the purchase of each commodity or commodities.

(g) (i) "Commodity option" means any account, agreement, or contract giving a party to the option the right but not the obligation to purchase or sell one or more commodities or one or more commodity contracts, or both whether characterized as an option, privilege, indemnity, bid, offer, put, call, advance guaranty, decline guaranty, or otherwise.

(ii) "Commodity option" does not include an option traded on a national securities exchange registered:

(A) with the United States Securities and Exchange Commission; or

(B) on a board of trade designated as a contract market by the Commodity Futures Trading Commission.

(h) "Director" means the director of the Division of Securities charged with the administration and enforcement of this chapter.

(i) "Division" means the Division of Securities established by Section 61-1-18.

(j) "Executive director" means the executive director of the Department of Commerce.

(k) "Federal covered adviser" means a person who:

(i) is registered under Section 203 of the Investment Advisers Act of 1940; or

(ii) is excluded from the definition of "investment adviser" under Section 202(a)(11) of

the Investment Advisers Act of 1940.

(l) "Federal covered security" means any security that is a covered security under Section 18(b) of the Securities Act of 1933 or rules or regulations promulgated under Section 18(b) of the Securities Act of 1933.

(m) "Fraud," "deceit," and "defraud" are not limited to their common-law meanings.

(n) "Guaranteed" means guaranteed as to payment of principal or interest as to debt securities, or dividends as to equity securities.

(o) (i) "Investment adviser" means any person who:

(A) for compensation, engages in the business of advising others, either directly or through publications or writings, as to the value of securities or as to the advisability of investing in, purchasing, or selling securities; or

(B) for compensation and as a part of a regular business, issues or promulgates analyses or reports concerning securities.

(ii) "Investment adviser" includes financial planners and other persons who:

(A) as an integral component of other financially related services, provide the investment advisory services described in Subsection (1)(o)(i) to others for compensation and as part of a business; or

(B) hold themselves out as providing the investment advisory services described in Subsection (1)(o)(i) to others for compensation.

(iii) "Investment adviser" does not include:

(A) an investment adviser representative;

(B) a bank, savings institution, or trust company;

(C) a lawyer, accountant, engineer, or teacher whose performance of these services is solely incidental to the practice of his profession;

(D) a broker-dealer or its agent whose performance of these services is solely incidental to the conduct of its business as a broker-dealer and who receives no special compensation for the services;

(E) a publisher of any bona fide newspaper, news column, news letter, news magazine,

or business or financial publication or service, of general, regular, and paid circulation, whether communicated in hard copy form, or by electronic means, or otherwise, that does not consist of the rendering of advice on the basis of the specific investment situation of each client;

(F) any person who is a federal covered adviser;

(G) a person described in Subsection (3); or

(H) such other persons not within the intent of this Subsection (1)(o) as the division may by rule or order designate.

(p) (i) "Investment adviser representative" means any partner, officer, director of, or a person occupying a similar status or performing similar functions, or other individual, except clerical or ministerial personnel, who:

(A) (I) is employed by or associated with an investment adviser who is licensed or required to be licensed under this chapter; or

(II) has a place of business located in this state and is employed by or associated with a federal covered adviser; and

(B) does any of the following:

(I) makes any recommendations or otherwise renders advice regarding securities;

(II) manages accounts or portfolios of clients;

(III) determines which recommendation or advice regarding securities should be given;

(IV) solicits, offers, or negotiates for the sale of or sells investment advisory services; or

(V) supervises employees who perform any of the acts described in this Subsection (1)(p)(i)(B).

(ii) "Investment advisor representative" does not include a person described in Subsection (3).

(q) (i) "Issuer" means any person who issues or proposes to issue any security or has outstanding a security that it has issued.

(ii) With respect to a preorganization certificate or subscription, "issuer" means the promoter or the promoters of the person to be organized.

(iii) "Issuer" means the person or persons performing the acts and assuming duties of a depositor or manager under the provisions of the trust or other agreement or instrument under which the security is issued with respect to:

(A) interests in trusts, including collateral trust certificates, voting trust certificates, and certificates of deposit for securities; or

(B) shares in an investment company without a board of directors.

(iv) With respect to an equipment trust certificate, a conditional sales contract, or similar securities serving the same purpose, "issuer" means the person by whom the equipment or property is to be used.

(v) With respect to interests in partnerships, general or limited, "issuer" means the partnership itself and not the general partner or partners.

(vi) With respect to certificates of interest or participation in oil, gas, or mining titles or leases or in payment out of production under the titles or leases, "issuer" means the owner of the title or lease or right of production, whether whole or fractional, who creates fractional interests therein for the purpose of sale.

(r) "Nonissuer" means not directly or indirectly for the benefit of the issuer.

(s) "Person" means:

(i) an individual;

(ii) a corporation;

(iii) a partnership;

(iv) a limited liability company;

(v) an association;

(vi) a joint-stock company;

(vii) a joint venture;

(viii) a trust where the interests of the beneficiaries are evidenced by a security;

(ix) an unincorporated organization;

(x) a government; or

(xi) a political subdivision of a government.

(t) "Precious metal" means the following, whether in coin, bullion, or other form:

(i) silver;

(ii) gold;

(iii) platinum;

(iv) palladium;

(v) copper; and

(vi) such other substances as the division may specify by rule.

(u) "Promoter" means any person who, acting alone or in concert with one or more persons, takes initiative in founding or organizing the business or enterprise of a person.

(v) (i) "Sale" or "sell" includes every contract for sale of, contract to sell, or disposition of, a security or interest in a security for value.

(ii) "Offer" or "offer to sell" includes every attempt or offer to dispose of, or solicitation of an offer to buy, a security or interest in a security for value.

(iii) The following are examples of the definitions in Subsection (1)(v)(i) or (ii):

(A) any security given or delivered with or as a bonus on account of any purchase of a security or any other thing, is part of the subject of the purchase, and has been offered and sold for value;

(B) a purported gift of assessable stock is an offer or sale as is each assessment levied on the stock;

(C) an offer or sale of a security that is convertible into, or entitles its holder to acquire or subscribe to another security of the same or another issuer is an offer or sale of that security, and also an offer of the other security, whether the right to convert or acquire is exercisable immediately or in the future;

(D) any conversion or exchange of one security for another shall constitute an offer or sale of the security received in a conversion or exchange, and the offer to buy or the purchase of the security converted or exchanged;

(E) securities distributed as a dividend wherein the person receiving the dividend surrenders the right, or the alternative right, to receive a cash or property dividend is an offer or

sale;

(F) a dividend of a security of another issuer is an offer or sale; or

(G) the issuance of a security under a merger, consolidation, reorganization, recapitalization, reclassification, or acquisition of assets shall constitute the offer or sale of the security issued as well as the offer to buy or the purchase of any security surrendered in connection therewith, unless the sole purpose of the transaction is to change the issuer's domicile.

(iv) The terms defined in Subsections (1)(v)(i) and (ii) do not include:

(A) a good faith gift;

(B) a transfer by death;

(C) a transfer by termination of a trust or of a beneficial interest in a trust;

(D) a security dividend not within Subsection (1)(v)(iii)(E) or (F);

(E) a securities split or reverse split; or

(F) any act incident to a judicially approved reorganization in which a security is issued in exchange for one or more outstanding securities, claims, or property interests, or partly in such exchange and partly for cash.

(w) "Securities Act of 1933," "Securities Exchange Act of 1934," "Public Utility Holding Company Act of 1935," and "Investment Company Act of 1940" mean the federal statutes of those names as amended before or after the effective date of this chapter.

(x) (i) "Security" means any:

(A) note;

(B) stock;

(C) treasury stock;

(D) bond;

(E) debenture;

(F) evidence of indebtedness;

(G) certificate of interest or participation in any profit-sharing agreement;

(H) collateral-trust certificate;

(I) preorganization certificate or subscription;

(J) transferable share;

(K) investment contract;

(L) burial certificate or burial contract;

(M) voting-trust certificate;

(N) certificate of deposit for a security;

(O) certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(P) commodity contract or commodity option;

(Q) interest in a limited liability company;

(R) viatical settlement interest; or

(S) in general, any interest or instrument commonly known as a "security," or any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the foregoing.

(ii) "Security" does not include any:

(A) insurance or endowment policy or annuity contract under which an insurance company promises to pay money in a lump sum or periodically for life or some other specified period;

(B) interest in a limited liability company in which the limited liability company is formed as part of an estate plan where all of the members are related by blood or marriage, there are five or fewer members, or the person claiming this exception can prove that all of the members are actively engaged in the management of the limited liability company; or

(C) (I) a whole long-term estate in real property;

(II) an undivided fractionalized long-term estate in real property that consists of ten or fewer owners; or

(III) an undivided fractionalized long-term estate in real property that consists of more than ten owners if, when the real property estate is subject to a management agreement:

(Aa) the management agreement permits a simple majority of owners of the real

property estate to not renew or to terminate the management agreement at the earlier of the end of the management agreement's current term, or 180 days after the day on which the owners give notice of termination to the manager;

(Bb) the management agreement prohibits, directly or indirectly, the lending of the proceeds earned from the real property estate or the use or pledge of its assets to any person or entity affiliated with or under common control of the manager; and

(Cc) the management agreement complies with any other requirement imposed by rule by the Real Estate Commission under Section 61-2-26.

(iii) For purposes of Subsection (1)(x)(ii)(B), evidence that members vote or have the right to vote, or the right to information concerning the business and affairs of the limited liability company, or the right to participate in management, shall not establish, without more, that all members are actively engaged in the management of the limited liability company.

(y) "State" means any state, territory, or possession of the United States, the District of Columbia, and Puerto Rico.

(z) "Threshold security" means a security that is a threshold security under Regulation SHO, 17 C.F.R. 242.200 et seq.

(aa) (i) "Undivided fractionalized long-term estate" means an ownership interest in real property by two or more persons that is a:

(A) tenancy in common; or

(B) any other legal form of undivided estate in real property including:

(I) a fee estate;

(II) a life estate; or

(III) other long-term estate.

(ii) "Undivided fractionalized long-term estate" does not include a joint tenancy.

(bb) (i) "Viatical settlement interest" means the entire interest or any fractional interest in any of the following that is the subject of a viatical settlement:

(A) a life insurance policy; or

(B) the death benefit under a life insurance policy.

(ii) "Viatical settlement interest" does not include the initial purchase from the viator by a viatical settlement provider [~~of viatical settlements~~].

(cc) "Whole long-term estate" means a person or persons through joint tenancy owns real property through:

(i) a fee estate;

(ii) a life estate; or

(iii) other long-term estate.

(dd) "Working days" means 8 a.m. to 5 p.m., Monday through Friday, exclusive of legal holidays listed in Section 63-13-2.

(2) A term not defined in this section shall have the meaning as established by division rule. The meaning of a term neither defined in this section nor by rule of the division shall be the meaning commonly accepted in the business community.

(3) (a) This Subsection (3) applies to:

(i) the offer or sale of a real property estate exempted from the definition of security under Subsection (1)(x)(ii)(C); or

(ii) the offer or sale of an undivided fractionalized long-term estate that is the offer of a security.

(b) A person who, directly or indirectly receives compensation in connection with the offer or sale as provided in this Subsection (3) of a real property estate is not an agent, broker-dealer, investment adviser, or investor adviser representative under this chapter if that person is licensed under Chapter 2, Division of Real Estate, as:

(i) a principal real estate broker;

(ii) an associate real estate broker; or

(iii) a real estate sales agent.

(4) The list of real property estates excluded from the definition of securities under Subsection (1)(x)(ii)(C) is not an exclusive list of real property estates or interests that are not a security.

Section 44. **Coordinating this H.B. 295 with H.B. 340 -- Technical changes.**

If this H.B. 295 and H.B. 340, Insurer Receivership Act, both pass, it is the intent of the Legislature that in preparing the Utah Code database for publication, the Office of the Legislative Research and General Counsel, modify Subsections 31A-27a-104(2)(k) and (l) to read:

"(k) viatical settlement provider; or

(l) viatical settlement producer."