Oregon Administrative Rules
1998 Compilation

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 1

GENERAL DEFINITIONS

836-001-0001

Statutory Authority; Purpose

OAR 836-001-0001 and 836-001-0005, are adopted pursuant to the general rulemaking authority of the Insurance Commissioner in ORS 731.244.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.052 et seq. & 731.244

Hist.: IC 65, f. & ef. 4-20-76; IC 5-1984, f. 10-15-84, ef. 11-1-84

836-001-0005

Insurance Code Definitions Adopted

The definitions given in the Oregon Insurance Code govern the meaning of terms used in administrative rules adopted by the Insurance Commissioner, except where the context otherwise requires.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.052 et seq. & 731.244

Hist.: IC 65, f. & ef. 4-20-76

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 5

PROCEDURAL RULES

836-005-0105

Notice to Interested Persons of Rulemaking

Except when acting in an emergency to adopt a temporary rule in accordance with ORS 183.335(5), the Insurance Commissioner will give prior notice of the proposed adoption, amendment, or repeal of an administrative rule:

(1) By causing notice of the proposed action to be published once, in the Secretary of State's Bulletin referred to in ORS 183.360, at least 21 days prior to the effective date of the rule.

(2) By mailing copies of the notice to persons on the Commissioner's mailing list established pursuant to ORS 183.335(7), at least 28 days prior to the effective date of the rule.

(3) By mailing or delivering copies of the notice to the Associated Press, the Daily Journal of Commerce and the Business Journal.

(4) By mailing copies of the notice to organizations and publications that may provide notice to persons who may have an interest, such as the following, depending on the subject matter of the proposal:

(a) Authorized insurers;

(b) Independent Insurance Agents of Oregon;

(c) Oregon Life Underwriters Association;

(d) National Association of Independent Insurers;

(e) American Insurance Association;

(f) Alliance of American Insurers;

(g) American Council of Life Insurance;

(h) Health Insurance Association of America;

(i) Oregon Professional Insurance Agents;

(j) Oregon Association of Health Underwriters;

(k) Western Insurance Information Service;

(l) Reinsurance Association of America;

(m) Insurance Information Institute;

(n) National Council on Compensation Insurance; and

(o) Insurance Services Office.

Stat. Auth.: ORS 183.341

Stats. Implemented: ORS 183.341

Hist.: IC 63, f. & ef. 12-5-75; IC 5-1982, f. 1-29-82, ef. 2-1-82; ID 4-1996, f. 2-28-96, cert. ef. 3-1-96

836-005-0107

Model Rules of Procedure

Pursuant to the provisions of ORS 183.341, for the purpose of the activities of the Insurance Division and enforcement of the Insurance Code, the Director adopts the Attorney General's Model Rules of Procedure under the Administrative Procedures Act as published in the Oregon Attorney General's Administrative Law Manual bearing the effective date of September 9, 1995, except for OAR 137-001-0007(2) and (3).

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedures is available from the Office of the Attorney General or the Insurance Division.]

Stat. Auth.: ORS 183.341

Stats. Implemented: ORS 183.025, 183.090, 183.310 to 183.550

Hist.: IC 2-1981, f. & ef. 11-20-81; IC 7-1983, f. & ef. 9-28-83; IC 3-1986, f. & ef. 3-5-86; IC 16-1988, f. & cert. ef. 10-12-88; ID 19-1990, f. & cert. ef. 12-13-90; ID 3-1992, f. & cert. ef. 2-13-92; ID 2-1994, f. & cert. ef. 3-23-94; ID 8-1995, f. & cert. ef. 12-8-95

836-005-0112

Persons Represented by Authorized Representative

(1) A party or limited party participating in a contested case hearing in which an insured appears under ORS 737.505 may be represented by authorized representative of the party or limited party.

(2) On or before the first appearance in a contested case by an authorized representative, the authorized representative must provide the presiding officer a letter from the party or limited party that authorizes the representative to appear on behalf of the party or limited party.

(3) The presiding officer may limit an authorized representative's presentation of evidence, examination and cross-examination of witnesses or presentation of factual arguments to ensure the orderly and timely development of the hearing record. The presiding officer may not allow an authorized representative to present any legal argument.

(4) As used in this rule:

(a) Authorized representative means a member of a partnership that is a party or limited party in the contested case, an authorized officer or regular employee of a corporation, association or organized group that is a party or limited party in the contested case, or an authorized officer or employee of a governmental authority other than a state agency, that is a party or limited party in the contested case;

(b) Legal argument includes any argument on:

(A) The jurisdiction of the Department to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirements; or

(C) The application of court precedent to the facts of the contested case.

(c) Legal argument does not include any argument on:

(A) The application of the facts to the statutes or rules that directly apply to the issues in the contested case;

(B) Comparison of prior actions of the Department;

(C) The literal meaning of the statutes or rules that directly apply to the issues in the contested case; or

(D) The admissibility of evidence or the correctness of procedures being followed.

(5) When an authorized representative represents a party of limited party in a hearing, the presiding officer shall advise the representative of the manner in which objections may be made and the manner in which matters may be preserved for appeal. The advice is of a procedural nature and does not change applicable law on waiver or applicable law on the duty to make timely objection. When an objection may involve a legal argument, the presiding officer shall provide reasonable opportunity for the authorized for the authorized representative to consult legal counsel and shall permit the legal counsel to file written legal argument within a reasonable time after conclusion of the hearing.

Stat. Auth.: ORS Ch. 821

Stats. Implemented: ORS 183.457(1)(d) , 2(b)

Hist.: IC 6-1988, f. & cert. ef. 3-30-88

836-005-0400

Annual Complaint Report

(1) The Director shall publish an annual statistical report on complaints against insurers as required under ORS 731.264, according to the method established in this rule. Each report shall contain the number, percentage, type and disposition of complaints against each insurer group and unaffiliated insurer that were closed by the Department of Insurance and Finance during the reporting period. The report shall be based on the records of the Department of Insurance and Finance. The report shall be structured as a cross tabulation of complaints closed during the reporting period, by complaint type and disposition, against each insurer group and each unaffiliated insurer with respect to whom one or more complaints were closed during the period for which the report is made.

(2) The Director shall also include the following in the report:

(a) A summary that relates the number of complaints against an insurer group or unaffiliated insurer that were closed during a reporting period to the volume of business of the insurer group or unaffiliated insurer. The Director shall

include in the summary those lines of insurance, other than workers' compensation insurance, and those insurer groups and unaffiliated insurers selected by the Director according to the accuracy, statistical credibility, reliability and usefulness of available information;

(b) A summary that relates the number of complaints concerning workers' compensation insurance against an insurer group or unaffiliated insurer that were closed during a reporting period to the number of Oregon employers insured under workers' compensation insurance policies of the insurer group or unaffiliated insurer.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.264(3)

Hist.: ID 3-1989(Temp), f. & cert. ef. 2-28-89; ID 11-1989, f. & cert. ef. 11-20-89

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 6

TAXATION

836-006-0001

Order for Taking Tax Credits and Offsets

(1) For each calendar or tax year beginning on or after January 1, 1997, an insurer shall apply in the following order the following offsets to the net corporate excise tax owing by the insurer as determined according to the revenue and tax laws under the jurisdiction of the Department of Revenue:

(a) The offset allowed by ORS 734.835 for the assessment by the Oregon Life and Health Insurance Guaranty Association; and

(b) The offset allowed by ORS 734.575 for the assessment by the Oregon Insurance Guaranty Association.

(2) For each calendar or tax year beginning on or after January 1, 1997, and before January 1, 2002, a foreign insurer shall apply any remaining portion of the offsets allowed for assessments by the Oregon Life and Health Insurance Guaranty Association and the Oregon Insurance Guaranty Association to the transition tax established under section 2, chapter 786, Oregon Laws 1995, after first applying the offsets to the corporate excise tax.

(3) For each calendar or tax year beginning on or after January 1, 1997, an insurer shall apply any remaining portion of the offset allowed for assessments by the Oregon Insurance Guaranty Association to the fire insurance gross premium tax after first applying the offset to the excise tax and then to the transition tax, if any.

(4) For purposes of this rule, "foreign insurer" also includes any alien insurer.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 731.820, 731.832, 731.854, 734.575 & 734.835 & section 2, chapter 786, Oregon Laws 1995

Hist.: ID 13-1997, f. & cert. ef. 10-14-97

836-006-0010

Payment of Transition and Retaliatory Taxes

(1) An insurer shall pay to the Director on April 1 of each year the tax due and payable under section 2, chapter 786, Oregon Laws 1995, and any amount of retaliatory tax due and payable under ORS 731.854, on the basis of the corporate excise tax obligation of the insurer that is owed or is estimated to be owed by the insurer for the preceding year ending December 31.

(2) If a foreign insurer is unable to determine the full amount of the tax that is due and payable under ORS 731.854 for the preceding year ending December 31 when the tax is due on April 1, the insurer shall pay to the Director on April 1 the amount it estimates to be due and payable under ORS 731.854. A foreign insurer shall pay the amount owing or estimated to be owing regardless of whether its domiciliary state has granted an extension or delay for filing or paying the taxes owing in the domiciliary state.

(3) When a foreign insurer files with its domiciliary state a final return that determines the amount of taxes owing to that state for a particular year, the insurer shall also file with the Director an amended return showing the amount of taxes owing to the State of Oregon or due as a credit to the insurer. The foreign insurer shall pay any additional tax shown to be due on the final return together with interest as required by the Insurance Code on the taxes owing to the State of Oregon.

(4) If a foreign insurer amends its return filed with its domiciliary state or files an amended Oregon excise tax return so as to change the amount of the tax due and payable under ORS 731.854 or the tax due and payable under section 2, chapter 786, Oregon Laws 1995, the insurer shall pay any additional tax owing to this state or shall be credited with any excess previously paid.

(5) An insurer shall pay taxes and other amounts due under this rule in accordance with forms prescribed by the Director.

(6) For purposes of this rule, "foreign insurer" also includes any alien insurer, and "state" includes a country other than the United States.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 731.854 & section 2, chapter 786, Oregon Laws 1995

Hist.: ID 13-1997, f. & cert. ef. 10-14-97

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 9

FEES AND CHARGES

836-009-0001

Purpose

The purpose of rules in OAR Chapter 836, Division 9 is to establish assessments, fees and charges for administering the regulatory program of the Insurance Division, Department of Consumer and Business Services.

Stat. Auth.: ORS 183.335, 293.445 & 731.804

Stats. Implemented: ORS 183.335(7) & 731.804(1-2)

Hist.: IC 4-1983, f. 6-27-83, ef. 7-1-83; ID 7-1993, f. & cert. ef. 9-3-93

836-009-0007

Fees

(1) The following fees apply to certificates of authority:

(a) The fee for application for a certificate of authority to transact insurance as an insurer is $2,200. The fee for application as a domestic insurer must be paid when application for a permit to organize as a domestic insurer is made. Otherwise, the fee must be paid when the application for the certificate is made;

(b) The fee for annual continuation of a certificate of authority issued under subsection (a) of this section is $1,100;

(c) The fee for reinstatement of a certificate of authority is $100.

(2) The fees in this section apply to examinations for licenses for agents, adjusters and insurance consultants. The fees are as follows:

(a) Examination fees:

(A) Agent, general lines insurance -- $99;

(B) Agent, life and health insurance -- $99;

(C) Agent, life insurance only -- $81;

(D) Agent, health insurance only -- $81;

(E) Surplus lines agent -- $81;

(F) Adjuster, general lines insurance -- $99;

(G) Adjuster, health insurance -- $81;

(H) Adjuster, any other line designated by rule -- $81;

(I) Consultant, life and health insurance -- $99;

(J) Consultant, life insurance only -- $81;

(K) Consultant, health insurance only -- $81;

(L) Consultant, general lines insurance -- $99;

(M) Consultant, any other line designated by rule -- $81.

(b) Reexamination fees, to be charged when the applicant retakes an examination:

(A) Agent, general lines insurance -- $99;

(B) Agent, life and health insurance -- $99;

(C) Agent, life insurance only -- $81;

(D) Agent, health insurance only -- $81;

(E) Surplus lines agent -- $81;

(F) Adjuster, general lines insurance -- $99;

(G) Adjuster, health insurance -- $81;

(H) Adjuster, any other line designated by rule -- $81;

(I) Consultant, life and health insurance -- $99;

(J) Consultant, life insurance only -- $81;

(K) Consultant, health insurance only -- $81;

(L) Consultant, general lines insurance -- $99;

(M) Consultant, any other line designated by rule -- $81.

(c) The fee for failing to keep an examination appointment or for cancelling an examination appointment, if cancellation is made after noon of the third working day before an examination appointment, is $40. This fee is in addition to the fee for a subsequent examination.

(3) The following fees apply to application for licenses for agents, adjusters and insurance consultants:

(a) Resident agent -- $60;

(b) Nonresident agent -- $60;

(c) Adjuster -- $60;

(d) Insurance consultant -- $60.

(4) The following fees apply to the renewal of licenses for agents, adjusters and insurance consultants:

(a) Resident agent -- $60;

(b) Nonresident agent -- $60;

(c) Adjuster -- $60;

(d) Insurance consultant -- $60.

(5) The applicable fee under sections (3) and (4) of this rule shall be paid for each category of insurance business appearing on a license.

(6) The following fees apply to certificates of registration for legal expense organizations:

(a) Application for a certificate of registration -- $350;

(b) Renewal of certificate of registration -- $350. The fee under this subsection shall be paid annually.

(7) Annual registration of a foreign risk retention group -- $350. The fee under this section shall be paid at the time of initial registration and annually thereafter.

(8) Annual registration of a purchasing group -- $100. The fee under this section shall be paid at the time of initial registration and annually thereafter.

(9) The license for a rating organization -- $180. The fee under this section shall be paid at the time of initial licensing and triennially thereafter.

(10) The Fire Marshal shall pay $50,000 each year for services provided by the Department in the collection of gross premium taxes on insurance covering the peril of fire under ORS 731.820.

(11) Fees paid as required under this rule are not refundable. If the Director determines that an amount paid exceeds the amount legally due and payable to the Department and the amount of the overpayment is less than $20, the Department shall refund the amount only upon receipt of a written request from the payer or the representative of the payer.

(12) The fees amended in section (2) of this rule first apply to payments for reexaminations made on and after September 10, 1993.

Stat. Auth.: ORS Ch. 183, 293.445, 731.244, 731.804, 744.001, 744.003, 744.066, 744.069, 744.075, 744.535, 744.619 & 744.621

Stats. Implemented: ORS 731.804(2)

Hist.: ID 6-1989(Temp), f. & cert. ef. 7-3-89; ID 14-1989, f. 12-12-89, cert. ef. 1-1-90; ID 21-1990, f. & cert. ef. 12-18-90; ID 4-1991, f. & cert. ef. 4-25-91; ID 8-1991, f. & cert. ef. 10-21-91; ID 7-1993, f. & cert. ef. 9-3-93

836-009-0008

Mailing List Fee

The fee for inclusion of each entry on the Insurance Division mailing list established under ORS 183.335 for giving notice of rulemaking is $35. The fee shall be paid annually. The fee established under this rule does not apply to any federal, state or local governmental entity.

Stat. Auth.: ORS Ch. 183 & 731

Stats. Implemented: ORS 183.335(7) & 731.804(2)

Hist.: ID 21-1990, f. & cert. ef. 12-18-90

836-009-0011

Assessments Against Insurers

(1) The percentage rates for assessments authorized under ORS 731.804 against authorized insurers shall be established as provided in this rule. An authorized insurer shall pay an assessment on each line of insurance transacted by the insurer in this state that is subject to assessment under ORS 731.804. This rule provides for establishment of a percentage rate for each of the following lines of insurance:

(a) Life insurance, not including annuities;

(b) Health insurance;

(c) Property and casualty insurance. For purposes of this rule, this line includes title insurance but does not include workers' compensation insurance.

(2) For each line of insurance in section (1) of this rule, the percentage rate for the assessment against each authorized insurer transacting the line of insurance shall be the rate established by dividing the amount of revenue needed to cover expenses to be incurred by the Department in administering the Insurance Code for a fiscal year with respect to the line of insurance by the gross amount of premiums received by all insurers or their agents from and under their policies covering direct domestic risks for that line of insurance, after deductions specified in ORS 731.804. The following is the formula for calculating the assessment rate for each line:

Total Amount to be derived from

assessment with respect to the line = Assessment

Total assessable premium from the line, rate (0.xxxx%)

for all insurers

(3) For a specific insurer:

(a) The assessment billed with respect to a line of insurance shall be determined by finding 0.xxxx% of the insurer's assessable premium for the line for the appropriate calendar year;

(b) The finance charge of charges imposed by the insurer shall be assessed at the lowest assessment rate established pursuant to this rule.

(4) The Director shall determine the amount of revenue needed by considering the legislatively approved expenditures for administration of the Insurance Code and the timing of cash revenues and expenditures, and subtracting therefrom other available revenue sources.

(5) The amount of premiums for all lines of insurance to be assessed against an insurer under sections (1) to (3) of this rule shall not exceed nine hundredths of one percent of the gross amount of premiums received by an insurer or its agents from and under its policies covering direct domestic risks, after deductions specified under ORS 731.804.

(6) Assessments under this rule shall be imposed and collected annually unless the Director determines that additional amounts need to be assessed and collected in order to support the legislatively authorized budget of the Department with respect to its functions under the Insurance Code or in order to support changes in the budget authorized by the Emergency Board. The additional amounts shall be assessed as provided in sections (1) to (3) of this rule, except that the numerator shall be the additional amounts so needed.

(7) The Director shall assess an insurer only if the insurer is authorized to transact insurance at the time of billing.

(8) The annual assessment that is based on 1990 premium and imposed in 1991 shall be billed on or after October 21, 1991. Beginning with the annual assessment that is based on 1991 premium and imposed in 1992, billings of annual assessments shall be issued not later than September 1 of each year.

(9) An insurer must pay each assessment imposed under this rule not later than the 30th day after the date of the billing of the assessment by the Department. An insurer shall pay interest at nine percent per annum on any assessment that is not paid when due.

(10) When the Director determines that an assessment or a part thereof paid by an insurer is in excess of the amount legally due and payable to the Department, if the amount of the refund owed by the Department is less than $50, the Department shall pay the refund only upon receipt of a written request from the insurer that paid the assessment. The written request must be received by the Department not later than three years from the date the assessment was paid to the Department.

(11) The Director shall not bill an assessment or an adjustment to an assessment of $25 or less.

Stat. Auth.: ORS Ch. 293, 731.244 & 731.804

Stats. Implemented: ORS 731.804(1)

Hist.: ID 8-1989, f. & cert. ef. 8-11-89; ID 8-1991, f. & cert. ef. 10-21-91

836-009-0015

Refunds

Except as provided by rule for fees and assessments under ORS 731.804, when the Director determines that the Department has received moneys in excess of the amount legally due and payable to the Department under the Insurance Code or that the Department in carrying out its functions under the Insurance Code has received moneys to which it has no legal interest, if the amount of the refund owed by the Department is less than $10, the Department shall pay the refund only upon receipt of a written request from the person who paid the money or the legal repre-sentative thereof. The written request must be received by the Department not later than three years from the date the moneys were paid to the Department.

Stat. Auth.: ORS Ch. 293 & 731

Stats. Implemented: ORS 293.445(4)

Hist.: ID 8-1989, f. & cert. ef. 8-11-89

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 10

GENERAL PROVISIONS

Rates and Forms

836-010-0000

Statutory Authority and Implementation

(1) OAR 836-010-0000, 836-010-0011 and 836-010-0021 are adopted under the authority of ORS 731.244 and 731.296, to aid in giving effect to provisions of ORS Chapters 737, 742 and 743 relating to the filing of rates and policy forms with the Director. The requirements of OAR 836-010-0000, 836-010-0011 and 836-010-0021 are in addition to any other requirements established by statute or by rule or bulletin of the Department.

(2) OAR 836-010-0000, 836-010-0011 and 836-010-0021 apply to all filings submitted or resubmitted to the Director on or after July 15, 1994.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 731.296, 737.205, 737.207, 743.003, 743.015 & 742.018

Hist.: ID 9-1994, f. 7-1-94, cert. ef. 7-15-94

Title Insurance Companies

836-010-0011

Filing, Review of Rates and Forms

(1) Except as provided in this section, this rule applies to filings of all insurers, including health care service contractors as defined in ORS 750.005 and fraternal benefit societies as governed by ORS Chapter 748. With respect to property and casualty insurance, this rule applies to all forms but applies only to rates for commercial liability insurance. This rule does not apply to:

(a) Title insurance filings;

(b) Workers' compensation insurance filings;

(c) Surety filings;

(d) Home protection insurance filings;

(e) Filings for mortgage insurance, which is the insurance against financial loss by reason of nonpayment of sums agreed to be paid, as defined in ORS 731.178, rather than a life insurance product offering payment of a mortgage in the event of death or disability;

(f) Purchasing group insurance filings;

(g) Filings by rating organizations licensed under ORS 737.355;

(h) Filings of health benefit plans, as that term is defined in ORS 743.730;

(i) Filings by legal expense organizations as defined in ORS 730.505; and

(j) Filings by multiple employer welfare arrangements subject to ORS 750.301 to 750.341.

(2) An insurer must submit a completed certification statement as provided in this section with each filing of a new or revised rate and each filing of a new or amended form. The insurer must use the statement in the Exhibit to this rule that applies to the line of insurance for which the filing is made. The statement must be completed and signed by:

(a) An officer of the insurer who is authorized by the insurer to do so; or

(b) An employee of the insurer who is specifically designated by the authorized officer to do so.

(3) An insurer filing changes to a form or forms that were previously approved must highlight or otherwise visually call attention to the changes and must submit the statement required by section (2) of this rule and a letter explaining the changes.

(4) A filing received for prior approval by the Department that does not comply with the requirements of this rule is disapproved and will be returned to the insurer without further review.

(5) A rate filing for commercial liability insurance received by the Department that does not comply with any applicable requirement of this rule is in noncompliance with the requirements and standards of ORS Chapter 737 and is thereby subject to issuance of an order of the Director under ORS 737.045(1) to discontinue or desist from use of the filed rate or rates.

[ED. NOTE: The Exhibit referred to or incorporated by reference in this rule is available from the Office of the Insurance Division.]

Stat. Auth.: 731.244 & 731.296

Stats. Implemented: ORS 731.296, 737.205, 737.207, 743.003, 743.015 & 743.018

Hist.: ID 9-1994, f. 7-1-94, cert. ef. 7-15-94; ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-010-0021

Required Actuarial Data

Except as provided in this rule, supporting actuarial data shall accompany every filing of property or casualty insurance rates submitted on a file and use basis under ORS 737.205. The data shall be in sufficient detail to justify the rate level change and shall demonstrate compliance with ORS 737.310 governing the making of rates. This rule does not apply to:

(1) Title insurance filings;

(2) Workers' compensation insurance filings;

(3) Surety filings;

(4) Home protection insurance filings;

(5) Filings for mortgage insurance, which is the insurance against financial loss by reason of nonpayment of sums agreed to be paid, as defined in ORS 731.178, rather than a life insurance product offering payment of a mortgage in the event of death or disability;

(6) Purchasing group insurance filings;

(7) Filings by legal expense organizations as defined in ORS 750.505; and

(8) Filings by multiple employer welfare arrangements subject to ORS 750.301 to 750.341.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 731.296, 737.205, 737.207, 743.003, 743.015 & 742.018

Hist.: ID 9-1994, f. 7-1-94, cert. ef. 7-15-94

Authorization of Insurers and General Requirements

836-010-0130

Statutory Authority; Purpose; Applicability

(1) OAR 836-010-0130 to 836-010-0145 are adopted pursuant to the general rulemaking authority of the Commissioner in ORS 731.244 to aid in the effectuation and enforcement of ORS 731.438.

(2) The purpose of OAR 836-010-0130 to 836-010-0145 is to prescribe title plant standards for title insurers.

(3) OAR 836-010-0130 to OAR 836-010-0145 applies to all authorized title insurers.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.438

Hist.: IC 1-1978, f. 3-27-78, ef. 4-1-78

836-010-0135

Definitions

As used in OAR 836-010-0130 to 836-010-0145, unless the context requires otherwise:

(1) "Adequate Maps" means:

(a) A map record of all recorded plats in the county covered by the title plant;

(b) Maps based on a complete set of government surveys showing all surveyed sections, government lots and donation land claims within the county covered by the title plant;

(c) Maps of such a scale that they are readily workable. In an area where the majority of the parcels are of less than one sixteenth of a section, maps shall be of a scale no smaller than 400 feet to the inch. A full section of land shall not be represented in a scale smaller than 2,000 feet to the inch;

(d) Maps showing all public streets, roads, highways, and railroad rights of way of record which can be accurately located by a reasonable search of the records.

(2) "General Index" means a complete compilation of matters affecting real property which do not describe, or cannot solely be assigned to a specific real property account, which may be found by a search of the proper records within the county covered by the title plant, and includes, not is not limited to:

(a) Unsatisfied judgments and tax liens;

(b) Conservatorships, guardianships, and estates of deceased persons arising during the preceding ten-year period;

(c) Divorce suits closed or pending during the preceding ten-year period;

(d) Powers of attorney during the preceding ten-year period.

(3) "Tract or Geographic Index" means a record of documents and proceedings which affect real property in the county covered by the title plant. Such an index may consist of summaries or replicas:

(a) Tract or geographic indexes relating to recorded plats are maintained separately, and may be referred to by name or by number, with accounts segregated to the block or in the absence of blocks to the smallest unit designated on the applicable recorded plat;

(b) Tract or geographic indexes which relate to ownership in all unplatted areas of the county, except land in national forest reserves, national parks and unpatented lands, are maintained in accounts segregated into section subdivisions and government lots. In the event ownership of parcels does not conform to section subdivisions or government lots, such parcels are assigned arbitrary reference numbers or symbols which correspond to like numbers or symbols shown on the arbitrary maps of the area, except if there are 30 or fewer ownership accounts in a quarter section that do not conform to section subdivisions or government lots or are not in a recorded plat then those ownership accounts can be filed under the designation of that particular quarter section without being assigned arbitrary reference numbers or symbols;

(c) Tract or geographic indexes may be maintained on ledger sheets, separate cards, sheets of film, or any other form or system, whether manual, mechanical, electronic or otherwise, or any combination of such forms or systems. The index ledger sheets, cards, sheets, or film may be bound in books or contained in envelopes or storage files. The segregated account contains a reference to deeds, contracts, suits, liens, unsatisfied mortgages, and other matters of record imparting constructive notice that specifically describe the real property that is subject to the account.

(4) "Currently posted" means, respects an OAR 836-010-0135(3) "tract or geographic index", and index in which postings or entries are made within 15 working days of recording or filing. The "tract or geographic index" shall extend continuously for a period of 20 years from the date of Certificate of Authority respects title insurers or date of execution of agency contract respects title agents.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.438

Hist.: IC 1-1978, f. 3-27-78, ef. 4-1-78

836-010-0140

Title Plant Standards

(1) The title plant shall maintain "adequate maps" as defined in OAR 836-010-0135, that will enable a person working the title plant to locate a tract of land which is the subject of a title search with reference to the government survey system.

(2) The title plant shall maintain a "general index", as defined in OAR 836-010-0135, in either alphabetical or phonetical order,so that any record pertaining to any person by name may be readily located.

(3) The title plant shall maintain a "currently posted" "tract or geographic index" as defined in OAR 836-010-0135.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.438

Hist.: IC 1-1978, f. 3-27-78, ef. 4-1-78

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 11

ANNUAL STATEMENTS AND REPORTS BY INSURERS

Annual Statements

836-011-0000

Annual Statement Blank and Instructions

(1) For the purpose of complying with ORS 731.574, every authorized insurer, including every health care service contractor, shall file its financial statement required by ORS 731.574 on the annual statement blank established by the National Association of Insurance Commissioners as of October 1, 1997, for the year ending December 31, 1997, for the type or types of insurance transacted by the insurer.

(2) Every authorized insurer, including every health care service contractor, shall complete its annual statement blank according to the applicable instructions prepared by the National Association of Insurance Commissioners as of October 15, 1997, for completing the blank referred to in section (1) of this rule, as required by ORS 731.574.

(3) Every authorized insurer, including every health care service contractor, shall file each annual statement supplement required by the applicable instructions prepared by the National Association of Insurance Commissioners as of October 15, 1997, and complete the supplement according to those instructions.

(4) This rule does not apply to any person exempt from the Insurance Code pursuant to ORS 731.032.

(5) This rule is adopted under the authority of ORS 731.574 and 733.210.

Stat. Auth.: ORS 731.574 & 733.210

Stats. Implemented: ORS 731.574 & 733.210

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 10-1994, f. & cert. ef. 12-14-94; ID 7-1995, f. & cert. ef. 11-15-95; Renumbered from 836-013-0000; ID 4-1996, f. 2-28-96, cert. ef. 3-1-96; ID 16 -1996, f. & cert. ef. 12-16-96; ID 11-1997, f. & cert. ef. 10-9-97

836-011-0010

Diskette Requirement; Authority and Implementation

(1) Each authorized insurer, including for purposes of this rule each health care service contractor, fraternal benefit society, multiple employer welfare arrangement and title insurer, shall file a copy of each annual statement and quarterly statement of the insurer with the National Association of Insurance Commissioners on diskette. The requirement under this section applies to the extent that the National Association of Insurance Commissioners has issued a diskette submission directive or has otherwise approved or prescribed an applicable diskette format for the particular class of insurer.

(2) Each domestic insurer, including for purposes of this rule each domestic health care service contractor, fraternal benefit society, multiple employer welfare arrangement and title insurer, shall file a copy of each annual statement and quarterly statement of the insurer with the Director on diskette.

(3) OAR 836-011-0010 is adopted under the authority of ORS 731.244 for the purpose of implementing ORS 731.574, 733.210 and 748.406.

Stat. Auth.: ORS 731.244, 731.574 & 733.210

Stats. Implemented: ORS 731.574, 733.210 & 748.406

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

AnnualAudited Financial Reports

836-011-0100

Authority; Effective Date

(1) OAR 836-011-0100 to 836-011-0230 are adopted by the Director pursuant to ORS 731.488.

(2) OAR 836-011-0100 to 836-011-0230 are effective upon filing with the Secretary of State. Each insurer to which OAR 836-011-0120 applies shall file the first audited financial report with the Director required by OAR 836-011-0120 on or before June 1, 1992, for the year ending December 31 immediately preceding.

(3) OAR 836-011-0100 to 836-011-0230 do not limit the Director's authority to order, conduct or perform examinations of insurers under the Insurance Code.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0110

Definition of Independent Certified Public Accountant

As used in OAR 836-011-0100 to 836-011-0230, "accountant" and "independent certified public accountant" mean an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in each state in which the accountant or accounting firm is licensed to practice. For a Canadian or British insurer, the term means a Canadian-chartered or British-chartered accountant.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(c)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0120

Filing and Extensions for Filing of Annual Audited Financial Reports

(1) Each insurer shall have an annual audit performed by an independent certified public accountant and shall file an audited financial report with the Director on or before June 1 for the year ending December 31 immediately preceding. The report must satisfy the requirements of OAR 836-011-0140.

(2) The Director may require an insurer to file an audited financial report on a date earlier than June 1 if the Director gives the insurer not less than 90 days' notice prior to the earlier date.

(3) The Director may grant one or more 30-day extensions of the June 1 filing date upon request of the insurer if the insurer and the independent certified public accountant performing the audit show the reasons for requesting the extension and if the Director determines that good cause exists for the extension. The request for extension must be submitted in writing not less than ten days prior to the filing date and must be signed by the insurer and the independent certified public accountant. The request must include sufficient detail to permit the Director to make an informed decision.

(4) The requirements under section (1) of this rule is subject to exemptions under OAR 836-011-0130.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(b)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0130

Exemptions

(1) The following insurers are exempt from the requirements of OAR 836-011-0100 to 836-011-0230:

(a) An insurer having direct premiums written in this state of less than $1,000,000 in any calendar year and having fewer than 1,000 policyholders or certificate holders of directly written policies nationwide at the end of the same calendar year is exempt from OAR 836-011-0100 to 836-011-0230 for such year unless the Director determines with respect to the insurer that compliance is necessary for the Director to carry out statutory responsibilities. The exemption under this subsection does not apply to any insurer that has assumed premiums pursuant to contracts or treaties of reinsurance, or both, of $1,000,000 or more;

(b) A foreign or alien insurer that has filed an audited financial report in another state pursuant to the other State's requirement of audited financial reports, if the Director determines that the other state's requirements are substantially similar to the requirements of OAR 836-011-0100 to 836-011-0230 and if the foreign or alien insurer does both of the following:

(A) Files with the Director a copy of the Audited Financial Report, the Report on Significant Deficiencies in Internal Controls and the Accountant's Letter of Qualifications that are filed with the other state, in accordance with the filing

dates specified in OAR 836-011-0120, 836-011-0200 and 836-011-0210. In lieu of the requirements of this paragraph, a Canadian insurer may file accountants' reports as filed with the Canadian Dominion Department of Insurance;

(B) Files with the Director a copy of any Notification of Adverse Financial Condition Report filed with the other state. The copy must be filed with the Director within the time specified in OAR 836-011-0190.

(c) An insurer to whom the Director has granted an exemption under section (2) of this rule, during the period in which the exemption is effective.

(2) Upon written application of any insurer, the Director may grant an exemption from compliance with OAR 836-011-0100 to 836-011-0230 if the Director finds upon review of the application that compliance would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(h)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0140

Contents of Annual Audited Financial Report

(1) An annual audited financial report required under OAR 836-011-0120 must report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed or otherwise permitted by the Department of Insurance of the state of domicile.

(2) The annual audited financial report shall include the following:

(a) A report of an independent certified public accountant;

(b) A balance sheet reporting admitted assets, liabilities and capital and surplus;

(c) A statement of operations;

(d) A statement of cash flows;

(e) A statement of changes in capital and surplus;

(f) Notes to financial statements. The notes shall include those required by the appropriate National Association of Insurance Commissioners Annual Statement Instructions and any other notes required by generally accepted accounting principles and shall also include the follows:

(A) A reconciliation of difference, if any, between the audited statutory financial statements and the annual statement filed pursuant to ORS 731.574, with a written description of the nature of the differences;

(B) A summary of ownership and relationships of the insurer and all affiliated companies.

(3) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Director. The financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file

an audited financial report, the comparative data may be omitted.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(a)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0150

Designation of Independent Certified Public Accountant

(1) An insurer shall obtain a letter from the certified public accountant retained by the insurer stating that the accountant is aware of the provisions of the Insurance Code and the rules of the Insurance Department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express the opinion of the accountant on the financial statements in terms of their conformity with the statutory accounting practices prescribed or otherwise permitted by that Department, specifying exceptions that the accountant believes appropriate.

(2) If the certified public accountant who was the certified public accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall so notify the Director not later than the fifth business day after the dismissal or resignation. The insurer shall also do the following:

(a) Notify the Director in a separate letter whether in the 24 months preceding the engagement there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure or auditing scope or procedure that, if not resolved to the satisfaction of the former accountant, would have caused the former accountant to make reference to the subject matter of the disagreement in connection with the accountant's opinion. The disagreements required to be reported in response to this subsection include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction, and are those disagreements that occur at the decision making level, between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report;

(b) Request the former accountant, in writing, to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which the accountant does not agree;

(c) Furnish the Director the letter received from the former accountant under subsection (b) of this section together with a response by the insurer to that letter.

(3) When an insurer engages a certified public accountant to audit the insurer's financial statements and the certified public accountant is not the certified public accountant who prepared the immediately preceding filed audited financial report for the insurer, the insurer shall notify the Director of the engagement not later than the 30th day after the effective date of the engagement.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(c)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0160

Qualifications of Independent Certified Public Accountant

(1) An insurer shall not retain any person as a certified public accountant for the purposes of OAR 836-011-0100 to 836-011-0230 who is not in good standing with the American Institute of Certified Public Accountants and in all states in which the person is licensed to practice as a certified public accountant. If the insurer is a Canadian or British insurer, the insurer shall not retain any person who is not a chartered accountant. The Director shall not recognize any person retained by an insurer contrary to the prohibitions in this section and may refuse to accept an audited report in the preparation of which the person participated.

(2) Except as otherwise provided in this rule, an insurer shall not retain a certified public accountant that does not conform to the standards of the certified public accountant profession, as contained in the **Code of Professional Ethics** of the American Institute of Certified Public Accountants and the rules and the **Code of Professional Conduct** of the Oregon State Board of Accountancy, or a similar code of conduct of the state board regulating the practice of accountancy in the state in which the accountant is licensed to practice.

(3) No partner or other person employed by an independent certified public accounting firm that is responsible for rendering a report may act in that capacity for more than seven consecutive years. Following any period of service, the partner or other person shall not act in that or a similar capacity for the same insurer or its insurance subsidiary or affiliate for a period of two years. An insurer may apply to the Director for relief from the prohibition in this section on the basis of unusual circumstances. The Director may consider the following factors in determining whether the relief should be granted:

(a) The number of partners, the expertise of the partners or the number of insurance clients in the currently registered firm;

(b) The premium volume of the insurer;

(c) The number of jurisdictions in which the insurer transacts insurance.

(4) Section (3) of this rule first applies January 1, 1994. For purposes of the initial application of section (3) of this rule, the period of seven consecutive years' service includes consecutive years of service immediately preceding January 1, 1994.

(5) An insurer shall not retain an individual as an independent certified public accountant, or submit any annual audited financial report required by OAR 836-011-0100 to 836-011-0230 that is prepared in whole or part by an individual, who:

(a) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, **18 U.S.C. Sections 1961-1968**, or any dishonest conduct or practices under federal or state law;

(b) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under OAR 836-011-0100 to 836-011-0230; or

(c) Has failed to detect or disclose material information in any report filed under OAR 836-011-0100 to 836-011-0230.

(6) The Director may hold a hearing to determine whether a certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing the accountant's opinion on the financial statements in the annual audited financial report made pursuant to OAR 836-011-0100 to 836-011-0230 and require the insurer to replace the accountant with another accountant who is qualified with respect to the insurer as provided in OAR 836-011-0100 to 836-011-0230.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(c)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0170

Consolidated or Combine Audits

An insurer may apply in writing to the Director for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurers that uses a pooling or one hundred percent reinsurance agreement affecting the solvency and integrity of the insurer's reserves and if the insurer cedes all of its direct and assumed business to the pool. In such a case, a columnar consolidating or combining worksheet shall be filed with the report as follows:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.

(2) Amounts for each insurer subject to this rule shall be stated separately.

(3) Noninsurance operations maybe shown on the worksheet on a combined or individual basis.

(4) Explanations of consolidating and eliminating entries shall be included.

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(a)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0180

Scope of Examination and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to OAR 836-011-0140 shall be examined by an independent certified public accountant. The examination of the insurer's financial statements must be conducted in accordance with generally accepted auditing standards. Consideration shall also be given to such other procedures illustrated in the **Financial Condition Examiner's Handbook** promulgated by the National Association of Insurance Commissioners as the certified public accountant determines to be necessary.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(d)-(e)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0190

Notification of Adverse Financial Condition

(1) An insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report in writing to the Board of directors or its audit committee any determination by the independent

certified public accountant that the insurer has materially misstated its financial condition as reported to the Director as of the date of the balance sheet currently under examination or that the insurer does not meet the minimum capital and surplus requirement of the **Oregon Insurance Code** as of that date. The insurer shall require the independent certified public accountant to submit the report not later than the fifth business day after the independent certified public accountant makes such a determination. An insurer that has received a report under this section shall forward a copy of the report to the Director not later than the fifth business day after receiving the report and shall provide the independent certified public accountant with evidence that the report was furnished to the Director. If the independent certified public accountant does not receive the evidence within the required period, the independent certified public accountant shall furnish to the Director a copy of its report not later than the fifth day after the end of the period within which the insurer was required to submit the report.

(2) An independent certified public accountant shall not be liable to any person for any statement made in connection with the requirements of section (1) of this rule if the statement is made in good faith and in compliance with section (1) of this rule.

(3) If the accountant, after the date of the audited financial report filed pursuant to OAR 836-011-0100 to 836-011-0230, becomes aware of facts that might have affected the report, the Director notes the obligation of the accountant to act as prescribed in **Volume 1, Section AU 561** of the **Professional Standards of the American Institute of Certified Pubic Accountants**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(f)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0200

Report on Significant Deficiencies in Internal Controls

(1) If an independent certified public accountant communicates to an insurer during an audit any significant deficiencies in the insurer's internal control structure, the insurer shall furnish the Director a written report prepared by the accountant describing the deficiencies. The report must be filed not later than the 60th day after the filing of the annual audited financial statement to which the report applies. Preparation of the report is subject to **SAS No. 60 Communications of Internal Control Structure Matter Noted in an Audit** (**AU Section 325 of the Professional Standards of the American Institute of Certified Public Accountants**), which requires an accountant to communicate significant deficiencies, known as "reportable conditions", noted during a financial statement audit to the appropriate parties within an entity.

(2) The insurer shall submit with the report required under section (1) of this rule a description of remedial actions taken or proposed to correct significant deficiencies, if the actions are not described in the accountant's report.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(g)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0210

Accountant's Letter of Qualifications

(1) An insurer shall include with the filing of each annual audited financial report with the Director a letter meeting the requirements of section (2) of this rule from the independent certified public accountant who prepared the report.

(2) The independent certified public accountant who prepares an annual audited financial report for an insurer shall furnish the insurer, in connection with the report, a letter stating the following:

(a) That the accountant is independent with respect to the insurer and conforms to the standards of the accounting profession as contained in the **Code of Professional Ethics** and pronouncements of the American Institute of Certified Public Accountants and the Rules of Professional Conduct of the Oregon State Board of Accountancy, or a similar code of conduct of the state board regulating the practice of accountancy in the state in which the accountant is licensed to practice;

(b) The background and experience in general, and the experience in audits of insurers specifically, of the staff assigned to the engagement and whether each is an independent certified public accountant;

(c) That the accountant understands that the annual audited financial report and the opinion of the accountant thereon must be filed in compliance with OAR 836-011-0100 to 836-011-0230 and that the Director may rely on the information contained in the report and opinion in the monitoring and regulation of the financial position of the insurers with respect to whom the report and opinion are filed;

(d) That the accountant consents to the requirements of OAR 836-011-0100 to 836-011-0230 and that the accountant agrees to make the workpapers described in OAR 836-011-0220 available for review by the Director;

(e) A representation that the accountant is currently licensed by an appropriate state licensing authority and is a member in good standing in the American Institute of Certified Public Accountants;

(f) A representation that the accountant is in compliance with OAR 836-011-0160.

(3) This rule does not prohibit an independent certified public accountant from using such staff as the accountant determines appropriate when use of the staff is consistent with the standards prescribed by generally accepted auditing standards.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(b)-(c)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0220

Certified Public Accountant Workpapers

(1) Each insurer required to file an audited financial report pursuant to OAR 836-011-0100 to 836-011-0230 shall require the independent certified public accountant performing the audit to make available for review by Department examiners the workpapers prepared in the conduct of the accountant's examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Insurance Division of the Department of Insurance and Finance, or at any other place designated by the Director. The insurer shall require that the accountant retain the audit workpapers and communications until the Director has filed a Report on Examination covering the period of the audit but in any event not longer than seven years from the date of the audit report. For purposes of this rule, workpapers include:

(a) The records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained and the conclusions reached pertinent to the examination by the accountant of the financial statements of the insurer;

(b) Audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of examination of the financial statements of an insurer, supporting the opinion of the accountant.

(2) In the conduct of an examination of an insurer by the Director, the insurer and independent certified public accountant shall allow the Director to make and retain copies of pertinent audit workpapers. Such reviews by the Director are investigations and all working papers and communications obtained in the course of such investigations are afforded the same confidentiality as other examination workpapers generated by the Director under the **Insurance Code**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(i)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

836-011-0230

Canadian and British Companies

In the case of Canadian and British insurers, the annual audited financial report is the annual statement of total business on the form filed by such companies with their domiciliary supervision authority and audited by an independent chartered accountant. For such insurers, the letter required under OAR 836-011-0150 shall state that the accountant is aware of the requirements relating to the annual audited statement filed with the Director under OAR 836-011-0120 and shall affirm that the opinion expressed is in conformity with such requirements.

Stat. Auth.: ORS 731.244 & 731.488

Stats. Implemented: ORS 731.488(2)(b)-(c)

Hist.: ID 4-1992, f. & cert. ef. 3-26-92

Risk-based Capital Reporting

836-011-0300

Statutory Authority; Statutes Implemented

(1) OAR 836-011-0300 to 836-011-0400 apply to insurers that are subject to the capital and surplus requirements of ORS 731.554 and insurers that are subject to the capital and surplus requirements of ORS 731.566.

(2) OAR 836-011-0300 to 836-011-0400 are adopted pursuant to the authority of ORS 731.244, 731.554, 731.574 and 733.210 for the purpose of implementing ORS 731.554 and 731.574.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0305

Definitions

As used in OAR 836-011-0300 to 836-011-0400:

(1) "Adjusted RBC report" means a risk-based capital (RBC) report that has been adjusted by the Director in accordance with OAR 836-011-0310(5).

(2) "Corrective order" means an order issued by the Director specifying corrective actions that the Director has determined are required.

(3) "NAIC" means the National Association of Insurance Commissioners.

(4) "Life or health insurer" means an insurer transacting life insurance or health insurance or both or an insurer authorized to transact property and casualty insurance but writing only health insurance.

(5) "Property and casualty insurer" means an insurer transacting property and casualty insurance, or either, but does not include an insurer transacting only monoline mortgage guaranty insurance, financial guaranty insurance or title insurance, or an insurer authorized to transact property and casualty insurance but writing only health insurance.

(6) "Negative trend" means, with respect to a life or health insurer, negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions.

(7) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(8) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC, defined as follows:

(a) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(b) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(c) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(d) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(9) "RBC plan" means a comprehensive financial plan containing the elements specified in OAR 836-011-0320(2). If the Director rejects the RBC plan and it is revised by the insurer with or without the Director's recommendation, the plan shall be called the "revised RBC plan."

(10) "RBC report" means the report required in OAR 836-011-0310.

(11) "Total adjusted capital" means the sum of:

(a) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under ORS 731.574; and

(b) Such other items, if any, as the RBC instructions may provide.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0310

RBC Reports

(1) Each domestic insurer shall, on or prior to each March 1 (the "filing date"), prepare and submit to the Director a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(A) 15 days from the receipt of notice to file its RBC report with that state; or

(B) The filing date.

(2) A life or health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between) the following, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between) the following, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in OAR 836-011-0300 to 836-011-0400 and the formulas, schedules and instructions referenced in OAR 836-011-0300 to 836-011-0400

is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by OAR 836-011-0300 to 836-011-0400. additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in OAR 836-011-0300 to 836-011-0400.

(5) If a domestic insurer files an RBC report that in the judgment of the Director is inaccurate, the Director shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is an "adjusted RBC report" for purposes of OAR 836-011-0300 to 836-011-0400.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0320

Company Action Level Event

(1) "Company action level event" means any of the following events:

(a) The filing of an RBC report by an insurer indicating that:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(B) If a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5 and has a negative trend;

(b) The notification by the Director to the insurer of an adjusted RBC report that indicates an event in subsection (a) of this section, if the insurer does not challenge the adjusted RBC report under OAR 836-011-0360; or

(c) If, pursuant to OAR 836-011-0360, an insurer challenges an adjusted RBC report that indicates the event in subsection (a) of this section, the notification by the Director to the insurer that the Director has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the Director an RBC plan that shall:

(a) Identify the conditions contributing to the company action level event;

(b) Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. The projections for both new and renewal business must include separate projections for each major line of business and separately identify each significant income, expense and benefit component, if the Director so requires;

(d) Identify the key assumptions affecting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of and problems associated with the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(3) The insurer shall submit the RBC Plan:

(a) Not later than the 45th day after the company action level event; or

(b) If the insurer challenges an adjusted RBC report pursuant to OAR 836-011-0360, not later than the 45th day after the Director's notification to the insurer that the Director has, after a hearing, rejected the insurer's challenge.

(4) Not later than the 60th day after an insurer has submitted an RBC plan to the Director, the Director shall notify the insurer whether the RBC plan shall be implemented or is unsatisfactory, in the judgment of the Director. If the Director determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory, in the judgment of the Director. Upon notification from the Director, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Director, and shall submit the revised RBC plan to the Director:

(a) Not later than the 45th day after the notification from the Director; or

(b) If the insurer challenges the notification from the Director under OAR 836-011-0360, not later than the 45th day after a notification to the insurer that the Director has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the Director to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the Director at the Director's discretion, subject to the insurer's right to a hearing under OAR 836-011-0360, may specify in the notification that the notification constitutes a regulatory action level event.

(6) A domestic insurer that files an RBC plan or revised RBC plan with the Director shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to transact insurance if such a state has an RBC provision substantially similar to section 4, chapter 638, Oregon Laws 1995, and the insurance commissioner of that state has notified the insurer of its request for the filing in writing. The insurer shall file the copy in that state not later than the later of the following:

(a) The 15th day after receipt of the notice to file a copy of its RBC plan or revised RBC plan with the state; or

(b) The date on which the RBC plan or revised RBC plan is filed under section (3) or (4) of this rule, as applicable.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0330

Regulatory Action Level Event

(1) "Regulatory action level event" means, with respect to an insurer, any of the following events:

(a) The filing of an RBC report by the insurer that indicates the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) Notification by the Director to the insurer of an adjusted RBC report that indicates the event in subsection (a) of this section (1), if the insurer does not challenge the adjusted RBC report under OAR 836-011-0360;

(c) If, pursuant to OAR 836-011-0360, the insurer challenges an adjusted RBC report that indicates the event in subsection (a) of this section (1), notification by the Director to the insurer that the Director has, after a hearing, rejected the insurer's challenge;

(d) Failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the Director and has cured the failure not later than the 10th day after the filing date;

(e) Failure of the insurer to submit an RBC plan to the Director within the time period established in OAR 836-011-0320(3);

(f) Notification by the Director to the insurer that:

(A) The RBC plan or revised RBC plan submitted by the insurer is unsatisfactory, in the judgment of the Director; and

(B) Such notification constitutes a regulatory action level event with respect to the insurer, if the insurer has not challenged the determination under OAR 836-011-0360;

(g) If, pursuant to OAR 836-011-0360, the insurer challenges a determination by the Director under subsection (f) of this section, the notification by the Director to the insurer that the Director has, after a hearing, rejected the challenge;

(h) Notification by the Director to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the Director has so stated in the notification, and if the insurer has not challenged the determination under OAR 836-011-0360; or

(i) If, pursuant to OAR 836-011-0360, the insurer challenges a determination by the Director under subsection (h) of this section (1), the notification by the Director to the insurer that the Director has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event, the Director shall:

(a) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis of the assets, liabilities and operations of the insurer as the Director determines to be necessary, including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue a corrective order specifying the corrective actions that the Director determines to be required.

(3) In determining corrective actions, the Director may take into account the factors that the Director determines to be relevant with respect to the insurer, based upon the Director's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Not later than the 45th day after the occurrence of the regulatory action level event;

(b) If the insurer challenges an adjusted RBC report pursuant to OAR 836-011-0360 and the challenge is not frivolous in the judgment of the Director, not later than the 45th day after the notification to the insurer that the Director has, after a hearing, rejected the insurer's challenge; or

(c) If the insurer challenges a revised RBC plan pursuant to OAR 836-011-0360 and the challenge is not frivolous in the judgment of the Director, not later than the 45th day after the notification to the insurer that the Director has, after a hearing, rejected the insurer's challenge.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.216, 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0340

Authorized Control Level Event

"Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the insurer indicating that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) Notification by the Director to the insurer of an adjusted RBC report indicating the event in subsection (a) of this section, if the insurer does not challenge the adjusted RBC report under OAR 836-011-0360;

(c) If, pursuant to OAR 836-011-0360, the insurer challenges an adjusted RBC report that indicates the event in subsection (a) of this section, notification by the Director to the insurer that the Director has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to respond to a corrective order, in a manner satisfactory to the Director, if the insurer has not challenged the corrective order under OAR 836-011-0360; or

(e) If the insurer has challenged a corrective order under OAR 836-011-0360 and the Director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond to the corrective order in a manner satisfactory to the Director subsequent to rejection or modification by the Director.

(2) In the event of an authorized control level event with respect to an insurer, the Director shall:

(a) Take such actions as are required under OAR 836-011-0330 regarding an insurer with respect to which an regulatory action level event has occurred; or

(b) If the Director determines it to be in the best interests of the policyholders and creditors of the insurer and of the public, take actions necessary to cause the insurer to be placed under regulatory control under ORS 734.059 to 734.440. If the Director takes such actions, the authorized control level event is sufficient grounds for the Director to take action under ORS 734.150 (1) or (4) or 734.170, and the Director shall have the rights, powers and duties with respect to the insurer as are set forth in ORS 734.059 to 734.440.

Stat. Auth.:ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0350

Mandatory Control Level Event

(1) "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report indicating that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by the Director to the insurer of an adjusted RBC report that indicates the event in subsection (a) of this section, if the insurer does not challenge the adjusted RBC report under OAR 836-011-0360; or

(c) If, pursuant to OAR 836-011-0360, the insurer challenges an adjusted RBC report that indicates the event in subsection (a) of this section, notification by the Director to the insurer that the Director has, after a hearing, rejected the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) With respect to an insurer transacting life insurance, the Director shall take actions necessary to place the insurer under regulatory control under ORS 734.059 to 734.440. In that event, the mandatory control level event is sufficient grounds for the Director to take action under ORS 734.150 (1) or (4) or 734.170, and the Director shall have the rights, powers and duties with respect to the insurer as are set forth in ORS 734.059 to 734.440. Notwithstanding the provisions of this subsection, the Director may forego action for not more than 90 days after the mandatory control level event if the Director finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(b) With respect to an insurer transacting property and casualty insurance, the Director shall take actions necessary to place the insurer under regulatory control under ORS 734.059 to 734.440, or, in the case of an insurer that is writing no business and that is running off its existing business, may allow the insurer to continue its run-off under the supervision of the Director. In either event, the mandatory control level event is sufficient grounds for the Director to take action under ORS 734.150 (1) or (4) or 734.170, and the Director shall have the rights, powers and duties with respect to the insurer as are set forth in ORS 734.059 to 734.440. Notwithstanding the provisions of this subsection, the Director, may forego action for not more than 90 days after the mandatory control level event if the Director finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90 day period.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0360

Hearings

An insurer may request a hearing, as provided in ORS 731.240, for the purpose of challenging any determination or action by the Director in connection with any event described in this rule. The insurer shall notify the Director of its request for a hearing not later than the fifth day after notification by the Director under any of the events described in this rule. Upon receipt of the insurer's request for a hearing, the Director shall set a date for the hearing. The date shall be not less than 10 nor more than 30 days after the date of the insurer's request. The events to which the opportunity for a hearing under this rule relates are as follows:

(1) Notification to an insurer by the Director of an adjusted RBC report;

(2) Notification to an insurer by the Director that the insurer's RBC plan or revised RBC plan is unsatisfactory, and such notification constitutes a regulatory action level event with respect to the insurer;

(3) Notification to any insurer by the Director that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(4) Notification to an insurer by the Director of a corrective order with respect to the insurer.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.240, 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0380

Supplemental Provisions; Exemption

(1) 836-011-0300 to 836-011-0400 are supplemental to any other provisions of the laws of this state, and do not preclude or limit any other powers or duties of the Director under such laws, including, but not limited to, OAR 836-011-0100 to 836-011-0120.

(2) OAR 836-011-0300 to 836-011-0400 do not apply to any domestic insurer transacting property and casualty insurance that:

(a) Writes direct business only in this state;

(b) Writes direct annual premiums of $2 million or less; and

(c) Assumes no reinsurance in excess of five percent of direct premium written.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0390

Foreign Insurers

(1) A foreign insurer shall, upon the written request of the Director, submit to the Director an RBC report as of the end of the calendar year just ended on the later of:

(a) The date by which an RBC report would be required to be filed by a domestic insurer under OAR 836-011-0300 to 836-011-0400; or

(b) The 15th day after the request is received by the foreign insurer.

(2) A foreign insurer shall, at the written request of the Director, promptly submit to the Director a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(3) In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign insurer as determined under the statute or rule governing risk based capital reporting applicable in the state of domicile of the insurer (or, if no such statute or rule is in force in that state, under the provisions of OAR 836-011-0300 to 836-011-0400), if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's statute or rule governing risk-based capital reporting (or, if no such statute or rule is in force in that state, under OAR 836-011-0320), the Director may require the foreign insurer to file an RBC plan with the Director. In such event, the failure of the foreign insurer to file an RBC plan with the Director shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(4) In the event of a mandatory control level event with respect to any foreign insurer, if a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Director may apply for an order under ORS 734.190 with respect to the conservation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application under ORS 734.150(1) or (4).

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0400

Phase-In Provision

For RBC reports required to be filed by insurers with respect to 1995, the following requirements shall apply in lieu of the provisions of OAR 836-011-0320, 836-011-0330, 836-011-0340 and 836-011-0350:

(1) In the event of a company action level event with respect to a domestic insurer, the Director shall take no regulatory action under OAR 836-011-0300 to 836-011-0400;

(2) In the event of a regulatory action level event under OAR 836-011-0330(1)(a), (b) or (c), the Director shall take the actions required under OAR 836-011-0320.

(3) In the event of a regulatory action level event under OAR 836-011-0330(1)(d), (e), (f), (g), (h) or (i) or an authorized control level event, the Director shall take the actions required under OAR 836-011-0330 with respect to the insurer.

(4) In the event of a mandatory control level event with respect to an insurer, the Director shall take the actions required under OAR 836-011-0340 with respect to the insurer.

Stat. Auth.: ORS 731.244, 731.554 & 733.210

Stats. Implemented: ORS 731.554 & 731.574

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

Disclosure of Material Transactions

836-011-0430

Scope and Authority

(1) OAR 836-011-0430 to 836-011-0460 apply to all domestic insurers and to all domestic health care service contractors under ORS 750.055 and multiple employer welfare arrangements under ORS 750.333. For purposes of OAR 836-011-0430 to 836-011-0460, "insurer" includes health care service contractors and multiple employer welfare arrangements.

(2) OAR 836-011-0430 to 836-011-0460 are adopted under the authority of ORS 731.244, 731.574 and 733.210.

Stat. Auth.: ORS 731.244 & 731.574

Stats. Implemented: ORS 731.574 & 733.210

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0440

Report

(1) Every domestic insurer shall file a report with the Director of the Department of Consumer and Business Services disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements have been submitted to the Director for review, approval or information purposes pursuant to other provisions of the Insurance Code, laws, rules or other requirements.

(2) The report required in section (1) of this rule is due not later than the 15th day after the end of the calendar month in which any of the transactions described in section (1) of this rule occurs.

(3) One complete copy of the report, including any exhibits or other attachments, shall be filed with:

(a) The insurance department of the insurer's state of domicile; and

(b) The National Association of Insurance Commissioners.

Stat. Auth.: ORS 731.244 & 731.574

Stats. Implemented: ORS 731.574 & 733.210

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0450

Acquisitions and Dispositions of Assets

(1) Materiality. No acquisitions or dispositions of assets need be reported pursuant to OAR 836-011-0440 if the acquisitions or dispositions are not material. For purposes of OAR 836-011-0430 to 836-011-0460, a material acquisition (or the aggregate of any series of related acquisitions during any 30-day period) or disposition (or the aggregate of any series of related dispositions during any 30-day period) is one that is non-recurring and not in the ordinary course of business and involves more than five percent of the reporting insurer's total allowed assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(2) Scope. OAR 836-011-0430 to 836-011-0460 apply to the following asset acquisitions and asset dispositions:

(a) Asset acquisitions subject to OAR 836-011-0430 to 836-011-0460 include every purchase, lease, exchange, merger, consolidation, succession or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(b) Asset dispositions subject to OAR 836-011-0430 to 836-011-0460 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction or other disposition.

(3) Information to be reported:

(a) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(A) Date of the transaction;

(B) Manner of acquisition or disposition;

(C) Description of the assets involved;

(D) Nature and amount of the consideration given or received;

(E) Purpose of, or reason for, the transaction;

(F) Manner by which the amount of consideration was determined;

(G) Gain or loss recognized or realized as a result of the transaction; and

(H) Name or names of the person or persons from whom the assets were acquired or to whom they were disposed.

(b) An insurer is required to report material acquisitions and dispositions on a non-consolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Stat. Auth.: ORS 731.244 & 731.574

Stats. Implemented: ORS 731.574 & 733.210

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-011-0460

Nonrenewals, Cancellations or Revisions of Ceded Reinsurance Agreements

(1) Materiality and scope:

(a) No nonrenewals, cancellations or revisions of ceded reinsurance agreements need be reported pursuant to OAR 836-011-0440 if the nonrenewals, cancellations or revisions are not material. For purposes of OAR 836-011-0430 to 836-011-0460, a material nonrenewal, cancellation or revision is one that affects:

(A) As respects property and casualty business, including accident and health business written by a property and casualty insurer:

(i) More than fifty percent of the insurer's total ceded written premium; or

(ii) More than fifty percent of the insurer's total ceded indemnity and loss adjustment reserves.

(B) As respects life, annuity, and accident and health business: more than fifty percent of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement;

(C) As respects either property and casualty business or life, annuity, and accident and health business, either of the following events shall constitute a material revision that must be reported:

(i) An authorized reinsurer representing more than ten percent of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) Previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent of a total cession.

(b) However, no filing shall be required if:

(A) As respects property and casualty business, including accident and health business written by a property and casualty insurer: the insurer's total ceded written premium represents, on an annualized basis, less than ten percent of its total written premium for direct and assumed business; or

(B) As respects life, annuity, and accident and health business: the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of the statutory reserve requirement prior to any cession.

(2) Information to be reported:

(a) The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of a ceded reinsurance agreement:

(A) Effective date of the nonrenewal, cancellation or revision;

(B) The description of the transaction with an identification of the initiator thereof;

(C) Purpose of, or reason for, the transaction; and

(D) If applicable, the identity of the replacement reinsurers.

(b) Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements on a non-consolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Stat. Auth.: ORS 731.244 & 731.574

Stats. Implemented: ORS 731.574 & 733.210

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

Questions about Administrative Rules?

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Oregon Administrative Rules
1998 Compilation

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 12

CREDIT FOR REINSURANCE

836-012-0000

Authority

(1) OAR 836-012-0000 to 836-012-0110 are adopted pursuant to ORS 731.508 to 731.511, and general rulemaking authority under ORS 731.244.

(2) OAR 836-012-0000 to 836-012-0110 are adopted for the purpose of establishing standards and procedural requirements that the Director determines to be necessary for carrying out ORS 731.508 to 731.511, relating to credit for reinsurance, for the protection of the insurance-buying public and the ceding insurers in this state.

(3) Form AR-1, Certificate of Assuming Insurer, **Exhibit 1** to this rule, is adopted for purposes of OAR 836-012-0000 to 836-012-0110, when the use of the form is required by such rules.

[ED. NOTE: Exhibit 1 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

Registration of Insurance Holding Company Systems

836-012-0011

Credit for Reinsurance - Reinsurer Authorized in this State

Pursuant to ORS 731.509 (2), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer holding a certificate of authority in this state as of the date of the financial statement filed by the ceding insurer under ORS 731.574, whether filed annually or more frequently.

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0021

Credit for Reinsurance - Accredited Reinsurers

(1) Pursuant to ORS 731.509 (3) and 731.511, the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is accredited as a reinsurer in this state as of the date of the financial statement filed by the ceding insurer under ORS 731.574, whether filed annually or more frequently. To obtain and maintain its accreditation, an accredited reinsurer must:

(a) File a properly executed Form AR-1 (**Exhibit 1**, OAR 836-012-0000) as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

(b) File with the Director a certified copy of a letter or a certificate of authority or of compliance as evidence that it is licensed or authorized to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed or authorized to transact insurance or reinsurance in at least one state;

(c) File annually with the Director a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed or authorized to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and

(d) Maintain capital and surplus in an amount not less than $20,000,000 and whose accreditation has not been denied by the Director on or before the 90th day after its submission or, in the case of a reinsurer with capital and surplus of less than $20,000,000, whose accreditation has been approved by the Director.

(2) If the Director determines that the assuming insurer has failed to meet or maintain any of the qualifications stated in section (1) of this rule, the Director, upon written notice and opportunity for hearing, may revoke the accreditation. No credit shall be allowed a domestic ceding insurer with respect to reinsurance ceded after January 1, 1994, if the assuming insurer's accreditation has been denied or revoked by the Director after notice and opportunity for hearing.

[ED. NOTE: Exhibit 1 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0031

Credit for Reinsurance - Reinsurer Domiciled and Licensed in Another State

(1) Pursuant to ORS 731.509 (4), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of the date of the ceding insurer's financial statement under ORS 731.574, whether filed annually or more frequently:

(a) Is domiciled and licensed or authorized in a state employing standards regarding credit for reinsurance that equal or

exceed those applicable under ORS 731.509 to 731.511 and OAR 836-012-0000 to 836-012-0110 or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed or authorized in a state employing such standards;

(b) Maintains capital and surplus in an amount not less than $20,000,000; and

(c) Files a properly executed Form AR-1 (**Exhibit 1**, OAR 836-12-000) with the Director as evidence of its submission to this state's authority to examine its books and records.

(2) The provisions of this rule relating to capital and surplus do not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

[ED. NOTE: Exhibit 1 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0041

Credit for Reinsurance -- Reinsurers Maintaining Trust Funds

(1) Pursuant to ORS 731.509 (5), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that, as of the date of the ceding insurer's financial statement under ORS 731.574, whether filed annually or more frequently, maintains a trust fund in an amount prescribed in this rule in a qualified United States financial institution as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the Director substantially the same information as that required to be reported on the National Association of Insurance Commissioners annual statement form by authorized insurers, to enable the Director to determine the sufficiency of the trust fund.

(2) The following requirements apply to the following categories of assuming insurer:

(a) The trust fund for a single assuming insurer must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to business written in the United States, and in addition, a trusteed surplus of not less than $20,000,000;

(b) The trust fund for a group that includes incorporated and individual unincorporated underwriters must consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100,000,000 must be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the Director annual certifications by the group's domiciliary regulator and its independent certified public accountants of the solvency of each underwriter member of the group; and

(c) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000, calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners, and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the assuming insurers' liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group. In addition, the group shall maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States ceding insurers of any

member of the group. The group shall file a properly executed Form AR-1 (**Exhibit 1**, OAR 836-012-0000) as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the Director annual certifications by the members' domiciliary regulators and their independent certified public accountants of the solvency of each member of the group.

(3) The trust must be established in a form approved by the Director and complying with ORS 731.509 and this rule. The trust instrument shall provide that:

(a) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States;

(b) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in interest;

(c) The trust shall be subject to examination as determined by the Director;

(d) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, has outstanding obligations under reinsurance agreements subject to the trust;

(e) Not later than March 1 of each year, the trustees of the trust shall submit to the Director in writing a report setting forth the balance in the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the next following December 31; and

(f) No amendment to the trust shall be effective unless reviewed and approved in advance by the Director.

[ED. NOTE: Exhibit 1 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 731.508 & 731.509

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 7-1995, f. & cert. ef. 11-15-95

836-012-0051

Credit for Reinsurance Required by Law

Pursuant to ORS 731.509 (6), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of ORS 731.509 (2), (3), (4) or (5), but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this rule, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0060

Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer

(1) Pursuant to ORS 731.510, the Director shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of ORS 731.509 in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in ORS 731.510 (1). The security may be in the form of any of the following:

(a) Cash;

(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as allowed assets;

(c) Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in ORS 731.510 (2), effective no later than December 31 of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs;

(d) Any other form of security acceptable to the Director.

(2) An allowed asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to subsections (a), (b) and (c) of section (1) of this rule shall be allowed only when the requirements of OAR 836-012-0070, 836-012-0080 and 836-012-0090 are met.

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0070

Trust Agreements Qualified under OAR 836-012-0060

(1) As used in this rule:

(a) "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.

(b) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unauthorized, unlicensed or unaccredited assuming insurer.

(c) "Obligations," as used in section (2)(k) of this rule, means:

(A) Reinsured losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer;

(B) Reserves for reinsured losses reported and outstanding;

(C) Reserves for reinsured losses incurred but not reported; and

(D) Reserves for allocated reinsured loss expenses and unearned premiums.

(2) The following are required conditions applicable to the trust agreement:

(a) The trust agreement must be entered into between the beneficiary, the grantor and a trustee that must be a qualified United States financial institution as defined in ORS 731.510 (1).

(b) The trust agreement must create a trust account into which assets must be deposited.

(c) All assets in the trust account must be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Director's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this rule. If the Director approves the use of the foreign branch office as trustee, its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in section (2)(d)(A) of this rule must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.

(d) The trust agreement must provide that:

(A) The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(B) No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(C) It is not subject to any conditions or qualifications outside the trust agreement; and

(D) It shall not contain references to any other agreements or documents except as provided for under subsection (k) of this section.

(e) The trust agreement shall be established for the sole benefit of the beneficiary.

(f) The trust agreement shall require the trustee to:

(A) Receive assets and hold all assets in a safe place;

(B) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(C) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(D) Notify the grantor and the beneficiary within ten days of any deposits to or withdrawals from the trust account;

(E) Upon written demand of the beneficiary, immediately take all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(F) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(g) The trust agreement shall provide that at least 30 days but not more than 45 days prior to termination of the trust

account, written notification of termination shall be delivered by the trustee to the beneficiary.

(h) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

(i) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to or reimbursing the expenses of the trustee.

(j) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

(k) Notwithstanding other provisions of OAR 836-012-0000 to 836-012-0110, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, when it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in OAR 836-012-0000 to 836-012-0110, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

(A) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(B) To pay the assuming insurer any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(C) When the ceding insurer has received notification of termination of the trust account and if the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in ORS 731.510(1), from its general assets, in trust for such uses and purposes specified in paragraphs (A) and (B) of this subsection may remain executory after such withdrawal and for any period after the termination date.

(l) The reinsurance agreement entered into in conjunction with the trust agreement may but need not contain the provisions required by section (4)(a)(B) of this rule, so long as these required conditions are included in the trust agreement.

(3) The following are permitted conditions applicable to the trust agreement:

(a) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice, and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, except that such a resignation or removal shall not be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(b) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(c) The trustee may be given authority to invest and accept substitutions of any funds in the account, except that an investment or substitution shall not be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in section (4)(a)(B) of this rule.

(d) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such a transfer may be conditioned upon the trustee receiving other specified assets prior to or simultaneously with the transfer.

(e) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall be delivered to the grantor with written approval by the beneficiary.

(4) The following are additional conditions applicable to reinsurance agreements:

(a) A reinsurance agreement that is entered into in conjunction with a trust agreement and the establishment of a trust account may contain provisions that:

(A) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specify what the agreement is to cover;

(B) Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash, which must be in United States legal tender; certificates of deposit, which must be issued by a United States bank and payable in United States legal tender; and investments of the types permitted by the Insurance Code or any combination thereof, except that such investments must be issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. When a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

(C) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(D) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(E) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be used and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such insurer, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(i) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(ii) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(iii) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred, including losses incurred but not reported, loss adjustment expenses and unearned premium reserves; and

(iv) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(b) The reinsurance agreement may also contain provisions that:

(A) Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all

or any part of the trust assets and transfer those assets to the assuming insurer. The ceding insurer shall not unreasonably or arbitrarily withhold its approval. The right to seek approval under this paragraph must be subject to one of the following requirements:

(i) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(ii) After withdrawal and transfer, the market value of the trust account is no less than 102 percent of the required amount.

(B) Provide for:

(i) The return of any amount withdrawn in excess of the actual amounts required for section (4)(a)(E)(i), (ii) and (iii), or in the case of section (4)(a)(E)(iv), any amounts that are subsequently determined not to be due; and

(ii) Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to section (4)(a)(E)(iii).

(C) Permit the award by any arbitration panel or court of competent jurisdiction of:

(i) Interest at a rate different from that provided in section (4)(a)(E)(ii);

(ii) Arbitration costs;

(iii) Attorney fees; and

(iv) Any other reasonable expenses.

(c) Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of OAR 836-012-0000 to 836-012-0110 when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(d) Existing agreements. Notwithstanding the effective date of OAR 836-012-0000 to 836-012-0110, any trust agreement or underlying reinsurance agreement in existence prior to January 1, 1994, will continue to be acceptable until January 1, 1994, at which time the agreements must be in full compliance with OAR 836-012-0000 to 836-012-0110 for the trust agreement to be acceptable.

(e) The failure of any trust agreement to specifically identify the beneficiary as defined in section (1) of this rule shall not be construed to affect any actions or rights that the Director may take or possess pursuant to the provisions of the laws of this state.

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0080

Letters of Credit Qualified under OAR 836-012-0060

(1) A letter of credit for purposes of OAR 836-012-0060 must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution as defined in ORS 731.510 (2). The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in section (9) (a) of this rule. As used in this rule, "beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator.

(2) The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(3) The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(4) The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause," which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of not less than 30 days' notice prior to expiration date or nonrenewal.

(5) The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 500), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

(6) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 500) the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 500 occur.

(7) The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit, pursuant to ORS 731.510 (2).

(8) If the letter of credit is issued by a qualified United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in section (7) of this rule, the following additional requirements must be met:

(a) The issuing qualified United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

(b) The "evergreen clause" shall provide for 30 days' notice prior to expiry date for nonrenewal.

(9) The following apply to reinsurance agreement provisions:

(a) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions described in this subsection. All of the provisions of this subsection must be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer. The provisions are as follows:

(A) A provision requiring the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

(B) A provision stipulating that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and must be used by the ceding insurer or its successors in

interest only for one or more of the following reasons:

(i) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(ii) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

(iii) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement (such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves); and

(iv) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(b) Nothing contained in subsection (a) of this section shall preclude the ceding insurer and assuming insurer from providing for either or both of the following:

(A) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to subsection (a)(B)(iii) of this section; and

(B) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of subsection (a)(B)(iv) of this section, any amounts that are subsequently determined not to be due.

(c) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, when it is customary practice to provide a letter of credit for a specific purpose, the reinsurance agreement may, in lieu of subsection (a)(B) of this section, require that the parties enter into a "Trust Agreement," which may be incorporated into the reinsurance agreement or be a separate document.

(10) A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the Department of Consumer and Business Services unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement that the letter of credit was intended to secure.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0090

Other Security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

Stat. Auth.: ORS 731.244, 731.508 & Sec. 65 - 67, Ch. 447, Oregon Laws 1993 (Enrolled HB 2119)

Stats. Implemented: ORS 731.508(1), (3), 731.509 & 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93

836-012-0100

Reinsurance Contract

Credit shall not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of OAR 836-012-0011, 836-012-0021, 836-012-0031, 836-012-0041 or 836-012-0060 or otherwise in compliance with ORS 731.509 after the adoption of OAR 836-012-0000 to 836-012-0110, unless the reinsurance agreement:

(1) Includes a proper insolvency clause pursuant to ORS 731.508; and

(2) Includes a provision pursuant to ORS 731.509 (7), whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected and has agreed to abide by the final decision of the court or panel.

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-012-0110

Contracts Affected

All new and renewal reinsurance transactions entered into on and after January 1, 1994, shall conform to the requirements of ORS 731.509 to 731.511 and OAR 836-012-0000 to 836-012-0110 if credit is to be given to the ceding insurer for such reinsurance.

Stat. Auth.: ORS 731.508 - 731.511 & 731.244

Stats. Implemented: ORS 731.508 - 731.511

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

Life Reinsurance Agreements

836-012-0300

Authority; Statement of Purpose; Director's Authority

(1) OAR 836-012-0300 to 836-012-0330 are adopted pursuant to the authority of ORS 731.244 and 731.508 for the purpose of implementing ORS 731.508 (6).

(2) OAR 836-012-0300 to 836-012-0330 apply to each domestic insurer transacting life insurance, health insurance or both, to each domestic health care service contractor, and to each other authorized insurer or health care service contractor transacting life insurance, health insurance or both who is not subject to substantially similar rules or regulations in its domiciliary state. OAR 836-012-0300 to 836-012-0330 do not apply with respect to assumption

reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophic reinsurance.

(3) The Director recognizes that authorized insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus. It is improper for an authorized insurer, however, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance and effect, the expected potential liability to the ceding insurer in agreements that do not transfer all of the significant risks remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival.

Stat. Auth.: ORS 731.244 & 731.508

Stats. Implemented: ORS 731.508(6)

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 7-1995, f. & cert. ef. 11-15-95

836-012-0310

Accounting Requirements

(1) An insurer that is subject to OAR 836-012-0300 to 836-012-0330 shall not, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Director if by the terms of the reinsurance agreement, in substance or effect, one or more of the following conditions exist:

(a) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes and direct expenses, including but not limited to expenses for billing, valuation, claims and maintenance expected by the ceding insurer at the time the business is reinsured;

(b) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations in which termination occurs because of unreasonable provisions that allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels, forcing the ceding insurer to prematurely terminate the reinsurance treaty;

(c) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for non-payment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets;

(d) The ceding insurer, at specific points in time scheduled in the agreement, must terminate or automatically recapture all or part of the reinsurance ceded;

(e) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding insurer to pay reinsurance premiums or other fees or charges to a reinsurer that are greater than the direct premiums collected by the ceding insurer;

(f) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table in this subsection identifies, for a representative sampling of products or type of business, the risks that are considered to be significant. For products not specifically included, the risks determined to be significant must be consistent with this table. The risk categories are as follows:

(A) Morbidity;

(B) Mortality;

(C) Lapse, which is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy;

(D) Credit Quality (C1), which is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. Credit quality excludes market value declines due to changes in interest rate;

(E) Reinvestment (C3), which is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase;

(F) Disintermediation (C3), which is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The insurer may have to sell assets at a loss to provide for these withdrawals.

For purposes of the following chart: + - Significant 0 - Insignificant

RISK CATEGORY

A B C D E F

Health Insurance - other than long + 0 + 0 0 0

term care insurance and long term

disability insurance

Health Insurance - long term care + 0 + + + 0

insurance and long term disability

insurance

Immediate Annuities 0 + 0 + + 0

Single Premium Deferred Annuities 0 0 + + + +

Flexible Premium Deferred Annuities 0 0 + + + +

Guaranteed Interest Contracts 0 0 0 + + +

Other Annuity Deposit Business 0 0 + + + +

Single Premium Whole Life 0 + + + + +

Traditional Non-Par Permanent 0 + + + + +

Traditional Non-Par Term 0 + + 0 0 0

Traditional Par Permanent 0 + + + + +

Traditional Par Term 0 + + 0 0 0

Adjustable Premium Permanent 0 + + + + +

Indeterminate Premium Permanent 0 + + + + +

Universal Life Flexible Premium 0 + + + + +

Universal Life Fixed Premium 0 + + + + +

Universal Life Fixed Premium 0 + + + + +

dump-in premiums allowed

(g)(A) The credit quality, reinvestment or disintermediation risk is significant for the business reinsured and the ceding insurer does not (other than for the classes of business excepted in paragraph (B) of this subsection (g) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the Director that legally segregates, by contract or contract provision, the underlying assets;

(B) Notwithstanding the requirements of paragraph (A) of this subsection (g), the assets supporting the reserves for the following classes of business and any classes of business that do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding insurer without segregation of such assets:

(i) Health Insurance - long term care insurance and long term disability insurance;

(ii) Traditional Non-Par Permanent;

(iii) Traditional Par Permanent;

(iv) Adjustable Premium Permanent;

(v) Indeterminate Premium Permanent; and

(vi) Universal Life Fixed Premium, (no dump-in premiums allowed).

(C) For assets that are not legally segregated, the associated formula for determining the reserve interest rate adjustment must reflect the ceding insurer's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

Rate = 2 (I + CG)

X + Y - I - CG

When: I -- is the net investment income;

CG -- is capital gains less capital losses;

X -- is the current year cash and

-- invested assets plus invest-

-- ment income due and accrued

-- less borrowed money; and

Y -- is the same as X but for the

-- prior year.

(h) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date;

(i) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured;

(j) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured; or

(k) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(2) Notwithstanding section (1) of this rule, with the prior approval of the Director, an insurer that is subject to OAR 836-012-0300 to 836-012-0330 may take such reserve credit or establish such asset as the Director determines to be consistent with the Insurance Code or rules adopted thereunder, including actuarial interpretations or standards adopted by the Director.

(3)(a) An agreement entered into on or after November 9, 1995, that involves the reinsurance of business issued prior to the effective date of the agreement, along with any subsequent amendments thereto, shall be filed by the ceding insurer with the Director not later than the 30th day after its date of execution. Each filing must include data detailing the financial effect of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider OAR 836-012-0300 to 836-012-0330 and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Director. The actuary shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to OAR 836-012-0300 to 836-012-0330.

(b) Any increase in surplus net of federal income tax resulting from arrangements described in subsection (a) of this section shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account) and recognition of the surplus increase as income must be reflected on a net of tax basis in the "Reinsurance ceded" line, as earnings emerge from the business reinsured. The following example applies to this subsection:

(A) On the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) that is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. $6.8 million (34% of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations;

(B) At the end of year N+1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66% of ($4 million - $1 million - $.5 million) up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and -$1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.

Stat. Auth.: ORS 731.244 & 731.508

Stats. Implemented: ORS 731.508(6)

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 7-1995, f. & cert. ef. 11-15-95

836-012-0320

Written Agreements

(1) A reinsurance agreement or amendment to any agreement shall not be used to reduce any liability or to establish any asset in any financial statement filed with the Director unless the agreement or amendment or a letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

(2) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

(3) The reinsurance agreement must contain provisions providing that:

(a) The agreement constitutes the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(b) Any change or modification to the agreement is void unless made by amendment to the agreement and signed by both parties.

Stat. Auth.: ORS 731.244 & 731.508

Stats. Implemented: ORS 731.508(6)

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 7-1995, f. & cert. ef. 11-15-95

836-012-0330

Existing Agreements

Insurers subject to OAR 836-012-0300 to 836-012-0330 shall reduce to zero by December 31, 1995, as shown in the annual statement filed as of December 31, 1995, any reserve credits or assets established with respect to reinsurance agreements entered into prior to November 9, 1995 that, under the provisions of OAR 836-012-0300 to 836-012-0330 as amended, would not be entitled to recognition of the reserve credits or assets, except that the reinsurance agreements must be in compliance with laws or rules in existence immediately preceding November 9, 1995.

Stat. Auth.: ORS 731.244 and 731.508

Stats. Implemented: ORS 731.508(6)

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 7-1995, f. & cert. ef. 11-15-95

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 13

ANNUAL STATEMENT; DIRECTOR'S AUTHORITY

Director's Authority to Take Corrective Action

836-013-0100

Authority

(1) OAR 836-013-0100 to 836-013-0120 are adopted pursuant to ORS 731.385.

(2) OAR 836-013-0100 to 836-013-0120 set forth the standards that the Director may use for identifying insurers who are in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.

(3) OAR 836-013-0100 to 836-013-0120 are not a limitation on the regulatory powers of the Director.

Stat. Auth.: ORS 731.385

Stats. Implemented: ORS 731.385

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-013-0110

Standards

The Director may consider the following standards, either singly or in combination of two or more, to determine whether the continued operation of any insurer transacting insurance in this state might be determined to be hazardous to the policy holders, its creditors or the general public:

(1) Adverse findings reported in financial condition and market conduct examination reports.

(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports.

(3) The ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premiums and net investment income that could lead to an impairment of capital and surplus.

(4) The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature.

(5) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining capital and surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

(6) Whether the insurer's operating loss in the last 12-month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets and cash dividends paid to shareholders, is greater than 50 percent of the insurer's remaining capital and surplus in excess of the minimum required.

(7) Whether any affiliate, subsidiary or reinsurer is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations.

(8) Contingent liabilities, pledges or guaranties that either individually or collectively involve a total amount that in the opinion of the Director may affect the solvency of the insurer.

(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer.

(10) The age and collectibility of receivables.

(11) Whether the management of an insurer, including officers, directors or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation determined by the Director to be necessary to serve the insurer in such position.

(12) Whether management of an insurer has failed to respond to inquiries relating to the condition of the insurer or has furnished false and misleading information concerning an inquiry.

(13) Whether management of an insurer either has filed a false or misleading sworn financial statement or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

(14) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

(15) Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems, or both.

Stat. Auth.: Sec. 14, Ch. 447, Oregon Laws 1993 (Enrolled HB 2119)

Stats. Implemented: ORS 731.385

Hist.: ID 8-1993, f. & cert. ef. 9-23-93

836-013-0120

Director's Authority

(1) For the purposes of making a determination of the financial condition of an insurer under OAR 836-013-0100 to 836-013-0120, the Director may do one or more of the following:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

(2) An order of the Director under Section 12, Chapter 447, Oregon Laws 1993 (Enrolled House Bill 2119), regarding a foreign insurer may be limited to the extent provided by statute.

Stat. Auth.: Sec. 14, Ch. 447, Oregon Laws 1993 (Enrolled HB 2119)

Stats. Implemented: ORS 731.385

Hist.: ID 8-1993, f. & cert. ef. 9-23-93

Examinations

Management Affirmation Letter

836-013-0200

Statutory Authority; Statutes Implemented

OAR 836-013-0210 and 836-013-0220 are adopted by the Director pursuant to ORS 731.244 and 731.236 for the purpose of implementing ORS 731.028, 731.300, 731.302, 731.308, 732.584 and 733.170.

Stat. Auth.: ORS 731.236 & 731.244

Stats. Implemented: ORS 731.028, 731.236, 731.300, 731.302, 731.308, 732.584 & 733.170

Hist.: ID 8-1994, f. & cert. ef. 6-7-94

836-013-0210

Management Affirmation Letter Requirement -- Insurers

(1) Each insurer transacting insurance in Oregon shall submit to the Department in connection with the examination of the insurer a management affirmation letter satisfying the requirements of this rule.

(2) The following requirements apply with regard to a management affirmation letter under this rule:

(a) The letter must be submitted on a form supplied by the Department and must be signed by a person whom the Director designates and who is either the chairperson of the board of directors of the insurer or the person designated by the board of directors to preside at board meetings;

(b) The signature of the person designated by the Director to sign the letter must be witnessed by a notary; and

(c) The person designated by the Director to sign the letter must certify in the letter that to the best of the person's knowledge and belief:

(A) The transactions and business affairs of the insurer are conducted in compliance with the statutes, rules and procedures of the Department in all material respects, except for instances specifically described in the letter;

(B) For the period under review, all operations of the insurer were conducted in such a manner as not to be hazardous to the insurance buying public for purposes of ORS 731.385 or 731.386 or in violation of the **Oregon Insurance Code**;

(C) All books, records, accounts, papers, documents and computer and other recordings in the insurer's possession and relating to its assets, accounts, transactions and affairs, to its treatment of policyholders and compliance with the **Insurance Code**, and to all matters relating to the period under examination, are kept in accordance with ORS 733.170 and have been made available in their entirety to Department examiners pursuant to ORS 731.308; and

(D) All corporate powers are exercised by or under the authority of the duly qualified and constituted board of directors of the insurer and the business affairs and transactions of the insurer are managed under the direction of such board of directors, all in accordance with the duties and responsibilities conferred upon the board of directors by the articles of incorporation and by-laws and by Oregon law.

(3) In addition to the requirements of section (2) of this rule, if the insurer is a member of an insurance holding company system, the person designated by the Director to sign the management affirmation letter must certify in the letter whether all books, records, accounts, papers, documents and computer and other recordings to which this section applies have or have not been made available in their entirety to Department examiners pursuant to ORS 732.584. This section applies to all books, records, accounts, papers, documents and computer and other recordings in the possession of the affiliate of the insurer and relating to the assets, accounts, transactions and affairs of the insurer, the treatment of policyholders and compliance with the **Insurance Code** by the insurer and all matters relating to the period under examination. This section does not apply to health care service contractors.

(4) The person designated by the Director to sign the management affirmation letter need not have personal knowledge of the matters certified, but may rely on information and assurances provided by officers of the insurer.

(5) An insurer must tender a management affirmation letter to the Department not later than the tenth day after completion of the Department examiners' work at the insurer's place of business, or after the insurer's receipt of the letter form from the Department, whichever occurs later.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.028, 731.236, 731.244, 731.300, 731.302, 731.308, 732.584 & 733.170

Stats. Implemented: ORS 731.028, 731.236, 731.300, 731.302, 731.308, 732.584 & 733.170

Hist.: ID 8-1994, f. & cert. ef. 6-7-94

836-013-0220

Management Affirmation Letter Requirements -- Affiliates

(1) When the Director requires an affiliate of an insurer to be examined, the Director may require the affiliate to submit

to the Department in connection with the examination a management affirmation letter satisfying the requirements of this rule.

(2) The following requirements apply with regard to a management affirmation letter under this rule:

(a) The letter must be submitted on a form supplied by the Department and must be signed by a person whom the Director designates and who is either the chairperson of the board of directors of the affiliate or the person designated by the board of directors of the affiliate to preside at board meetings;

(b) The signature of the person designated by the director to sign the letter must be witnessed by a notary; and

(c) The person designated by the Director to sign the letter must certify in the letter that to the best of the person's knowledge and belief, all books, records, accounts, papers, documents and computer and other recordings in the possession of the affiliate that relate to the insurer's assets, accounts, transactions and affairs, to the insurer's treatment of policyholders and compliance with the **Insurance Code**, and to all matters relating to the period under examination of the insurer, have been made available to the Department examiners in their entirety pursuant to ORS 732.584.

(3) The person designated by the Director to sign the management affirmation letter on behalf of an affiliate need not have personal knowledge of the matters certified, but may rely on information and assurances provided by officers of the insurer or affiliate.

(4) An affiliate must tender a management affirmation letter to the Department not later than the tenth day after completion of the Department examiners' work at the insurer's place of business, or after the affiliate's receipt of the letter form from the Department, whichever occurs later.

(5) This rule does not apply to health care service contractors.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.028, 731.236, 731.244, 731.300, 731.302, 731.308 & 732.584

Stats. Implemented: ORS 731.028, 731.236, 731.300, 731.302, 731.308, 732.584 & 733.170

Hist.: ID 8-1994, f. & cert. ef. 6-7-94

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 14

ALTERNATIVE INSURANCE ORGANIZATIONS

Legal Expense Organizations

836-014-0001

Purpose, Authority and Effective Date

(1) OAR 836-014-0001 to 836-014-0045 are adopted to carry out the purpose of ORS 750.505 to 750.715, that of regulating the operation of legal expense organizations in this state.

(2) OAR 836-014-0001 to 836-014-0045 are adopted pursuant to the general rule-making authority of the Director under ORS 731.244 and the specific authority in ORS 750.715.

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.505 & 750.715 et seq.

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0005

Applicability and Scope

(1) Except as otherwise specifically provided in section (2) of this rule, OAR 836-014-0001 to 836-014-0045 apply to:

(a) All legal expense organizations doing business in this state;

(b) All legal expense plans and membership agreements of legal expense organizations delivered or issued for delivery in this state on or after January 1, 1990;

(c) All legal expense provider agreements in force in this state on or after January 1, 1990.

(2) OAR 836-014-0001 to 836-014-0045 do not apply to arrangements specified in ORS 750.525.

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.505 & 750.715 et seq.

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0010

Required Capitalization

A legal expense organization shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $25,000 or an amount equal to 25 percent of the gross written prepaid fees collected from plan members in the preceding calendar year, whichever is greater, but in no case shall the required amount be more than $300,000.

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.535(3)(a)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0015

Annual Financial Statement

A legal expense organization shall file with the Director an annual financial statement, using the form prescribed in **Exhibit 1** of this rule, not later than March 1 following the calendar year to which the statement applies. The statement shall be:

(1) Provided on a statutory accounting basis pursuant to the provisions of ORS Chapter 733 applicable to organizations under ORS 750.705.

(2) Verified as to the financial condition of the legal expense organization as of the end of the preceding calendar year:

(a) If the organization is a corporation, by two executive officers;

(b) If the organization is a partnership, by two partners;

(c) If the organization is a sole proprietorship, by the individual proprietor;

(d) If the organization is an association, by two executive officers;

(e) If the organization is an entity other than one to which subsection (a), (b), (c) or (d) of this section applies, by two executive officers.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.645(1)(a)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0020

Deposits

(1) A deposit under ORS 750.685 shall be with a bank qualified under ORS 731.642 to act as a trust company and as a depository of state funds to hold and service securities by insurers with the state, or with any other depository bank as defined in ORS 295.005.

(2) For compliance with ORS 750.685, a deposit trust agreement shall have the prior approval of the Director for adequate safeguards providing:

(a) Retention of deposits so long as there is outstanding any liability of the legal expense organization as to which the deposit was required;

(b) Release of deposit only upon written directions of the Director.

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.685(2)-(3)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0025

Bond

A legal expense organization posting a bond under ORS 750.685 shall use the form prescribed in **Exhibit 1** of this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.685(2)-(3)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0030

Sales Representatives

Every legal expense organization shall submit to the Director, on the form prescribed in **Exhibit 1** of this rule, the names and addresses of its sales and marketing representatives transacting business in this state. The notification must be submitted not later than January 1 and July 1 of each year.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.645(2)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0035

Registration of Legal Expense Organization

A legal expense organization may not transact business in this state unless the organization holds a valid certificate of registration. An organization may apply for registration with the Director by submitting to the Director the following documents:

(1) A completed registration application. The registration application must be on the form provided in **Exhibit 1** of this rule.

(2) A statement designating a registered agent and a registered office. The statement must be on the form provided in **Exhibit 2** of this rule. The requirement under this section is in addition to the filing requirements of other law regarding designation of a registered office and registered agent in the State of Oregon for service of process, notice and demand.

(3) A list of its sales and marketing representatives. The names of the sales and marketing representatives must be submitted on the form prescribed in OAR 836-014-0030 (**Exhibit 1**, OAR 836-014-0030).

(4) A Financial Statement. The statement must follow the prescribed form of OAR 836-014-0015 (**Exhibit 1**, OAR 836-014-0015) and comply with OAR 836-014-0015, except for the filing date.

(5) Copies of the following forms and related schedules used or to be used by the organization:

(a) The provider agreement forms used or to be used in this state;

(b) The membership agreement forms delivered or issued or to be delivered or issued in this state;

(c) The legal expense plan forms delivered or issued or to be delivered or issued in this state;

(d) The schedule of rates charged or to be charged members in this state for each type of agreement or plan.

(6) A marketing plan for conducting legal expense plan business in this state. The plan must include the following:

(a) The geographical area in which business is intended to be done in the first five years;

(b) The types of plans intended to be written in the first five years, including specification whether and to what extend indemnity rather than service benefits are to be provided;

(c) The proposed marketing methods;

(d) Data affirmatively demonstrating the anticipated income and expenses of the organization in the first five years, including, without limitation, the projected expenditures for legal services and the projected source of funds to make up any anticipated deficits. Except as provided in this subsection, the data must b documented and verified by an actuary or a person who has the background for the practice of actuarial science. If, however, the applicant legal expense organization provides or will provide service rather than indemnity benefits, the documentation and verification may be made instead by an executive employee of the applicant who has at least four years of experience in the design, pricing and administration of legal expense or similar plans. The executive employee must also document and certify in the application that the applicant has provider agreements in force, subject to issuance of a certificate of registration, adequate to provide the covered legal services throughout the geographic area in which business is intended to be done. The Director may require the applicant to furnish, in support of its application, publicly available data regarding the costs and benefits of comparable plans in this state and elsewhere.

(7) Evidence of the deposit or surety bond required by ORS 750.685 and in accordance with OAR 836-014-0020 or 836-014-0025.

(8) A statement of the incorporators, directors and officers, which provides the names of all incorporators and proposed

directors and officers of the legal service organization, and all of their addresses and occupations for the preceding five years.

(9) A certified copy of the articles and by-laws, partnership agreement, or the association agreement and association by-laws.

(10) A copy of all contracts with principals including a copy of all agreements relating to the legal service organization to which any incorporator or proposed director or officer is a party.

(11) A statement of the amount and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other persons.

(12) A statement of compensation of all principals and all corporate officers and directors, or partners, or other principal as it relates to the applicant's operation as a legal service organization.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.515, 750.535 & 750.545

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0040

Amendments to Registration

(1) A legal service organization shall amend its registration in this state when any of the following events occur:

(a) The organization changes its principal place of business;

(b) The insurance or surety bond required for compliance with ORS 750.685 is cancelled or replaced;

(c) The organization experiences a material change in ownership under events defined in ORS 732.505 and 732.510.

(2) When a legal expense organization changes its principal place of business, the organization shall include the following in the amended registration:

(a) The street address, including city and state;

(b) The mailing address, if different;

(c) The telephone number.

(3) If an organization changes its registered office or agent, the organization must file a statement of the change with the Director on the form provided in **Exhibit 1** of this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.535 & 750.575

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0042

Renewal of Legal Expense Organization Registration

In order for an organization to renew its certificate of registration, the organization must apply for renewal by submitting a completed renewal application. The renewal application must be on the form provided in **Exhibit 1** of this rule. If mailed, the renewal application must be postmarked by the United States Postal Service not later than the expiration date of the registration.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.515 & 750.565(2)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

836-014-0045

Unfair Trade Practice

Failure of a legal service organization to comply with OAR 836-014-0001 to 836-014-0045 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 731 & 750

Stats. Implemented: ORS 750.240 & 750.325(3)

Hist.: ID 4-1990, f. & cert. ef. 1-24-90

Multiple Employer Welfare Arrangements

836-014-0100

Actuarial Certification; Guidelines

(1) The actuarial opinion required by ORS 750.315 and 750.325 to be submitted annually must meet the requirements of this rule. The annual statement of a multiple employer welfare arrangement must include a certification prepared according to the requirements of this rule. Attached to page 1 of the annual statement must be the statement of a qualified actuary setting forth the opinion of the actuary relating to loss reserves, provision for experience rating refunds and any other actuarial items.

(2) An applicant for a certificate of multiple employer welfare arrangement must submit an actuarial opinion meeting the requirements of this rule in order to satisfy ORS 750.305(8) which requires proof of adequate reserves according to the requirements of ORS 750.315 to be submitted to the Director along with the application for the certificate of multiple employer welfare arrangement and other supporting materials. The actuarial opinion must be the statement of a qualified actuary setting forth the opinion of the actuary relating to loss reserves, provision for experience rating refunds and any other actuarial items.

(3) For purposes of this rule, a qualified actuary means a member in good standing of the American Academy of

Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such an actuarial valuation, or a person who otherwise has demonstrated competency in such an actuarial evaluation to the satisfaction of the Director.

(4) The statement of the actuary's opinion must consist of a paragraph identifying the actuary, a scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary's work as provided in sections (7) to (9) of this rule, and an opinion paragraph expressing the opinion of the actuary with respect to such subjects as provided in sections (10) to (12) of this rule. The actuary may include one or more additional paragraphs in individual cases if the actuary considers it necessary to state a qualification of opinion or to explain some aspect of the annual statement that is not already sufficiently explained in the annual statement.

(5) The opening paragraph of the statement of opinion must generally indicate the relationship of the actuary to the multiple employer welfare arrangement as follows:

(a) For an actuary who is an employee of the multiple employer welfare arrangement, the opening paragraph of the opinion must contain a sentence such as: **"I, (name and title of actuary), am an officer (employee) of the trust carrying on the business of (name of multiple welfare arrangement) and a member of the American Academy of Actuaries"**;

(b) For a consulting actuary, the opening paragraph of the statement of opinion must contain a sentence such as: **"I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the trust carrying on the business of (name of the multiple employer welfare arrangement) with regard to loss reserves, actuarial liabilities and related items"**;

(c) For a person other than a member of the American Academy of Actuaries, the opening paragraph of the opinion must contain a sentence such as:

(A) **"I, (name and title), am an officer (employee) of the trust carrying on the business of (name of the multiple employer welfare arrangement) and I (SELECT ONE:) (have competency in actuarial valuations for organizations of this kind) -or- (am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind)"**; or

(B) **"I, (name and title of consultant), am associated with the firm of (name of firm). I (SELECT ONE:) (have competency in actuarial valuations for organizations of this kind) -or- (am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind) and have been retained by the trust carrying on the business of (name of multiple employer welfare arrangement) with regard to the valuation"**.

(6) Sections (7) to (11) and (13) are examples, for illustrative purposes, of language that in typical circumstances would be included in the remainder of the statement of opinion. The illustrative language must be modified as needed to meet the circumstances of a particular case. The actuary must in any case use language that clearly expresses the professional judgment of the actuary.

(7) The scope paragraph:

(a) Must contain a sentence such as the following: **"I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials as of December 31, 19--"**.

(b) Must list those items and amounts with respect to which the actuary is expressing an opinion. The list must include but need not be limited to:

(A) Claims unpaid. Anticipated salvage and subrogation included as a reduction to Loss Reserves as reported in Underwriting and Investment Exhibit, and on Page 3 -- Liabilities, Surplus and Special Funds, Line 1 $_____;

(B) Other actuarial liabilities. (Opinion, under this Item, with respect to actuarial liabilities, if any); and

(C) Premium items, such as receivables, due and unpaid, unearned, and paid in advance as they may relate to actuarial items.

(8) If the actuary has examined the underlying records or summaries, or both, the scope paragraph must also include a sentence such as the following: **"My examination included such review of the assumptions and methods used and of the underlying basic records or summaries, or both, and such tests and calculations as I considered necessary"**.

(9) If the actuary has not examined the underlying records or summaries, or both, but has relied upon those prepared by the trust carrying on the business of the multiple employer welfare arrangement, the scope paragraph must include a sentence such as one of the following:

(a) **"I relied upon underlying records or summaries, or both, prepared by the responsible officers or employees of the organizations. In other respects, my examination included such review of the assumptions and methods used and such tests of the calculations as I considered necessary"**;

(b) **"I relied upon (name of firm) for the accuracy of the underlying records or summaries, or both. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary"**.

(10) The opinion paragraph must include a sentence the covers at least the points listed in the following illustration: **"In my opinion, the amounts carried in the balance sheet on account of the items identified above:**

"Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

"Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared,

"Meet the requirements of the laws of (state of domicile),

"Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements,

"Are computed on the basis of assumptions consistent with those used in computing thecorresponding items in the annual statement of the preceding year-end,

"Include appropriate provision for all actuarial items that ought to be established".

(11) If there has been any material change in the assumptions or methods, or both, from those previously employed, that change must be described in the statement of opinion by inserting a phrase such as: **"A material change in assumptions (or methods, or both) was made during the past year but the change accords with accepted actuarial standards"**. A brief description of the change must follow. The adoption of new coverages requiring underlying assumptions that differ from assumptions used for prior coverages is not a change in assumption for purposes of this section.

(12) If the actuary is unable to form an opinion, the actuary must refuse to issue a statement of opinion. If the opinion is adverse of qualified, the actuary must issue an adverse or qualified opinion explicitly stating the reason or reasons for the opinion.

(13) If the actuary does not express an opinion as to the accuracy and completeness of underlying listings or summaries used in the evaluation of the actuary, there should be included on or attached to page 1 of the statement blank the statement of an officer or trustee of the trust or an accounting firm that prepared the underlying data similar to the following: **"I (name of officer or trustee of trust), (title of officer or trustee), of (name and address of trust), (or accounting firm), hereby affirm that the listing and summaries of data prepared for and submitted to (name of**

actuary) were prepared under my direction and, to the best of my knowledge and believe, are accurate and complete".

Stat. Auth.: ORS 750.305, 750.315 & 75.0325

Stats. Implemented: ORS 750.315(2)

Hist.: ID 11-1993(Temp), f. & cert. ef. 11-17-93; ID 3-1994, f. & cert. ef. 4-1-94

Life Settlements

836-014-0200

Statutory Authority and Implementation

(1) OAR 836-014-0200 to 836-014-0330 are adopted under the authority of ORS 731.244, 731.804 and 746.240 and sections 7, 14 and 18, chapter 342, Oregon Laws 1995, for the purpose of implementing sections 5, 6, 7, 11, 14 and 18, chapter 342, Oregon Laws 1995.

(2) OAR 836-014-0210 and 836-014-0220 are operative on and after the date that OAR 836-014-0200 to 836-014-0330 are filed with the Secretary of State. OAR 836-014-0200 and 836-014-0230 to 836-014-0330 are operative on or after March 1, 1996.

Stat. Auth.: ORS 731.244 & Sections 7, 14 & 18, Ch. 342, Oregon Laws 1995.

Stats. Implemented: Sections 5, 7, 11, 14 & 18, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0210

License Fees

(1) The fee for filing an application for a license to transact business as a life settlement provider is $400.

(2) The fee for annual renewal of a license to transact business as a life settlement provider is $200.

(3) The fee for filing an application for a license to transact business as a life settlement broker is $60.

(4) The fee for biennial renewal of a license to transact business as a life settlement broker is $60.

Stat. Auth.: ORS 731.244 & 731.804 & Sections 7 and 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Sections 5 & 7, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0220

Life Settlement Provider License Requirements

(1) For an applicant to qualify for authority to transact business as a life settlement provider:

(a) The applicant's assets must exceed its liabilities by an amount of not less than $150,000;

(b) The applicant must file with the State Treasurer, as is authorized by the Insurance Code, a surety bond in the sum of $100,000; or

(c) The applicant must deposit with the State Treasurer, as is authorized by the Insurance Code, cash or securities in the sum of $100,000.

(2) As a condition of maintaining a license to act as a life settlement provider, a life settlement provider must do one of the following:

(a) At all times maintain assets that exceed its liabilities by an amount of not less than $150,000; or

(b) At all times maintain with the State Treasurer a surety bond or the deposit of cash or securities. The surety bond, cash or securities must be as authorized by the Insurance Code and must be in the sum of $100,000.

(3) A bond filed or deposit made in this state under this rule shall be held for the faithful performance by the life settlement provider of all transactions of the provider subject to chapter 342, Oregon Laws 1995.

Stat. Auth.: ORS 731.244 & section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 6, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 6-1996(Temp), f. & cert. ef. 5-8-96; ID 14-1996, f. & cert. ef. 11-1-96

836-014-0230

Renewal Requirements

(1) A licensee applying for renewal must do the following, as applicable:

(a) Submit a completed renewal application, on a form provided by the Director; and

(b) Submit the renewal fee.

(2) If a renewal application is submitted by mail, the renewal application must be postmarked by the United States Postal Service not later than the license expiration date.

(3) The Director may allow a licensee not more than 30 days to submit missing information on the renewal application form, if the fee has been submitted on or before the expiration date.

(4) The Director may request on the renewal application any information requested on the original application for a license.

Stat. Auth.: Section 7, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 7, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0240

Filing Requirements, Life Settlement Contracts

(1) An applicant for a license as a life settlement provider must file with the Director a copy of each life settlement contract form that the applicant intends to use in business under the license.

(2) A life settlement provider must file with the Director, prior to use in this state, any amendment to a previously-filed life settlement contract form and any new life settlement contract form.

(3) Contract forms and amendments thereto are subject to approval prior to use in this state, as provided in section 11, chapter 342, Oregon Laws 1995.

(4) Each form of life settlement contract filed with the Director must contain all of the following:

(a) A life settlement contract, completed in John Doe fashion;

(b) A copy of a policyholder's or certificate holder's application, completed in John Doe fashion; and

(c) A copy of any written disclosure material that will be provided to a policyholder certificate holder as required by section 14, chapter 342, Oregon Laws 1995 and OAR 836-014-0280.

(5) A life settlement contract form is subject to disapproval by the Director:

(a) If the Director finds it does not comply with the law;

(b) If the Director finds it contains any provision or has any description of its contents, title, heading or other indication of its provisions, that is unintelligible, uncertain, ambiguous or abstruse, or likely to mislead a person to whom the contract is offered or with whom the contract is made;

(c) If, in the Director's judgment, its use would be prejudicial to the interest of the persons with whom the life settlement provider contracts; or

(d) If the Director finds it contains provisions that are unjust, unfair or inequitable.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Sections 5 and 11, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0250

Contents of Life Settlement Contracts

(1) In addition to the requirements of section 11, chapter 342, Oregon Laws 1995, each life settlement contract must be in writing, in a type size of not less than 12 points, and written in clear, understandable and straightforward wording.

(2) A life settlement contract may not contain any limitation or restriction on the use of the proceeds by the policyholder or certificate holder.

(3) Each life settlement contract shall specify any effect that entering into the contract will have upon the continuation or continued availability of supplemental benefits or riders that are or may be attached to the life insurance policy that is the subject of the life settlement contract, including assignment of the responsibility for the continued payment of premiums. The contract must require the provider to pay the premium on supplemental benefits and riders added to the policy before the life settlement contract was entered, when so elected according to OAR 836-014-0260, and must

require the provider to notify the former policyholder or certificate holder of any option that may arise to select any supplemental benefits or riders. The benefits and riders considered shall include, but need not be limited to, the following:

(a) Guaranteed insurability options;

(b) Accidental death benefits, or accidental death and dismemberment benefits;

(c) Disability income or loss of income protection; and

(d) Family, spousal or children's riders or benefits.

(4) The life settlement contract must provide for rescission by the policyholder or certificate holder entering the life settlement contract as set forth in section 11, chapter 342, Oregon Laws 1995. The rescission provision must appear on the first page of the contract. The rescission period specified in section 11, chapter 342, Oregon Laws 1995, may not be less than 30 days after the date on which the contract is executed by all parties or less than 15 days after the date on which the policyholder or certificate holder receives the life settlement proceeds, whichever is the lesser period. The rescission provision must also provide that if the insured dies during the period of time for rescission:

(a) The contract is rescinded effective on the date of application; and

(b) The provider will return the amount by which the insurance proceeds according to the terms of the policy exceed the compensation paid by the provider pursuant to the life settlement contract and any premiums paid by the provider on the policy so that all parties, including any beneficiaries, are returned to their original positions under the insurance policy.

(5) A life settlement contract must provide a method for giving notice of rescission, including but not limited to the address or addresses to which the rescission notice must be sent, and a telephone number that the insured may call for information.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 11, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97

836-014-0260

Rights and Duties of Parties to Life Settlement Contract

(1) A policyholder or certificate holder who has entered a life settlement contract has the right to retain additional benefits or optional riders that were part of the life insurance policy, including but not limited to disability income, accidental death and dismemberment and spouse, children and family riders, but not including term riders. Any premiums payable on the insurance policy or certificate that is the subject of the life settlement contract, including premiums payable for additional benefits retained at the option of the policyholder or certificate holder, shall be paid by the life settlement provider when due, for the remaining duration of the life that is the subject of the life settlement contract.

(2) Except as provided in this section (2), any additional benefit or optional rider that the policyholder or certificate holder elects not to continue must be terminated when the life settlement takes place. A waiver of premium provision may be continued by the life settlement provider.

(3) The life settlement provider does not have the right to any cash surrender value unless all additional benefits retained by the policyholder or certificate holder, whether by rider or endorsement, are in a paid-up status and will be unaffected by any change in cash surrender value.

(4) The life settlement provider shall make the payment of proceeds of a life settlement as required in section 17, chapter 342, Oregon Laws 1995, by means of wire transfer or by cashier's check.

(5) Not later than the date on which the life settlement proceeds are paid to the policyholder or certificate holder, the life settlement provider must give the policyholder or certificate holder a written statement of the date on which the rescission period expires. The statement must include a notice to the policyholder or certificate holder that a rescission is not complete until the full payment, including any premiums paid by the life settlement provider, is returned to the life settlement provider and that the full payment must be returned not later than the 30th day after the date specified for expiration of the rescission period.

(6) If the statement required in section (5) of this rule is given by mail, it shall be considered to be given when deposited in the United States mail, first class postage prepaid.

(7) If notice of rescission is given by mail, it shall be considered to be given when deposited in the United States mail, first class postage prepaid.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Sections 11 and 17, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97

836-014-0265

Response by Insurer

(1) An insurer shall provide information requested by a life settlement provider on the status of the life insurance policy or certificate of a policyholder or certificate holder not later than the 20th day after the insurer has received the later of the following documents or as soon as reasonably possible thereafter:

(a) A request in writing from the life settlement provider to release specified information regarding the policy or certificate to the life settlement provider or to a life settlement broker designated by the provider; and

(b) An instruction executed by the policyholder or certificate holder requiring the insurer to release the specified information referred to in subsection (a) of this section to the life settlement provider or to the life settlement broker designated by the provider.

(2) A life settlement provider who submits a request for information under section (1) of this rule must state in the request that it is licensed as a life settlement provider in this state and must disclose its license number.

(3) Nothing in this rule prohibits a certificate holder from assigning rights or benefits under the certificate to a licensed life settlement provider if assignment is allowed in the group policy, or from converting the coverage to an individual life insurance policy as provided by law and any applicable terms of the group policy.

Stat. Auth.: ORS 731.244 & Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 18, Ch. 342, Oregon Laws 1995

Hist.: ID 14-1997, f. & cert. ef. 10-17-97

836-014-0270

Standards for Evaluation of Reasonable Payments; Definition of "Terminal Illness or Condition"

(1) Payments under life settlement contracts must be fair and equitable and may not in any event be less than the following: Insured's Life Expectancy -- Minimum Percentage of Face Value Less Outstanding Loans Received by Policyholder or Certificate Holder

(a) Less than six months -- 85 percent;

(b) At least six but less than 12 months -- 80 percent;

(c) At least 12 but less than 18 months -- 75 percent;

(d) At least 18 but less than 24 months -- 70 percent;

(e) At least 24 but less than 36 months -- 60 percent;

(f) 36 months or more -- 50 percent.

(2) A payment may be reduced by the minimum premium required to keep the contract in force for the duration of the remaining life expectancy of the life that is the subject of the life settlement contract. The minimum premium includes any premiums payable for additional benefits retained at the option of the policyholder or certificate holder. Other than this allowable reduction in payment, there shall be no other retention for expenses or broker's fees that would reduce payments below the minimum levels established in this rule.

(3) The estimated life expectancy of an insured person must be determined according to sound actuarial principles.

(4) For the purpose of entering into a life settlement contract, a terminal illness or condition of an insured person is one or more of the following:

(a) A medical condition that will result in a drastically limited life span not exceeding 24 months.

(b) A medical condition that has required or requires extraordinary medical intervention, such as a major organ transplant or continuous artificial life support, without which the insured person would die.

(c) Any condition that usually requires continuous confinement in a nursing home, convalescent center or other care facility, if the insured person is expected to remain there for the rest of the insured person's life.

(d) A medical condition that in the absence of extensive or extraordinary medical treatment will result in a drastically limited life span. Such medical conditions include but are not limited to the following:

(A) Coronary artery disease resulting in an acute infarction or requiring surgery;

(B) Permanent neurological deficit resulting from cerebral vascular accident;

(C) End-stage renal failure; or

(D) Acquired Immune Deficiency Syndrome.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 18, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97

836-014-0280

Disclosure Required

(1) A life settlement provider shall disclose the information specified in section 14, chapter 342, Oregon Laws 1995, in the form of the disclosure statement in Attachment 1 to this rule or in a disclosure statement in a form approved by the Director as sufficiently similar to the statement in Attachment 1. A provider may also distribute the first two pages of Attachment 1 as general information apart from a specific transaction. The statement must be in not less than 12 point type. The Director may update names, telephone numbers and similar information in Attachment 1 from time to time as necessary.

(2) For each life settlement contract entered into by a life settlement provider, the provider must keep a copy of the disclosure statement in the provider's file on the contract, along with an affidavit signed by the provider showing the date the statement was delivered to the policyholder or certificate holder and attesting to the provider's belief that the policyholder or certificate holder had an opportunity to read and understand the statement. The provider must also send a copy of the statement and the signed affidavit to the life settlement broker.

(3) Upon receipt of an application from a policyholder or certificate holder, the life settlement broker shall furnish to the applicant a disclosure statement described in this section. The disclosure statement shall be the disclosure statement in Attachment 2 to this rule or a disclosure statement approved by the director as sufficiently similar to the statement in Attachment 2. The broker shall obtain the signature of the person on a copy of the disclosure statement for purposes of records in section (4) of this rule. The statement must be in not less than 12 point type. The Director may update names, telephone numbers and similar information in Attachment 2 from time to time as necessary.

(4) A life settlement broker shall retain a copy of a disclosure statement given to a person under section (3) of this rule, that is signed by the person, in the broker's files.

(5) A life settlement broker to whom a copy of a disclosure statement and signed affidavit is sent by the life settlement provider must retain the copies in the broker's files on the contract.

(6) A life settlement provider shall not enter a life settlement contract affecting a life insurance policy issued by an insurer with which the life settlement provider is affiliated or of which the life settlement provider is a subsidiary, unless the relationship between the insurer and the life settlement provider is fully disclosed, in writing, to the policyholder or certificate holder.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 14, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97

836-014-0290

Contacts by Life Settlement Provider or Broker

(1) After a life settlement provider has entered into a life settlement contract, neither the life settlement provider nor the life settlement broker may make contact with the policyholder or certificate holder:

(a) More frequently than once every three months if the policyholder or certificate holder has a life expectancy of more than one year; and

(b) More frequently than once each month if the policyholder or certificate holder has a life expectancy of one year or less.

(2) The life settlement provider shall explain the procedure for contacts authorized in section (1) of this rule to the

policyholder or certificate holder when the life settlement contract is entered into.

(3) The limitation in this rule on contacts by a life settlement provider or life settlement broker does not apply to contacts initiated by the policyholder or certificate holder or to contacts required for keeping the life insurance policy in force.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 18, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97

836-014-0300

Advertising Standards

(1) Advertising must be truthful and not misleading by fact or implication.

(2) If a life settlement provider or broker mentions the speed with which the life settlement will occur, the advertising must disclose the average time from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the policyholder or certificate holder during the past six months.

(3) If advertising of a life settlement contract mentions the dollar amounts available to policyholders and certificate holders, the advertising must disclose the average purchase price with regard to a particular life expectancy as a percent of face value paid to policyholders and certificate holders contracting with the life settlement provider or broker during the past six months and must disclose factors that go into determining the specific amounts charged.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 18, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0310

Reporting Requirements

The report required by section 12, chapter 342, Oregon Laws 1995, to be filed for the preceding calendar year with the Director must contain at least the following information:

(1) For each policy for which a life settlement contract has been entered into during the preceding calendar year or that was entered into prior to the preceding calendar year and for which deaths had not yet been reported as of the beginning of the preceding year:

(a) The date the life settlement contract was entered into;

(b) The life expectancy of the policyholder or certificate holder at the time of the contract;

(c) The face amount of the policy.

(d) The amount paid by the life settlement provider for purposes of making a life settlement on the policy and the percentage that amount represents of the face amount;

(e) If the policyholder or certificate holder has died:

(A) The date of death; and

(B) The total insurance premiums paid by the life settlement provider to maintain the policy in force; and

(f) The amount of commission paid by the life settlement provider to the life settlement broker.

(2) A breakdown, by disease category, of applications, received, accepted and rejected during the preceding calendar year.

Stat. Auth.: Sections 12 & 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 12, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0320

Requirements for Brokers

(1) A life settlement broker may not seek or obtain any compensation from the policyholder or certificate holder without the written agreement of the policyholder or certificate holder obtained before the broker performs any services in connection with the life settlement.

(2) In the absence of a written agreement making a life settlement broker the agent of a policyholder or certificate holder, the life settlement broker is presumed to be an agent of the life settlement provider.

(3) A life settlement broker may not transact business under the license unless appointed as a life settlement broker by each life settlement provider represented. Each appointment must be filed with the Insurance Division.

Stat. Auth.: Section 18, Ch. 342, Oregon Laws 1995

Stats. Implemented: Section 18, Ch. 342, Oregon Laws 1995

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

836-014-0330

Unfair Trade Practices

(1) Violation of any provision of OAR 836-014-0270, 836-014-0280, 836-014-0290, 836-014-0300 or 836-014-0310 is an unfair trade practice for purposes of ORS 746.240.

(2) The provisions of OAR 836-014-0200 to 836-014-0330 are in addition to applicable provisions of ORS chapter 746, governing trade practices.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 746.240

Hist.: ID 3-1996, f. & cert. ef. 2-26-96

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 20

ADVERTISEMENTS OF HEALTH INSURANCE

836-020-0200

Purpose and Authority

The purpose of this rule is to assure truthful and adequate disclosure of all material and relevant information in the advertising of health insurance. This purpose is intended to be accomplished by the establishment of minimum standards and guidelines of conduct for such advertising. This rule is promulgated under the provisions of ORS 731.244, 742.009 and 746.075.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73; ID 15-1996, f. & cert. ef. 11-12-96

836-020-0205

Applicability

(1) This rule applies to all health insurance advertisements intended for presentation, distribution, or dissemination in this state.

(2) Every insurer shall establish and maintain a system of control over the content, form, and method of presentation, distribution, and dissemination of all such advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, presented, distributed, or disseminated, shall be the responsibility of the insurer whose policies are advertised.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0210

Definitions

(1) Definitions given in the Insurance Code and in this rule govern the construction of this rule.

(2) "Advertisement" includes:

(a) Written, oral, and pictorial material used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, and other similar mediums for reaching the public;

(b) Written, oral, and pictorial material intended for individual presentation to the public, including, but not limited to, circulars, leaflets, booklets, depictions, illustrations; and

(c) Written, oral, and pictorial material prepared for any other use by agents or other representatives of an insurer.

(3) "Policy" includes any certificate of insurance or statement of coverage.

(4) "Insurer" includes fraternal benefit societies and health care service contractors.

(5) "Health Insurance" does not include incidental coverages issued with or supplemental to liability insurance, or coverages included within the Insurance Code definition of life insurance.

(6) "Exception" means any policy provision whereby coverage for a specified hazard is entirely eliminated. An "exception" is a statement of a risk not assumed under the policy.

(7) "Reduction" means any policy provision which reduces the amount of the policy benefit. Under the terms of a "reduction", a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period that is less than would otherwise be the case had the reduction provision not been used.

(8) "Limitation" means any policy provision which restricts coverage under the policy, other than an "exception" or a "reduction".

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0215

Method of Disclosure of Required Information

All information required to be disclosed by this rule shall be set out conspicuously, and in close conjunction with the statements to which the information relates or under appropriate captions of sufficient prominence that the information is not minimized, rendered obscure, presented in an ambiguous fashion or so intermingled with the content of the advertisement as to be confusing or misleading.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0220

Form and Content of Advertisements

(1) The form and content of an advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive will be determined by the Insurance Commissioner from the overall impression that the advertisement may reasonably be expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(2) Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0225

Advertisements of Benefits Payable, Losses Covered, or Premiums Payable

(1) Deceptive Words, Phrases, or Illustrations Prohibited:

(a) No advertisement shall omit particular information or use particular words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the offered policy is made available to a prospective insured for inspection prior to consummation of sale, or that an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements;

(b) No advertisement shall use words or phrases such as "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will help pay your hospital and surgical bills", "this policy will help fill some of the gaps that Medicare and your present insurance leave out", "this policy will help to replace your income" (when used in reference to loss-of-time benefits), or similar words or phrases, in a manner which exaggerates any benefit beyond the terms of the policy;

(c) No advertisement shall contain descriptions of a policy limitation, exception, or reduction worded in a positive manner to imply that it is a benefit. Examples of this are describing a waiting period as a "benefit builder", or stating that "even pre-existing conditions are covered after two years". Words and phrases used in an advertisement to describe policy limitations, exceptions, or reductions shall fairly and accurately describe the negative features of the limitation, exception, or reduction;

(d) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free", "extra cash", "extra income", "extra pay", or substantially similar words or phrases in a manner which has the capacity, tendency, or effect of misleading prospective purchasers into believing that the policy advertised will in some way enable them to make a profit from being hospitalized. This rule does not prohibit the use of complete and accurate terminology explaining the federal Internal Revenue Service rules applicable to the taxation of various types of health insurance benefits. It is noted that such rules provide that premiums paid for and benefits received from hospital indemnity policies are subject to the same rule as loss-of-time premiums and benefits, and are not afforded the same favorable tax treatment as expense-incurred hospital, medical, and surgical benefit coverages;

(e) No advertisement of a hospital or similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is on a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, the limit must appear in the advertisement;

(f) No advertisement of a policy covering only one or more specified diseases shall imply coverage beyond the terms of the policy. Several synonymous terms shall not be used to refer to any one disease so as to imply broader coverage than is the fact;

(g) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy;

(h) An advertisement of an insurance policy sold by direct mail shall not imply that, because "no insurance agent will call and no commission will be paid to agents", it is a "low cost plan", or use similar phrases. A statement that "no agent will call" is not of itself misleading.

(2) Limitations, Exceptions, and Reductions:

(a) When an advertisement refers to a dollar amount of a benefit, a period of time for which a benefit is payable, the cost of the policy or of a specific policy benefit, or the loss for which such benefit is payable, it shall also disclose the limitations, exceptions, and reductions affecting the basic provisions of the policy without which disclosure the advertisement would have the capacity or tendency to mislead or deceive;

(b) When a policy contains a waiting elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy, or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement to which the preceding paragraph is applicable shall disclose the existence of such periods;

(c) An advertisement shall not use the words "only", "just", "merely", "minimum", or similar words or phrases to describe the applicability of any exceptions and reductions. An example is: "This policy is subject to the following minimum exceptions and reductions:".

(3) Pre-Existing Conditions:

(a) An advertisement to which section (2) of this rule is applicable shall disclose in negative terms the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. No use of the term "pre-existing condition" shall be made without an appropriate definition or description;

(b) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of claim thereunder. This paragraph prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue";

(c) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance coverage, the application form shall contain a question or statement, immediately preceding the blank space for the applicant's signature, which reflects the pre-existing condition provisions of the policy. The question or statement shall be substantially as follows:

(A) (Question) **"Do you understand that this policy will not pay benefits during the first _____ year(s) after the issue date for a disease or physical condition which you now have or have had in the past?"**

(B) (Statement) **"I understand that this policy will not pay benefits for any loss incurred during the first year(s) after the issue date on account of a disease or physical condition which I now have or have had in the past."**

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0230

Necessity for Disclosing Policy Provisions Relating to Renewal, Cancellation, and Termination

When an advertisement refers to a dollar amount of a benefit, a period of time for which a benefit is payable, the cost of the policy or of a specific policy benefit, or the loss for which such benefit is payable, it shall also disclose the provisions relating to renewal, cancellation, and termination and any modification of benefits or losses covered or increase in premiums because of age or other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0235

Testimonials or Endorsements by Third Parties

(1) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer in using a testimonial makes as its own all of the statements contained therein, and the entire advertisement including such testimonial is subject to all the provisions of this rule.

(2) If the person making a testimonial, an endorsement, or an appraisal has a financial interest in the insurer or a related entity, as a stockholder, director, officer, employee or otherwise, this fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, this fact shall be disclosed in the advertisement by the phrase "paid endorsement" or its equivalent. This subsection does not require disclosure of payment of "union scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for travel or entertainment or similar expenditures for filming or recording of TV or radio advertisements requires disclosure.

(3) An advertisement shall not state or imply that the insurer or the policy has been approved or endorsed by any individual, group of individuals, society, association or other person, unless such is the fact and unless any proprietary relationship between such person and the insurer is disclosed. If the person making the endorsement or testimonial has been formed by the insurer, or is owned or controlled by the insurer or the persons who own or control the insurer, this fact shall be disclosed in the advertisement.

(4) When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss and other pertinent information, shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0240

Use of Statistics

(1) An advertisement stating the dollar amount of claims paid, the number of persons insured or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and must accurately reflect all of the relevant facts. Such an advertisement shall not imply that the statistics are derived from the advertised policy unless such is the fact. When the statistics are applicable to other policies or plans, the advertisement shall specifically so state.

(2) An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous" or use words of similar import, or represent or imply that claim settle-ments are or will be beyond the actual terms of the policy. No unusual amount paid for a unique claim under an advertised policy shall be used.

(3) The source of any statistics used in an advertisement shall be identified in the advertisement.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0245

Identification of Plan or Number of Policies

(1) When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits depends on the plan selected and that the premium will vary with the amount of benefits selected.

(2) When an advertisement refers to various benefits which may be contained in two or more policies other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0250

Disparaging Comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits, or comparisons of non-comparable policies, of other insurers, shall not disparage other insurers or their policies, services or business methods, and shall not disparage or unfairly characterize other methods of marketing insurance.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0255

Licensed Jurisdictions and Status of Insurer

(1) An advertisement which is intended to be seen or heard beyond the limits of the jurisdictions in which the insurer is licensed shall not imply licensing beyond those limits.

(2) An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, the payment of its claims, or the merits, desirability or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by this state or the federal government or any agency or official of either.

(3) If an advertisement states either that the insurer or the policy being offered is approved or licensed by this state or its Insurance Commissioner, it must also qualify the statement with words: **"This does not constitute a recommendation or endorsement of (this company) (this policy)"** or equivalent words.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0260

Identity of Insurer and Policy

(1) The name of the actual insurer and, except for general invitations to inquire about details of individual policies, the form number or numbers of the policy advertised shall be clearly identified in all advertisements.

(2) No advertisement shall use any material, envelope, or combination of words or symbols which, by content, phraseology, shape, color, or other characteristics, is similar to material, envelopes, or combinations of words or symbols used by an agency of the federal government or this state, or which is otherwise of such a nature as to tend to confuse or mislead prospective insureds into believing that the solicitation is connected with an agency of the federal or a state government.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0265

Group or Quasi-Group Implication

An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0270

Introductory, Initial, or Special Offers

(1)(a) An advertisement shall not directly or by implication represent that a policy or combination of policies is an introductory, initial, or special offer, that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special" or "limited", or similar words or phrases, if the insurer uses such enrollment periods as its usual method of marketing health insurance;

(b) An enrollment period during which a particular insurance coverage may be purchased on an individual basis shall not be offered unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same coverage and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised in this state for the first time. This requirement applies to all advertising media used by the insurer. It does not apply to solicitations of employees or members of a group or association who are eligible under the Insurance Code for group, blanket, or franchise health insurance. All affiliated insurers in a group of insurers under common management or control are considered as one insurer for the purpose of this paragraph. "A particular insurance coverage" refers for the purpose of this paragraph to an insurance policy which provides substantially different benefits than those contained in any other policy of the insurer. Different terms of renewability, an increase or decrease in the dollar amount of benefits or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be considered sufficient to constitute a different coverage which is eligible for concurrent or overlapping enrollment periods.

(2) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium shall be stated in a juxtaposition in each portion of the advertisement where the initial reduced premium appears.

(3) An advertisement shall not offer special awards such as a "safe driver's award".

(4)(a) If benefits are less for a particular age group, the reduced benefits for that group must be prominently set out in a separate section of an advertisement in such a manner that it would normally come to the attention of a casual reader;

(b) An advertisement for a policy covering accidental injury only must prominently state that illness or disease is not covered;

(c) An insurer soliciting business from customers, employees, or members of a particular company, employer, union, or other person must display the name of the insurer as prominently as that of the company, employer, union, or such other person, and must clearly indicate that there is no affiliation between the insurer and such person unless some significant affiliation does in fact exist.

(5)(a) An advertisement of an individual policy which provides for a direct response by including an application or enrollment form shall contain a "policy summary" setting out the essential features of the policy that will be issued upon acceptance of an application by the insurer;

(b) The policy summary shall be prominently displayed and readily distinguishable from all other portions of the advertisement. The policy summary shall explain the essential features of the policy in simple, concise, and readily understandable language, as in the following example:

POLICY SUMMARY

(or other descriptive title)

-A- This policy provides $16.27 daily hospital benefits.

-B- This policy is guaranteed renewable to age 65.

-C- The insurance company can change the premium.

-D- Pre-existing conditions are not covered for the first two years.

-E- Benefits are payable from the first day of accidents and the eighth day of sickness.

-F- Benefits are reduced at age 65.

-G- This policy does not cover mental illness, alcoholism, or drug addiction.

-H- (Other significant policy provisions).

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73; ID 2-1987, f. & ef. 3-3-87

836-020-0275

Statements About an Insurer

An advertisement shall not contain statements which are untrue in fact, or misleading by implication, with respect to the assets, corporate structure, financial standing, age, or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0280

Enforcement Procedures

(1) Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every advertisement prepared for its individual policies, and typical advertisements prepared for its blanket, franchise and group policies, for dissemination after the effective date of this rule in this or any other state, whether or not licensed in such other state. A notation shall be attached to each advertisement which shall indicate the manner and extent of distribution and the form number of any individual policy advertised. This file shall be available at all times for inspection by the Insurance Commissioner. Advertisements shall be maintained in the file for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

(2) Statement of Compliance. Each insurer subject to this rule must file with its annual statement a statement of compliance executed by an authorized officer of the insurer. The officer shall state that, to the best of his knowledge, information and belief, the advertisements disseminated by the insurer during the preceding calendar year complied, or were made to comply, in all respects with this rule.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0285

Prior Approval

No advertising which includes an application or enrollment form may be used without its prior approval by the Insurance Commissioner.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0290

Severability

If any portion of this rule, or the applicability of this rule to any person or circumstance, is held invalid by a court, the remainder of the rule or the applicability of the rule to other persons or circumstances shall not be affected thereby.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

836-020-0295

Effective Date

This rule shall be effective March 15, 1973.

Stat. Auth.: ORS Ch. 731, 743 & 746

Stats. Implemented: ORS 742.009 & 746.075

Hist.: IC 53, f. 3-5-73, ef. 3-15-73

Disclosure of Health Insurance Coverages

836-020-0300

Statutory Authority

(1) OAR 836-020-0300 to 836-020-0305 are adopted by the Director of the Department of Insurance and Finance pursuant to the requirements of ORS 742.009, 743.010 and 743.013 (Section 2, Chapter 474, Oregon Laws 1989).

(2) OAR 836-020-0300 to 836-020-0305 apply to solicitations of health insurance occurring on or after September 1, 1990.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.009, 743.010 & 743.013

Hist.: ID 12-1990, f. 6-12-90, cert. ef. 9-1-90

839-020-0305

Disclosure; Application for Coverage

(1) When an agent or representative of an insurer accepts an application for individual health insurance coverage other than coverage described in section (2) of this rule, the agent or representative shall provide the applicant the documents required under this section. In the case of direct response solicitations of such individual health insurance coverage, the documents required under this section must be provided in conjunction with any application form. The following are the documents required to be provided under this section:

(a) A completed disclosure statement in the form shown in **Exhibit 1** to this rule;

(b) An outline of coverage in the form shown for the applicable coverage in **Exhibit 2** to this rule. If the offered policy provides coverage other than a coverage described in an outline of coverage in **Exhibit 2** to this rule, the agent or representative or the direct response insurer must deliver an outline that has first been approved by the Director under section (6) of this rule.

(2) When an agent or representative of an insurer accept an application for individual accidental death and dismemberment insurance, accident only insurance or hospital indemnity insurance, the agent or representative shall provide the applicant the documents required under this section. In the case of direct response solicitations of such insurance, the documents required under this section must be provided in conjunction with any application form. The following are the documents required to be provided under this section:

(a) A completed disclosure statement in the form shown in **Exhibit 3** to this rule;

(b) An outline of coverage in the form shown for the applicable coverage in **Exhibit 2** to this rule. If the offered policy provides coverage other than a coverage described in an outline of coverage in **Exhibit 2** to this rule, the agent, representative or insurer must deliver an outline that has first been approved by the Director under section (5) of this

rule.

(3) When an agent or representative of an insurer accepts an application for group health insurance coverage, including group accidental death and dismemberment insurance, accident only insurance or hospital indemnity insurance, the agent or representative shall provide to the applicant an outline of coverage in the form shown for the applicable coverage in Exhibit 2 to this rule. In the case of direct response solicitations, the outline must be provided in conjunction with any application form. If the offered policy provides coverage other than a coverage described in an outline of coverage in **Exhibit 2** to this rule, the outline must first be approved by the Director under section (5) of this rule.

(4) For purposes of sections (1) to (3) of this rule, the following forms shall be used for the following coverages:

(a) **Exhibit 2**, **form A**, shall be used for comprehensive major medical expense coverage;

(b) **Exhibit 2**, **form B**, shall be used for hospital confinement indemnity coverage;

(c) **Exhibit 2**, **form C**, shall be used for accidental death and dismemberment only coverage and for accident only coverage;

(d) **Exhibit 2**, **form D**, shall be used for specified illness or specified accident coverage;

(e) **Exhibit 2**, **form E**, shall be used for limited benefit health coverage;

(f) **Exhibit 2**, **form F**, shall be used for basic hospital and medical-surgical expense coverage.

(5) An agent or representative of an insurer may use a form or material other than the statements set forth in **Exhibits 1** and **3** to this rule or the outlines set forth in **Exhibit 2** to this rule only if the form or material is first approved by the Director for the purpose of disclosure under this rule. Forms and other material submitted under this section are subject to the standards for advertising under OAR 836-020-0220 and 836-020-0225.

(6) When an agent or representative of an insurer provides an applicant the applicable information required under section (1), (2) or (3) of this rule, or a form or material approved under section (5) of this rule, the agent or representative shall obtain from the applicant an acknowledgement that the applicable information required under this rule was provided. In the case of direct response solicitations, the insurer or its representative or agent shall maintain proof that the documents required under this rule have been mailed to the applicant.

(7) This rule applies to all solicitations for health insurance, whether for initial, replacement or added coverage, except for solicitations for the following:

(a) Renewal of a health insurance policy, unless the application is to be used for the purpose of underwriting the policyholder;

(b) Medicare supplement insurance policies;

(c) Long term care insurance policies;

(d) Disability income insurance policies, as exempted from these rules under ORS 743.013;

(e) Accidental death and dismemberment insurance coverage and accident only insurance coverage when sold as a rider to a life insurance policy;

(f) Any individual policy issued under a conversion privilege in an insurance policy or contract.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.009, 743.010 & 743.013

Hist.: ID 12-1990, f. 6-12-90, cert. ef. 9-1-90

Use of Coordination of Benefits Provisions in Group and Blanket Health Insurance

836-020-0700

Purpose and Scope

(1) The purpose of this rule is to establish standard coordination of benefits (COB) provisions, and uniform guidelines for their interpretation and administration, for group and blanket health insurance policies which may have their benefits reduced because of other existing coverages. This rule applies to policies delivered or issued for delivery in Oregon. Except where the context otherwise requires, the definitions given in the Oregon Insurance Code govern the construction of this rule.

(2) This rule permits, but does not require, plans to include COB provisions. If a group or blanket health insurance policy does include a COB provision, it must be consistent with this rule.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0705

Authority and Supporting Rationale

OAR 836-020-0700 to 836-020-0765 are adopted by the Insurance Commissioner pursuant to ORS 743.552. The supporting rationale for the provisions of these rules are contained in the Second Report of the Industry Task Force on Coordination of Benefits, with attachments, as adopted by the National Association of Insurance Commissioners in December, 1970 **(Proceedings, NAIC, 1971, Vol. I, pp. 225-249)** and as amended in model regulations adopted by the NAIC in December, 1979 **(NAIC Proceedings, 1980, Vol. I., pp. 90-96)**. Further supporting rationale is contained in the Report of the Advisory Committee to the NAIC COB Task Force, June 1985, **(Proceedings, NAIC, 1985, Vol. II, COB)**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 6-1982, f. 1-29-82, ef. 2-1-82; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0710

Provisions for Coordination of Benefits

A group or blanket health insurance policy which provides for coordination of benefits shall contain the provisions set

forth in OAR 836-020-0715 to 836-020-0750, or provisions which are not less favorable to the insured or his beneficiary. Such provisions shall be preceded individually by the caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve. Such provisions collectively constitute the "coordination of benefits provision", which is referred to therein as "this provision". A Plan that does not include such a provision may not take into account the benefits of another Plan, as defined in OAR 836-020-0720, when it determines its benefits. There is one exception. A contract holder's coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0715

Benefits Subject to Coordination

(1) A group or blanket health insurance policy which provides for coordination of all benefits thereunder shall contain a provision as follows:

"BENEFITS SUBJECT TO THIS PROVISION: This coordination of benefits provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. 'Plan' and 'This Plan' are defined herein."

(2) If one or more of the policy benefits are to be exempt from reduction under the COB provision, appropriate changes shall be made in the wording set forth in section (1) of this rule. A contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0720

"Plan" Defined

(1) A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision stating what benefits from that policy and other sources are to be recognized under the coordination provision. Each such source shall be defined as a "Plan".

(2) The definition of a "Plan" may include such sources of benefits or services for or by reason of medical or dental care or treatment as:

(a) Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;

(b) Other prepaid coverage under service plan contracts, or under group or individual practice;

(c) Labor-management trusteed plans, labor organization plans, employer organizations plans, or employee benefit

organization plans;

(d) Medical benefits coverage in group, group-type, and individual automobile "no fault" and traditional automobile "fault" type contracts;

(e) Medicare or other governmental benefits. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program. However, "Plan" shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan; or

(f) Other group-type contracts. Group-type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of Plan, at the option of the insurer or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). This description of group-type contracts is not intended to include individually underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

(3) This provision shall include the following wording or its equivalent:

"'Plan' is any of these which provides benefits or services for, or because of, medical or dental care or treatment:" (The appropriate list is to be inserted at this point.) "Each contract or other arrangement for coverage described above is a separate Plan. Also, if an arrangment has two parts and the coordination of benefits provisions apply only to one of the two, each of the parts is a separate Plan."

(4)(a) This provision shall include the following wording or its equivalent:

"'This Plan' is the part of the group contract that provides benefits for health care expenses."

(b) Appropriate changes are to be made to the wording set forth if one or more policy benefits are to be exempt from reduction under the coordination provision. Any benefits that are not subject to this provision constitute another Plan.

(5) Except as provided in subsections (2)(d) and (f) of this rule, "Plan" shall not include individual or family benefits provided through any of the following: insurance contracts; subscriber contracts; coverage through Health Maintenance Organizations (HMOs); or other prepayment, service, group practice or individual practice plans.

(6) "Plan" shall not be construed to include group or group-type hospital indemnity benefits of $100 per day or less. It may be construed to include the amount by which group or group-type hospital indemnity benefits exceed $100 per day. "Hospital indemnity benefits" are those not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(7) "Plan" shall not include school accident-type coverages. These cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

(8) A Primary Plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:

(a) The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation; or

(b) All plans which cover the person use the order of benefit determination rules required by this regulation and under those rules the Plan determines its benefits first.

(9) A Secondary Plan is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the

order of benefit determination rules of this regulation decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0725

Allowable Expense

(1) A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision stating what expenses are to be recognized under the coordination provision, as follows:

"ALLOWABLE EXPENSE: 'Allowable Expense' means any necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. "The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan."

(2) Items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A Plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

(3) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both Allowable Expense and a benefit paid.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0730

Claim Determination Period

(1) A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision stating the period to be used in applying the coordination provision, as follows:

"CLAIM DETERMINATION PERIOD: 'Claim Determination Period' means _____". An appropriate period of time shall be inserted in the blank, such as "calendar year" or "Benefit Period as defined elsewhere in the policy."

(2) A claim determination period may not be less than 12 months. However, it may exclude a period before a person's coverage starts, or after it ends.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0735

Effect on Benefits

(1) A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision stating the manner in which benefits are reduced by coordination, as set forth below. Changes in words and format may be made to fit the language and style of the rest of the contract or to reflect the difference among Plans which provide services, those which pay benefits for expenses incurred, and those which indemnify. Substantive changes are allowed only as set forth in OAR 836-020-0700 to 836-020-0765:

"ORDER OF BENEFIT DETERMINATION RULES:

"(A) If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

"(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

"(ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

"(B) General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

"(i) the other Plan has rules coordinating its benefits with those of This Plan; and

"(ii) both those rules and This Plan's rules, in subparagraph (C) below, require that This Plan's benefits be determined before those of the other Plan.

"(C) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

"(i) Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

"(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (C)(iii) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

"a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

"b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the

other plan does not have the rules described in a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

"(iii) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

"a. first, the Plan of the parent with custody of the child;

"b. then, the Plan of the spouse of the parent with the custody of the child; and

"c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

"(iv) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule (iv) is ignored.

"(v) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

"EFFECT ON THE BENEFITS OF THIS PLAN:

"(D)(i) When This Section Applies. This section (D) applies when, in accordance with section (C) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in (ii) immediately below.

"(ii) Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

"a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this coordination of benefits provision; and

"b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."!

(2) For the purpose of determining length of coverage under section (1) of this rule (paragraph (C) of Order of Determination Rules):

(a) In determining the length of time a person in a given group has been covered under a given Plan, two successive

Plans covering the group shall be considered one continuous Plan if the person was eligible for coverage under the second Plan within 24 hours after the first Plan terminated. A change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, or a change from one type of Plan to another does not of itself constitute the start of a new Plan for purposes of section (1) of this rule (paragraph (C) of Orders of Determination Rules;

(b) If a person's effective date of coverage under a Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned, the carrier shall assume for the purposes of section (1) of this rule (paragraph (C) of Orders of Determination Rules), in the absence of specific information to the contrary, that the person's length of time covered under the Plan is measured from his effective date of coverage. If a person's effective date of coverage under a Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, the carrier shall request the group to furnish the date the person first became covered under the earliest of any prior Plans the group may have had. If such date is not furnished, the date the person first became a member of the group shall be used as the date from which to determine the length of time his coverage under the Plan has been in force.

(3) Any amount by which Secondary Plan's benefits have been reduced in accordance with section (1) of this rule (paragraph (D) of Effects on the Benefits of This Plan) shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

Stat. Auth.: ORS Ch. 731 & 743

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 6-1982, f. 1-29-82, ef. 2-1-82; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0740

Information Rights; Coordination Procedures; Time Limit; Small Claim Waivers

(1) A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision as follows:

"RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: Certain facts are needed to apply these coordination of benefits provisions. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to pay the claim."

(2) Insurers shall use the following claims administration procedures to expedite claim payments where coordination of benefits is involved:

(a) There should be continuing education of claim personnel, stressing accurate and prompt completion of the Health Insurance Council's Duplicate Coverage Inquiry Form (DUP-1) by the inquiring carrier and the responding carrier. This education effort should also be encouraged through local claim associations;

(b) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of coordination of benefits information;

(c) Insurers should encourage building a local data file with at least basic information on group health plans for major employers in the local area.

(3) Chapter 143, Oregon Laws 1973, specifies a time limit of 14 days for the insurer to be allowed to delay payment of a claim by reason of the application of a coordination of benefits provision. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other Plan

coverage shall be conducted concurrently, so as to create no further delay in the ultimate payment of benefits. If an insurer is required by the time limit to make payment as the primary Plan because it then has insufficient information to make it a secondary Plan, it may exercise its rights as set forth in the policy's "Right of Recovery" provision to recover any excess payments made thereby.

(4) Insurers are urged to waive the investigation of possible other Plan coverage on claims less than $50, but if additional liability is incurred which raises the claim above $50, the entire liability may be included in the coordination of benefits computation.

Stat. Auth.: ORS Ch. 731 & 743

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0745

Facility of Payment

A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision as follows:

"FACILITY OF PAYMENT: Any payment made under another Plan may include an amount which should have been paid under This Plan. If so, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term 'payment made' includes providing benefits in the form of services, in which case 'payment made' means reasonable cash value of the benefits provided in the form of services."

Stat. Auth.: ORS Ch. 731 & 743

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0750

Right of Recovery

(1) A group or blanket health insurance policy which provides for coordination of benefits shall contain a provision as follows:

"RIGHT OF RECOVERY: If the amount of the payments made by (The XYZ Company) is more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The 'amount of the payments made' includes the reasonable cash value of any benefits provided in the form of services."

(2) A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require

a Plan to reimburse a covered person in cash for the value of services provided by a Plan which provides benefits in the form of services.

Stat. Auth.: ORS Ch. 731 & 743

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

836-020-0755

Coordination and Subrogation

The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group or blanket health insurance policy without compelling the inclusion or exclusion of the other.

Stat. Auth.: ORS Ch.

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74

836-020-0760

Disclosure of Coordination in Group Certificate; Other Disclosure

(1) Each certificate of coverage under a group or blanket health insurance policy which provides for coordination of benefits must contain, at least in summary form, a description of the coordination provision.

(2) In addition, each insurer shall urge its group clients to take reasonable steps so that those insured by the group policy are exposed to reasonably concise explanations, with as little technical terminology as is consistent with accuracy, of the purpose and operation of the coordination of benefits provision. Such educational effort may, for example, take the form of articles in company magazines or newspapers, speeches before labor organizations or other employee groups, brochures in pay envelopes, notices on the bulletin boards, and materials used by employers in counseling employees.

Stat. Auth.: ORS Ch.

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74

836-020-0765

Effective Date

(1) This regulation takes effect on January 1, 1986. It applies to every group or blanket health insurance policy which provides health care benefits and is issued on or after that date. A group or blanket health insurance policy which includes a COB provision and was issued before that date shall be brought into compliance with this regulation by the later of:

(a) The next anniversary date or renewal date of the policy; or

(b) The expiration of any applicable collectively bargained contract pursuant to which it was written.

(2) All such policies issued or amended shall include the substance of the provision in section (1) of OAR 836-020-0735 (paragraph (C)(ii) of Order of Benefit Determination Rules). That provision shall become effective on January 1, 1987. Until that provision becomes effective, the group contract shall, instead, use wording like this:

"Except as stated in (iii), the benefits of a Plan which covers a person as a dependent of a male are determined before those of a Plan which covers the person as a dependent of a female."

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.552

Hist.: IC 55, f. 12-20-73, ef. 1-11-74; IC 9-1985, f. 12-24-85, ef. 1-1-86

Automobile Insurance

836-020-0900

Advance Payments

The notice required by ORS 12.155 shall contain the following:

(1) The time and location of the occurrence in regard to which the advance payment is made.

(2) A statement to the effect that the amount of any advance payment will be credited against any judgment entered in favor of the payee.

(3) The following words: "The period of limitation for commencement of an action for damages as set by Chapter 12 of Oregon Revised Statutes will expire on _____", or such other similar words as the Commissioner approves.

(4) The signature of the party to whom the advance payments are made or his representative, and the signature of a person authorized to act for the insurer.

(5) The date on which notice is delivered to the party entitled to the advance payment.

(6) The type size used in the portion of the notice described in section (3) of this rule shall not be smaller than the type used for other typed or printed material required by this rule and shall not be arranged or displayed in such a way as to obscure the content of the notice.

Stat. Auth.: ORS 12.155 & 731.244

Stats. Implemented: ORS 12.155

Hist.: IC 48, f. 8-18-71, ef. 9-1-71; Renumbered from 836-020-0060; ID 15-1996, f. & cert. ef. 11-12-96

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 24

DOMESTIC INSURERS; ORGANIZATION; CORPORATE PROCEDURES

Shares, Shareholders, and Members

836-024-0003

Statutory Authority; Purpose

OAR 836-024-0003 to 836-024-0061 are authorized by ORS 732.415(4). These rules are adopted to carry out the purposes of ORS 732.415, to prevent fraud or deception in connection with the solicitation of proxies, consents, and other authorizations, and to protect the insurance-buying public in accordance with the purpose of the Insurance Code.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0006

Definitions

The definitions and instructions set out in Schedule SIS are applicable for purposes of OAR 836-024-0003 to 836-024-0061. In addition, as used in these rules, unless the context otherwise requires:

(1) "Solicit" and "Solicitation" include:

(a) A request for a proxy, whether or not accompanied by or included in a form of proxy;

(b) A request to execute or not to execute, or to revoke, a proxy; and

(c) The furnishing of a form of proxy or other communication to security holders under circumstances reasonably calculated to result in the procurement, withholding, or revocation of a proxy.

(2) "Solicit" and "Solicitation" do not include:

(a) A solicitation by a person in respect to securities of which he is the beneficial owner;

(b) Action by a broker or other person in respect to securities carried in his name or in the name of his nominee:

(A) In forwarding to the beneficial owner of such securities soliciting material received from the insurer;

(B) In impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy; or

(C) In impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date; or

(c) The furnishing of a form of proxy to a security holder upon the unsolicited request of such security holder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

(3) "Schedule A" means the list of information itemized by OAR 836-024-0056.

(4) "Schedule B" means the list of information itemized by OAR 836-024-0061.

(5) "Schedule SIS" means the Schedule SIS, Stockholders' Information Supplement, included in the form prescribed by the Commissioner for the annual financial statement required by ORS 731.574.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0011

Compliance with Rules Required to Solicit Proxies, Consents, and Authorizations

Except as provided by OAR 836-024-0013, a domestic stock insurer and any director, officer, or employe of such an insurer and any other person shall not, in contravention of OAR 836-024-0003 to 836-024-0061, solicit, or permit the use of his name to solicit by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity security of such insurer held of record by 100 or more persons.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0013

Application of Rules

OAR 836-024-0003 to 836-024-0061 apply to each domestic stock insurer that has any class of equity security held of record by 100 or more persons; but such rules do not apply:

(1) To an insurer if 95 percent or more of its equity securities are owned or controlled by a parent or an affiliated insurer

and its remaining equity securities are held of record by less than 500 persons.

(2) With respect to any class of securities that is subject to the jurisdiction of the Securities and Exchange Commission if the insurer files with the Securities and Exchange Commission forms of proxies, consents, and authorizations with regard to such securities that comply with the Securities Exchange Act of 1934, as amended, and the regulations promulgated thereunder.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0016

Equivalent Information Must Be Disclosed

Unless proxies, consents, or authorizations in respect to a class of equity security of a domestic insurer are solicited by or on behalf of the management of the insurer from the holders of record of such security in accordance with OAR 836-024-0003 to 836-024-0061 prior to an annual or other meeting of the security holders, the insurer shall, in accordance with OAR 836-024-0003 to 836-024-0061, file with the Commissioner and transmit to all security holders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made. The insurer shall transmit a written information statement containing the information specified in section (4) of OAR 836-024-0026 to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited on behalf of the management of the insurer. However, in the case of a class of securities in unregistered or bearer form the statement may be transmitted only to those security holders whose names and addresses are known to the insurer.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0026

Information to Be Furnished to Security Holders

(1) A solicitation shall not be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of security holders at which directors are to be elected, each proxy statement furnished pursuant to section (1) of this rule shall be accompanied or preceded by an annual report (in preliminary or final form) to such security holders containing financial statements for the last fiscal year as referred to in Schedule SIS under the heading "Financial Reporting to Stockholders". Subject to the requirements of this section, the annual report to security holders may be in any form the management considers suitable.

(3) Two copies of each report sent to the security holders pursuant to this section shall be mailed to the Commissioner not later than the date on which the report is first sent or given to security holders, or the date on which preliminary copies of solicitation material are filed with the Commissioner pursuant to OAR 836-024-0036(1), whichever date is later.

(4) If a solicitation is not being made by management of the insurer with respect to an annual or other meeting, an insurer shall mail to every security holder of record at least 20 days prior to the meeting date a statement as required by OAR 836-024-0016, containing the information called for by all of the items of Schedule A, other than Items 1, 3, and 4, that would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting. If the information statement relates to an annual meeting at which directors are to be elected, it shall be accompanied by an annual report to security holders in the form provided in section (2) of this rule.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0031

Requirements as to Proxy and Information Statement

(1) The form of proxy shall:

(a) Indicate in bold-face type whether or not the proxy is solicited on behalf of the management;

(b) Provide a specifically designed blank space for dating the proxy; and

(c) Identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management or by the security holders. It is not necessary to refer to proposals as to which discretionary authority is conferred pursuant to section (3) of this rule.

(2)(a) Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to in the proxy, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in bold-face type how it is intended to vote the shares or authorization represented by the proxy in each such case;

(b) A form of proxy that provides both for elections to office and for action on other specified matters shall be prepared so as to clearly provide, by a box or otherwise, means by which the security holder may withhold authority to vote for elections to office. A form of proxy that is executed by the security holder in a manner so as not to withhold authority to vote for elections to office shall be considered a grant of such authority, if the form of proxy so states in bold-face type.

(3) A proxy may confer discretionary authority with respect to other matters that may come before the meeting, if:

(a) The persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting; and

(b) A specific statement to the effect that they are not aware of any other matters is made in the proxy statement or in the form of proxy.

(4) A proxy shall not confer authority:

(a) To vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement; or

(b) To vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to security holders.

(5) The proxy statement or form of proxy shall, subject to reasonable specified conditions, provide:

(a) That the proxy will be voted; and

(b) That, where the person solicited specified by means of ballot provided pursuant to subsection (2)(a) of this rule a choice with respect to any matter to be acted upon, the vote will be in accordance with the specification so made.

(6) The information included in the proxy statement or information statement shall be clearly presented. The statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements or information statements shall be clearly and legibly presented.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0036

Material Required to Be Filed

(1) Two preliminary copies of the information statement or the proxy statement and form of proxy, and any other soliciting material to be furnished to security holders concurrently with the statement and proxy, shall be filed with the Commissioner at least ten days prior to the date definitive copies of such material are first sent or given to security holders, or a shorter period prior to that date that the Commissioner may authorize upon a showing of good cause.

(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to security holders subsequent to the proxy statements shall be filed with the Commissioner at least two days (exclusive of Saturdays, Sundays, or holidays) prior to the date copies of the material are first sent or given to security holders, unless on a showing of good cause the Commissioner reduces the two-day period.

(3) Two definitive copies of the information statement or the proxy statement, form of proxy and all other soliciting material, in the form in which the material is furnished to security holders, shall be filed with, or mailed for filing to, the Commissioner not later than the date the material is first sent or given to the security holders.

(4) If an information statement or proxy statement, form of proxy or other material filed pursuant to this section is amended or revised, two of the copies of the amendment or revision shall be marked to clearly show the changes.

(5) Copies of replies to inquiries from security holders requesting further information and copies of communications that do no more than request that the proxy form previously solicited be signed and returned need not be filed pursuant to this section.

(6) Notwithstanding the provisions of sections (1) and (2) of this rule and of OAR 836-024-0055(1), copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by section (3) of this rule not later than the date the material is used or published. Sections (1) and (2) of this rule and OAR 836-024-0055(1) apply, however, to any reprints or reproductions of all or any part of such material.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0041

False or Misleading Statements

A proxy statement, form of proxy, notice of meeting, information statement, and any other communication, written or oral, that is subject to OAR 836-024-0003 to 836-024-0061 shall not contain any statement that:

(1) At the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact; or

(2) Omits to state any material fact that is necessary in order to make the statements in the communication not false or misleading, or that is necessary to correct any statement in an earlier communication with respect to the same meeting or subject matter that has become false or misleading.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0046

Prohibition of Certain Solicitations

A person making a solicitation shall not solicit any undated or postdated proxy, or any proxy that provides it will be considered to be dated as of any date subsequent to the date on which it is signed by the security holder.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0051

Definitions Applicable to Election Contests

As used in OAR 836-024-0051 to 836-024-0055, unless the context requires otherwise:

(1) "Counter Solicitation" means a solicitation that is subject to OAR 836-024-0051 to 836-024-0055 as provided by OAR 836-024-0052.

(2) "Participant" and "participant in a solicitation" include:

(a) The insurer;

(b) A director of the insurer, and a nominee for whose election as a director proxies are solicited; and

(c) Any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing, or financing the solicitation.

(3) "Participant" and "Participant in a Solicitation" do not include:

(a) A bank, broker, or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of securities and who is not otherwise a participant;

(b) A person or organization retained or employed by a participant to solicit security holders, or a person who merely transmits proxy soliciting material or performs ministerial or clerical duties;

(c) A person employed in the capacity of attorney or accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;

(d) A person regularly employed as an officer or employe of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or

(e) An officer or director of, or a person regularly employed by, any other participant, if the officer, director, or employe is not otherwise a participant.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0052

Special Provisions Applicable to Election Contests

OAR 836-024-0051 to 836-024-0055 apply to a solicitation by any person or group for the purpose of opposing a solicitation by another person or group with respect to the election or removal of directors at an annual or special meeting of security holders.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0053

Filings Required in an Election Contest

(1) A counter solicitation shall not be made by a person other than the management of an insurer unless there is filed with the Commissioner, by or on behalf of each participant in the solicitation, a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to security holders in furtherance of the solicitation. If preliminary copies of materials are filed, distribution to security holders shall be deferred until the Commissioner's comments have been received and complied with. The materials required to be filed with the Commissioner shall be filed with him at least five business days prior to the solicitation unless on a showing of good cause the Commissioner reduces the five-day period.

(2) Within five business days after a counter solicitation is made by the management of an insurer, or within a longer period that the Commissioner authorizes on a showing of good cause, there shall be filed with the Commissioner by or on behalf of each participant in the solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

(3) If a solicitation on behalf of management or another person has been made, or if proxy material is ready for

distribution, prior to a solicitation counter thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the Commissioner, by or on behalf of each participant in the prior solicitation, other than the insurer, as soon as it is reasonably practical after the commencement of the counter solicitation.

(4) If, subsequent to the filing of the statements required by sections (1) to (3) of this rule, additional persons become participants in a counter solicitation, there shall be filed with the Commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B within three business days after such person becomes a participant, or within a longer period that the Commissioner authorizes upon a showing of good cause.

(5) If any material change occurs in the facts reported in a statement filed by or on behalf of a participant, an appropriate amendment to the statement shall be filed promptly with the Commissioner.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0054

Counter Solicitations Prior to Furnishing Required Written Proxy Statement

Notwithstanding the provisions of OAR 836-024-0026(1), a counter solicitation may be made prior to furnishing security holders a written proxy statement containing the information specified in Schedule A with respect to the solicitation, if:

(1) The statements required by OAR 836-024-0053 are filed by or on behalf of each participant in the solicitation.

(2) A form of proxy is not furnished to security holders prior to the time the proxy statement required by OAR 836-024-0026(1) is furnished to such persons; however, this section does not apply if a proxy statement then meeting the requirements of Schedule A has been furnished to security holders.

(3) Statements containing at least the information specified by OAR 836-024-0053(2) and (3), or an appropriate summary thereof, are included in each communication sent or given to security holders in connection with the solicitation.

(4) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given security holders at the earliest practical date.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0055

Filing Requirements for Preliminary Counter Solicitation Material; Portions of Annual Report

(1) Two copies of any soliciting material proposed to be sent or given to security holders prior to the furnishing of the proxy statement required by OAR 836-024-0026(1) shall be filed with the Commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons unless on a showing of good cause the Commissioner reduces the five-day period.

(2) Notwithstanding the provisions of OAR 836-024-0026(2) and (3), two copies of any portion of the annual report referred to in OAR 836-024-0026(2) that comments upon or refers to a counter solicitation, or to a participant in a counter solicitation, other than the solicitation by the management, shall be filed with the Commissioner. It shall be filed with the Commissioner, in preliminary form, at least five business days prior to the date copies of the report are first sent or given to security holders.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0056

Schedule A

The following information shall be included in a proxy statement or information statement required by OAR 836-024-0003 to 836-024-0061:

(1) *Item 1:* Revocability of Proxy. State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe the limitation or procedure.

(2) *Item 2:* Dissenters' Rights of Appraisal. Outline briefly the rights of appraisal or similar rights of dissenting security holders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such security holders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment or other similar act, state whether the person solicited will be notified of such date.

(3) *Item 3:* Persons Making Solicitations Not Subject to OAR 836-024-0051 to 836-024-0055:

(a) If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action that he intends to oppose.

(b) If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

(c) If the solicitation is to be made by specially engaged employes or paid solicitors, state:

(A) The material features of any contract or arrangement for such solicitation and identify the parties; and

(B) The cost or anticipated cost of the solicitation.

(4) *Item 4:* Interest of Certain Persons in Matters to Be Acted Upon. Describe briefly any substantial interest, direct or indirect, by security holdings or otherwise, of any director, nominee for election as director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon, other than elections to office.

(5) *Item 5:* Voting Securities:

(a) State, as to each class of voting securities of the insurer entitled to be voted at the meeting, the number of shares

outstanding and the number of votes to which each class is entitled;

(b) Give the date as of which the record list of security holders entitled to vote at the meeting will be determined. If the right to vote is not limited to security holders of record on that date, indicate the conditions under which other security holders may be entitled to vote;

(c) If action is to be taken with respect to the election of directors, and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise of such rights.

(6) *Item 6:* Nominees and Directors:

(a) If action is to be taken with respect to the election of directors, furnish the information described in subsections (2) to (5) of this item, in tabular form to the extent practical, with respect to each person whose term of office as a director will continue after the meeting;

(b) Name the person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him; and indicate whether he is a nominee for election as director at the meeting;

(c) State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of security holders at a meeting for which proxies were solicited under OAR 836-024-0003 to 836-024-0061 or under the former similar rule compiled in OAR 836-011-0006 to 836-011-0061, adopted by Administrative Order IC-44, effective from January 1, 1970 to June 22, 1976;

(d) If he is or has previously been a director of the insurer, state the period or periods during which he served as such;

(e) State, as of the most recent practical date, the approximate amount of each class of equity securities of the insurer or any of its parents, subsidiaries or affiliates, other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such securities, make a statement to that effect.

(7) *Item 7:* Remuneration and Other Transactions with Management and Others:

(a) Furnish the information reported or required in Item One of Schedule SIS under the heading "Information Regarding Management and Directors" if action is to be taken with respect to:

(A) The election of directors;

(B) Any remuneration plan, contract, or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate;

(C) Any pension or retirement plan in which any such person will participate; or

(D) The granting or extension to any such persons of any options, warrants, or rights to purchase any securities, other than warrants or rights issued to security holders on a pro rata basis.

(b) If the solicitation is made on behalf of persons other than the management, information shall be furnished only as to Item One-A under such heading of Schedule SIS.

(8) *Item 8:* Bonus, Profit Sharing, and Other Remuneration Plans. If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan of the insurer, furnish:

(a) A brief description of the material features of the plan, each class of persons who will participate in the plan, the

approximate number of persons in each such class and the basis of such participation;

(b) The amounts which would have been distributable under the plan during the last calendar year, if the plan had been in effect, to:

(A) Each person named in Item Seven of this schedule;

(B) Directors and officers as a group; and

(C) All other employes as a group.

(c) If the plan to be acted upon may be amended (other than by a vote of security holders) in a manner which would materially increase the cost thereof to the insurer or materially alter the allocation of the benefits as between the groups specified in subsection (2) of this item, the nature of such amendments shall be specified.

(9) *Item 9:* Pension and Retirement Plans. If action is to be taken with respect to any pension or retirement plan of the insurer, furnish:

(a) A brief description of the material features of the plan, each class of persons who will participate in the plan, the approximate number of persons in each class and the basis of such participation.

(b) State:

(A) The approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period;

(B) The estimated annual payment to be made with respect to current services; and

(C) The amount of such annual payments to be made for the benefit of:

(i) Each person named in Item Seven of this schedule;

(ii) Directors and officers as a group; and

(iii) Employes as a group.

(D) If the plan to be acted upon may be amended (other than by a vote of security holders) in a manner which would materially increase the cost of the plan to the insurer or materially alter the allocation of the benefits as between the groups specified in paragraph (c) of subsection (2) of this item, the nature of such amendments shall be specified.

(10) *Item 10:* Options, Warrants, or Rights. If action is to be taken with respect to the granting or extension of any options, warrants, or rights (all referred to in this item as "warrants") to purchase securities of the insurer or any subsidiary or affiliate, other than warrants issued to all security holders on a pro rata basis:

(a) Furnish the title and amount of securities called for or to be called for; the prices, expiration dates, and other material conditions upon which the warrants may be exercised; the consideration received or to be received by the insurer, subsidiary, or affiliate for the granting or extension of the warrants; and the market value of the securities called for or to be called for by the warrants, as of the latest practical date;

(b) If known, state separately the total amount of securities called for or to be called for by warrants received or to be received by the following persons and name each such person:

(A) Each person named in Item Seven of this schedule; and

(B) Each other person who will be entitled to acquire five percent or more of the securities called for or to be called for by such warrants.

(c) If known, state the total amount of securities called for or to be called for by such warrants received or to be received by all directors and officers of the company as a group and all employes, without naming them.

(11) *Item 11:* Authorization or Issuance of Securities:

(a) If action is to be taken with respect to the authorization or issuance of any securities of the insurer, furnish the title, amount, and description of the securities to be authorized or issued;

(b) If the securities are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: Dividend, voting, liquidation, preemptive and conversion rights, redemption and sinking fund provisions, interest rate, and date of maturity;

(c) If the securities to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial statements comparable to those contained in the annual financial statement required under ORS 731.574.

(12*) Item 12:* Mergers, Consolidations, Acquisitions, and Similar Matters:

(a) If action is to be taken with respect to a merger, consolidation, acquisition or similar matter, furnish in brief outline:

(A) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon and indicate any procedure required to be followed by dissenting security holders in order to perfect such rights;

(B) The material features of the plan or agreement;

(C) The business done by the company to be acquired or whose assets are being acquired;

(D) If available, the high and low sales prices for each quarterly period within the last two years;

(E) The percentage of outstanding shares that must approve the transaction before it is consummated.

(b) For each company involved in a merger, consolidation or acquisition, the following financial statements shall be furnished:

(A) A comparative balance sheet as of the close of the last two fiscal years;

(B) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earnings per share after related taxes and cash dividends paid per share;

(C) A pro forma combined balance sheet and income and expense statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

(13) *Item 13:* Restatement of Accounts. If action is to be taken with respect to the restatement of an asset, capital or surplus account of the insurer:

(a) State the nature of the restatement and the date it is to be effective;

(b) Outline briefly the reasons for the restatement and for the selection of the particular effective date;

(c) State the name and amount of each account affected by the restatement and the effect of the restatement on each account.

(14) *Item 14:* Matters Not Required to Be Submitted. If action is to be taken with respect to any matter which is not required to be submitted to a vote of security holders, state:

(a) The nature of such matter;

(b) The reason for submitting it to a vote of security holders; and

(c) What action is intended to be taken by the management in the event of a negative vote on the matter by the security holders.

(15) *Item 15:* Amendment of Charter, By-Laws, or Other Documents. If action is to be taken with respect to any amendment of the insurer's charter, by-laws, or other documents as to which information is not required under any other item in this schedule, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

836-024-0061

Schedule B

The following information shall be included in statements filed by or on behalf of each participant (other than the insurer) in a proxy solicitation in an election contest:

(1) *Item 1:* Insurer. State the name and address of the insurer.

(2) *Item 2:* Identify and Background:

(a) State the participant's name and business address and present principal occupation or employment; and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(b) State the participant's residence address and information as to all material occupations, positions, offices, or employments during the last 10 years, giving:

(A) Starting and ending dates of each; and

(B) The name, principal business and address of any business corporation, or other business organization in which each such occupation, position, office, or employment was carried on.

(c) State whether or not the participant is or has been a participant in any other proxy contest involving this insurer or other companies within the past ten years. If so, identify the principals, the subject matters, and the relationship of the participant to the parties and the outcome.

(d) State whether or not, in a judicial or administrative proceeding during the last ten years, the participant has been convicted of any offense (excluding Class C and Class D traffic infractions, Class C misdemeanors and similar offenses) and, if so, give the date, nature of conviction, name and location of the court or administrative agency, and penalty imposed or other disposition of the case. A negative answer to this sub-Item need not be included in the proxy statement or other proxy soliciting material.

(3) *Item 3:* Interest in Securities of the Insurer:

(a) State the amount of each class of securities of the insurer that the participant owns beneficially, directly, or indirectly;

(b) State the amount of each class of securities of the insurer that the participant owns of record but not beneficially;

(c) State with respect to all securities of the insurer purchased or sold within the past two years, the dates on which they were purchased or sold by the participant and the amount purchased or sold on each such date;

(d) If any part of the purchase price or market value of any of the securities specified in subsection (c) of this item is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding the securities, so state and indicate the amount of the indebtedness as of the latest practical date. If the funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker, or dealer, briefly describe the transaction and state the names of the parties;

(e) State whether or not the participant is a party to any contract, arrangement, or understanding with any person with respect to any securities of the insurer, including, but not limited to, a joint venture, loan, or option arrangement, puts or calls, guarantee against losses or guarantee of profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom such a contract, arrangement or understanding exists and give the details thereof;

(f) State the amount of securities of the insurer owned beneficially, directly, or indirectly, by each associate of the participant and the name and address of each such associate;

(g) State the amount of each class of securities of any parent, subsidiary or affiliate of the insurer that the participant owns beneficially, directly, or indirectly.

(4) *Item 4:* Further Matters:

(a) Describe the time and circumstances under which the participant became a participant in the solicitation and state the nature and extent of his activities or proposed activities as a participant;

(b) Describe briefly, and where practical state the approximate amount of any material interest, direct or indirect, of the participant and of each of his associates in any material transactions since the beginning of the insurer's last fiscal year, or in any material proposed transactions, to which the insurer or any of its subsidiaries or affiliates was or is to be a party;

(c) State whether or not the participant or any of his associates have any arrangement or understanding with any person:

(A) With respect to any future employment by the insurer or its subsidiaries or affiliates; or

(B) With respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

(d) Describe any arrangement or understanding stated under subsection (3) of this item and state the names of the parties thereto.

(5) *Item 5:* Signature. The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct to the best of my knowledge and belief.

_____(Date)_____

_____

Signature of participant or authorized representative

Stat. Auth.: ORS Ch. 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 27

DOMESTIC INSURERS; ORGANIZATION; CORPORATE PROCEDURES

Holding Company Systems

836-027-0001

Statutory Authority and Purpose of OAR 836-027-0005 to 836-027-0180

OAR 836-027-0005 to 836-027-0180 are adopted pursuant to authority in ORS 732.572. They are adopted to carry out ORS 732.517 to 732.592. The information required by OAR 836-027-0005 to 836-027-0180 is declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this state.

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 732.517 - 732.592

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0005

Definitions

(1) Unless the context otherwise requires, as used in OAR 836-027-0005 to 836-027-0180:

(a) "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

(b) "Foreign insurer" includes an alien insurer except where specifically noted otherwise.

(c) "Form A" means the form prescribed by OAR 836-027-0100, **Exhibit 1**, Form A.

(d) "Form B" means the form prescribed by OAR 836-027-0010, **Exhibit 2**, Form B.

(e) "Form C" means the form prescribed by OAR 836-027-0012, **Exhibit 3**, Form C.

(f) "Form D" means the form prescribed by OAR 836-027-0160, **Exhibit 4**, Form D.

(g) "Ultimate controlling person" means the person who is not controlled by any other person.

(2) Unless the context requires otherwise, other terms used in OAR 836-027-0005 to 836-027-0180 are used as defined in ORS 732.548.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 732.517 - 732.592

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

Registration

836-027-0010

Registration of Insurers--Statement Filing

An insurer required to file an annual registration statement pursuant to ORS 732.517 to 732.592 shall furnish the required information on Form B, which is incorporated in and made a part of this rule as **Exhibit 2**.

[ED. NOTE: Exhibit 2, Form B, referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 732.517 - 732.592

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93; ID 13-1993, f. & cert. ef. 12-1-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0012

Summary of Registration - Statement Filing.

An insurer required to file an annual registration statement pursuant to ORS 732.517 to 732.592 is also required to furnish information required on Form C, which is incorporated in and made a part of this rule as **Exhibit 3**. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the Insurance Commissioner of that state.

[ED. NOTE: Exhibit 3, Form C, referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0020

Alternative and Consolidated Registrations

(1) An authorized insurer may file a registration statement, Form B, on behalf of an affiliated insurer or insurers that are required to register under ORS 732.551. A registration statement may include information not required by ORS 732.517 to 732.592 regarding any insurer in the insurance holding company system even if the insurer is not an authorized insurer. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report that it is required to file in its state of domicile, if:

(a) The statement or report contains information substantially similar to that required to be furnished on Form B; and

(b) The filing insurer is the principal insurer in the insurance holding company system.

(2) The question of whether the filing insurer is the principal insurer in the insurance holding company system is a question of fact, and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a brief statement of facts that will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

(3) With the prior approval of the Director, an unauthorized insurer may follow any of the procedures that could be followed by an authorized insurer under section (1) of this rule.

(4) An insurer may take advantage of the provisions of ORS 732.562 and 732.564 without obtaining the prior approval of the Director. The Director reserves the right, however, to require individual filings if the Director considers such filings necessary in the interest of clarity, ease of administration or the public good.

[ED. NOTE: The Form(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.705

Stats. Implemented: ORS 732.517 - 732.592 & 732.551

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0025

Disclaimers and Termination of Registration

(1) A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (referred to as the "subject" in this section) shall contain:

(a) The number of authorized, issued and outstanding voting securities of the subject;

(b) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities that are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

(c) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person; and

(d) A statement explaining why such person should not be considered to control the subject.

(2) A request for termination of registration shall be considered granted unless the Director, within ten days after the

Director receives the request, notifies the registrant otherwise.

Stat. Auth.: ORS Ch. 731 & 732.705

Stats. Implemented: ORS 732.558 & 732.568

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93

Forms Generally

836-027-0030

Forms; General Requirements

(1) Forms A, B, C and D are intended to be guides in the preparation of the statements required by ORS 732.517 to 732.592, including but not limited to the registration provisions thereof. The forms are not intended to be blank forms that are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted if the answers to the items are prepared so as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer to any item is in the negative, an appropriate statement to that effect shall be made.

(2) One complete copy of each statement, including exhibits and all other papers and documents filed as a part of the statement, shall be filed with the Director by personal delivery or mail addressed to: Director of the Oregon Department of Consumer and Business Services, Insurance Division, Labor and Industries Building, Salem, Oregon 97310. A copy of Form C shall be filed in each state in which an insurer is authorized to do business if the Commissioner of that state has notified the insurer of its request in writing. An insurer who has been so notified shall file the form not later than the 30th day after the date of receipt of the notice. At least one of the copies shall be manually signed and certified in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

(3) Statements must be prepared on paper 8-1/2" X 11" or 8-1/2" X 13" in size and bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements or exhibits shall be clear, easily readable, and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency shall be converted into United States currency.

[ED. NOTE: The Form(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.705

Stats. Implemented: ORS 732.517 - 732.592

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0035

Forms; Incorporation by Reference, Summaries, and Omissions

(1) Information required by any item of Form A, B or D may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority or any other document may be incorporated by reference in answer or partial answer to any item of Form A, B or D if the document or paper is filed as an exhibit to the statement. Excerpts of documents may be attached as exhibits if the documents are extensive. Documents currently on file with the Director that were filed within three years need not be filed as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case in which the incorporation would render the statement incomplete, unclear, or confusing.

(2) If an item requires a summary or outline of the provisions of any document, only a brief statement of the pertinent provisions of the document shall be made. The summary or outline may in addition incorporate by reference particular parts of any exhibit or document currently on file with the Director that was filed within three years and may be qualified in its entirety by such reference. If two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution or other details, a copy of only one of such documents need be filed, but it shall have attached a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents of which a copy is filed.

Stat. Auth.: ORS Ch. 731 & 732.705

Stats. Implemented: ORS 732.523, 732.552 & 732.574

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93

836-027-0040

Forms; Information Unknown or Unavailable and Extension of Time to Furnish

(1) Required information need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because obtaining it would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted. However, the person filing shall:

(a) Give such information on the subject as the person possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and

(b) Include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

(2) If it is impractical to furnish any required information, document, or report at the time it is required to be filed, an application may be filed with the Director:

(a) Identifying the information, document, or report in question;

(b) Stating why the filing thereof at the time required is impractical; and

(c) Requesting an extension of time for filing the information, document, or report to a specified date.

(3) An application submitted under section (2) of this rule shall be considered granted unless the Director, within 30 days after receipt thereof, enters an order denying the application.

Stat. Auth.: ORS Ch. 731 & 732.705

Stats. Implemented: ORS 732.523, 732.552 & 732.574

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93

836-027-0045

Forms; Additional Information and Exhibits

In addition to the information expressly required to be included in Forms A, B, C and D there shall be included further material information, if any, as may be necessary to make the information contained in the form not misleading. The person filing may also file exhibits in addition to those expressly required by the statement. Such exhibits shall be marked to indicate clearly the subject matters to which they refer.

Stat. Auth.: ORS Ch. 731 & 732.705

Stats. Implemented: ORS 732.523, 732.552, 732.553 & 732.574

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-23-93

836-027-0050

Instructions; Amendments

A change to Form A, B, C or D shall include on the top of the cover page the phrase: **"Change No. _____ to"** and shall indicate the date of the change and not the date of the original filing.

Stat. Auth.: ORS Ch. 731 & 732.705

Stats. Implemented: ORS 732.523, 732.552, 732.554 & 732.574

Hist.: IC 68, f. & ef. 6-22-76; ID 8-1993, f. & cert. ef. 9-24-93

Subsidiaries of Domestic Insurers

836-027-0070

Subsidiaries of Domestic Insurers

The authority to invest in subsidiaries under ORS 733.630 is in addition to any authority to invest in subsidiaries that may be contained in any other provision of the Insurance Code.

Stat. Auth.: ORS 732.705

Stats. Implemented: ORS 733.510 & 733.630

Hist.: ID 8-1993, f. & cert. ef. 9-23-93

Acquisitions and Mergers

836-027-0100

Acquisition of Control - Statement Filing

A person required to file a statement pursuant to ORS 732.517 to 732.592 shall furnish the required information on Form A, which is incorporated in and made a part of this rule as **Exhibit 1**.

[ED. NOTE: Exhibit 1, Form A, referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.705

Stats. Implemented: ORS 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0110

Amendments to Form A

An applicant who has filed a statement pursuant to ORS 732.517 to 732.592 shall promptly advise the Director of any changes in the information so furnished on Form A arising subsequent to the date upon which the information was furnished but prior to disposition of the application by the Director.

Stat. Auth.: ORS 732.705

Stats. Implemented: ORS 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0120

Acquisition of Certain Persons Considered to be Insurers

(1) If the person being acquired is considered to be a "domestic insurer" solely because of the definition of "domestic insurer" in ORS 732.518, the name of the domestic insurer on the cover page shall be indicated as follows: "ABC Insurance Company, a subsidiary of XYZ Holding Company."

(2) When a person who is considered to be a "domestic insurer" solely because of the definition of "domestic insurer" in ORS 732.518, is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Stat. Auth.: ORS 732.705

Stats. Implemented: ORS 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0130

Information to be Included in Statement Required by ORS 732.517 to 732.592

The statement to be filed with the Director pursuant to ORS 732.517 to 732.592 shall include the following information, to be set forth in Form A:

(1) If any acquiring party required to file a statement is an individual, the principal occupation of the person and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past 10 years; and

(2) If any acquiring party required to file a statement is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as the acquiring party and any predecessors of the acquiring party have been in existence, an informative description of the business intended to be done by the acquiring party and its subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of the acquiring party or who perform or will perform functions appropriate to the positions. The list shall include for each individual the information required by section (1) of this rule.

(3) The number of shares of any security that each acquiring party required to file a statement proposes to acquire in connection with the acquisition, the terms of any proposed offer or agreement relating to the acquisition and a statement as to the method by which the fairness of the proposal was determined.

(4) The amount of each class of any security of the type to be acquired in connection with the acquisition that is beneficially owned or concerning which there is a right to acquire beneficial ownership by any acquiring party.

(5) A full description of any contracts, arrangements or understandings with respect to any security of the type to be acquired in connection with the acquisition in which any acquiring party required to file a statement is involved, including, without limitation, those involving transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered.

(6) A description of the purchase of any security of the type to be acquired in connection with the acquisition during the 12 calendar months preceding the filing of the statement, by any acquiring party required to file a statement, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid for the security.

(7) A description of any recommendation to purchase any security of the type to be acquired in connection with the acquisition made by any acquiring party required to file a statement, or by anyone based upon interviews or at the suggestion of any acquiring party required to file a statement, during the 12 calendar months preceding the filing of the statement.

(8) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities of the type to be acquired in connection with the acquisition and, if distributed, copies of additional soliciting material relating thereto.

(9) A description of the terms of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation for tender of securities of the type to be acquired in connection with the acquisition, including the amount of any fees, commissions or other compensation to be paid to any broker-dealer in connection with the agreement, contract or understanding.

Stat. Auth.: ORS 732.523 & 732.572

Stats. Implemented: ORS 732.574, 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

Internal Transactions and Extraordinary Dividends

836-027-0160

Transactions Subject to Prior Notice - Notice Filing

An insurer required to give notice of a proposed transaction pursuant to ORS 732.574 shall furnish the required information on Form D, which is incorporated in and made a part of this rule as **Exhibit 4**.

[ED. NOTE: Exhibit 4, Form D, referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0170

Extraordinary Dividends and Other Distributions

(1) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

(a) The amount of the proposed dividend;

(b) The date established for payment of the dividend;

(c) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

(d) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper must include the following information:

(A) The amounts, dates and form of payment of all dividends or distributions, including regular dividends but excluding distributions of the insurer's own securities, paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(B) Total capital and surplus as of the 31st day of December immediately preceding;

(C) If the insurer transacts life insurance, the net gain from operations of the insurer after dividends to policyholders and federal income taxes and before realized capital gains or losses, for the 12-month period ending the 31st day of December immediately preceding;

(D) If the insurer does not transact life insurance, the net income for the 12-month period ending the 31st day of December immediately preceding and the two preceding 12-months periods; and

(E) If the insurer does not transact life insurance, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.

(e) A balance sheet and statement of income for the period intervening from the last annual statement filed with the Director and the end of the month preceding the month in which the request for dividend approval is submitted; and

(f) A brief statement as to the effect of the proposed dividend upon the insurer's capital and surplus and the reasonableness of combined capital and surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

(2) Subject to ORS 732.576, each registered insurer shall report to the Director all dividends and other distributions to shareholders within five business days following the declaration thereof, including the same information required by section (1)(d)(A) to (E) of this rule.

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

836-027-0180

Adequacy of Surplus

The factors set forth in ORS 731.554, as referred to in ORS 732.582, for the purpose of determining the reasonableness and adequacy of the insurer's capital and surplus, are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's capital and surplus, no single factor is necessarily controlling. Instead, the Director shall consider the net effect of all of such factors and also other factors bearing on the financial condition of the insurer. In comparing the capital and surplus maintained by other insurers, the Director shall consider the extent to which each of such factors varies from insurer to insurer. In determining the quality and liquidity of investments in subsidiaries, the Director shall consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

Stat. Auth.: ORS 732.572

Stats. Implemented: ORS 731.554, 732.517 - 732.592

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 28

PURCHASING GROUPS AND RISK RETENTION GROUPS

836-028-0005

Statutory Authority, Purpose

OAR 836-028-0005 to 836-028-0045 are adopted pursuant to ORS 731.244 and 735.360 in order to carry out the Oregon Liability Risk Retention Law and to protect the insurance-buying public.

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.300 - 735.365

Hist.: IC 7-1988, f. & cert. ef. 4-14-88; ID 19-1988, f. & cert. ef. 12-6-88

836-028-0008

Unfair Trade Practice

Failure of a purchasing group to comply with OAR 836-028-0013 or 836-028-0020 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 731, 731 & 746

Stats. Implemented: ORS 746.240

Hist.: IC 7-1988, f. & cert. ef. 4-14-88; ID 19-1988, f. & cert. ef. 12-6-88

836-028-0010

Registration of Purchasing Groups; Forms

Before doing business in this state, a purchasing group shall notify and register with the Director by completing and submitting to the Director the following documents:

(1) A registration. The registration must be made on the form provided in **Exhibit 1** of this rule.

(2) An appointment of the Director as the agent for service of legal documents for the purchasing group. The appointment must be made on the form provided in **Exhibit 2** of this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies may be obtained from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735,330

Hist.: IC 7-1988, f. & cert. ef. 4-14-88; ID 19-1988, f. & cert. ef. 12-6-88

836-028-0013

Permitted Insurers

A purchasing group may not purchase insurance from a risk retention group or an insurer for members of the purchasing group in this state:

(1) Unless the risk retention group is registered in this state.

(2) Unless the insurer is authorized to transact insurance in this state or is an eligible nonadmitted insurer under ORS 735.415.

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.335

Hist.: ID 19-1988, f. & cert. ef. 12-6-88

836-028-0016

Amendments to Registration by Purchasing Group

(1) A purchasing group shall amend its registration in this state when the purchasing group changes any of the following.

(a) The principal place of business of the purchasing group;

(b) The insurer or risk retention group from whom coverage is purchased;

(c) The lines or classifications of liability insurance that the purchasing group purchases.

(2) When a purchasing group changes its principal place of business, the purchasing group shall include the following in the amended registration:

(a) The street address, including city and state;

(b) The mailing address, if different;

(c) The telephone number.

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.330(1)(e)

Hist.: IC 7-1988, f. & cert. ef. 4-14-88

836-028-0020

Use of Agents by Purchasing Groups

A purchasing group shall employ an agent to procure insurance for its members in Oregon. Such an agent:

(1) Must hold a current agent's license issued by the Insurance Division, in order to transact insurance in Oregon; or

(2) Must hold a current surplus line licensee's license issued under the Oregon Surplus Lines Law, in order to place business with a surplus lines insurer.

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.350

Hist.: ID 19-1988, f. & cert. ef. 12-6-88

836-028-0035

Registration of Foreign Risk Retention Groups; Forms

Before doing business in this state, a risk retention group chartered in a state other than this state shall submit to the Director the following documents:

(1) A registration. The registration must be made on the form provided in **Exhibit 1** of this rule.

(2) A plan of operation or feasibility study, certified by the state of domicile or incorporation.

(3) A copy of the most recent financial statement of the risk retention group, certified by the state of domicile or incorporation, with evidence that the financial statement was certified by an independent certified public account.

(4) A statement of opinion on loss and loss adjustment expense reserves, certified by a member of the American Academy of Actuaries or by a loss reserve specialist qualified under criteria established by the National Association of Insurance Commissioners as of the effective date of this rule.

(5) A copy of the most recent examination report conducted by the Insurance Department of the state of domicile or incorporation.

(6) An appointment of the Director as the agent for services of legal documents for the risk retention group. The appointment must be made on the form provided in **Exhibit 2** of this rule.

[ED. NOTE:The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.315

Hist.: IC 7-1988, f. & cert. ef. 4-14-88

836-028-0040

Amendments to Registration by Foreign Retention Groups

When a foreign risk retention group changes its principal place of business, the group shall amend its registration in this state to show, with respect to the new principal place of business:

(1) The street address, including city and state;

(2) The mailing address, if different;

(3) The telephone number.

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.315(2)(d)

Hist.: IC 7-1988, f. & cert. ef. 4-14-88

836-028-0045

Financial Statement of Foreign Risk Retention Group; Audit

(1) Not later than the date on which the financial statement of a foreign risk retention group doing business in this state is due in its state of domicile, the group shall submit a copy of that financial statement to the Director.

(2) When an audit or examination is performed with respect to a foreign risk retention group doing business in this state, the group shall file a copy of the report of the audit or examination with the Director.

Stat. Auth.: ORS Ch. 731, 735 & 746

Stats. Implemented: ORS 735.315(2)(a)-(c)

Hist.: IC 7-1988, f. & cert. ef. 4-14-88

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 30

AGENCIES

Agent's Service Fees

836-030-0050

Purpose and Authority

(1) The general purpose of OAR 836-030-0050 to 836-030-0065 is to regulate the charging of service fees by agents.

(2) ORS 737.025 states, in part, that the purpose of Insurance Code Chapter 737 (Rates and Rating Organization) is "to promote the public welfare by regulating insurance rates to the end they shall not be excessive, inadequate, or unfairly discriminatory." ORS 737.205 requires every insurer to file its rates with the Commissioner. ORS 746.015 prohibits unfair discrimination "between risks of essentially the same hazard in the application of rates for insurance policies or in any other terms or conditions thereof." The commissioner finds that, with respect to personal lines of insurance, it is reasonable and customary for the public to consider all of the charges made by the insurer or its agent to be either an insurance premium charge or a premium financing charge.

(3) OAR 836-030-0050 to 836-030-0065 are issued under the general rulemaking authority of ORS 731.244:

(a) With respect to personal lines insurance coverages to give effect to the rate regulatory provisions of ORS Chapter 737 and the anti-discrimination provisions of ORS 746.015; and

(b) With respect to commercial lines insurance coverage to give effect to the provisions of ORS 746.015 (Discriminations), ORS 746.405 to 746.525 (Premium Financing) and ORS 742.009 (relating to necessary information for insureds).

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.205, 742.009, 746.015 & 746.405 to 746.525

Hist.: IC 58, f. 8-9-74, ef. 9-11-74; IC 9-1983(Temp), f. 11-10-83, ef. 11-15-83; ID 15-1996, f. & cert. ef. 11-12-96

836-030-0055

Scope of OAR 836-030-0050 to 836-030-0065; Definitions

(1) OAR 836-030-0050 to 836-030-0065 do not apply to the transaction of life insurance, mortgage insurance, or title insurance.

(2) The definitions given in the Oregon Insurance Code govern the construction of OAR 836-030-0050 to 836-030-0065.

(3) "Service fee" means a charge made by an agent with respect to an insurance transaction to a party other than the insurer, which charge is not a part of the insurer's rate filing under ORS Chapter 737. "Service fee" does not include finance or service charges governed by ORS 746.405 to 746.525 (Premium Financing).

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.205, 742.009, 746.015 & 746.405 to 746.525

Hist.: IC 58, f. 8-9-74, ef. 9-11-74; IC 9-1983(Temp), f. 11-10-83, ef. 11-15-83; ID 15-1996, f. & cert. ef. 11-12-96

836-030-0060

Service Fees Prohibited on Personal Lines

No service fee shall be charged with respect to the transaction of insurance covering an individual's person, property, or liability. Coverage of several individuals as members of the same family or household will be considered individual coverage for the purpose of this rule.

Stat. Auth.: ORS Ch.

Stats. Implemented: ORS 737.205, 742.009, 746.015, 746.405 to 746.525

Hist.: IC 58, f. 8-9-74, ef. 9-11-74; IC 9-1983(Temp), f. 11-10-83, ef. 11-15-83

836-030-0065

Service Fees Allowed on Commercial Lines; Conditions

(1) Service fees may be charged with respect to the transaction of insurance which covers other than an individual's person, property, or liability.

(2) A service fee may only be charged in those instances where the agent has provided service additional to what is the usual and customary practice of insurance agents under similar circumstances. The charge and the reason for it must be explained to the person charged.

(3) A service fee may not be charged with respect to arranging the financing of premium payments. This does not preclude finance charges by agents on their own accounts, or service charges by premium finance companies, which conform to the provisions of ORS 746.405 to 746.525.

Stat. Auth.: ORS Ch.

Stats. Implemented: ORS 737.205, 742.009, 746.015, 746.405 to 746.525

Hist.: IC 58, f. 8-9-74, ef. 9-11-74; IC 9-1983(Temp), f. 11-10-83, ef. 11-15-83

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 31

ACCOUNTING AND INVESTMENTS (ORS CHAPTER 733); REHABILITATION AND LIQUIDATION OF INSURERS (ORS CHAPTER 734)

Minimum Reserve Standards for Individual and Group

Health Insurance Contracts

836-031-0200

Scope, Authority; Statutes Implemented; Application

(1) OAR 836-031-0200 to 836-031-0300 apply to all individual and group health insurance coverages except credit insurance and establish minimum standards for the following three categories of health insurance reserves:

(a) Claim reserves, under OAR 836-031-0230;

(b) Premium reserves, under OAR 836-031-0240; and

(c) Contract reserves, under OAR 836-031-0250.

(2) OAR 836-031-0200 to 836-031-0300 are adopted pursuant to the authority of ORS 731.244 and 733.080 for the purpose of implementing ORS 733.080.

(3) Reserving requirements under OAR 836-031-0200 to 836-031-0300 must be incorporated in the annual statement of an insurer for the year ending December 31, 1995 and for each year thereafter.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0210

Definitions, Application and Explanation of Technical Terms Used

As used in OAR 836-031-0200 to 836-031-0300, the following terms have the following definitions and applications and are explained as follows:

(1) "Annual claim cost" means the net annual cost per unit of benefit before the addition of claim settlement expenses, other policy expenses or a margin for profit or contingencies.

(2) "Date of disablement" means the earliest date on which the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(3) "Elimination period" means a number of days, weeks or months specified in a policy, starting at the beginning of each period of loss, during which no benefits are payable.

(4) "Gross premium" means the amount of premium charged by the insurer and includes the net premium (based only on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

(5) "Group insurance" includes blanket insurance and any other forms of group insurance, and franchise insurance.

(6) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy or some shorter projected period of years. The premium need not be guaranteed. If the premium is not guaranteed, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based is revised at a later time.

(7) "Long-term care insurance" has the meaning given that term in ORS 743.652.

(8) "Modal premium" means the premium paid according to the billing frequency selected in the contract, which could be annual, semi-annual quarterly, monthly or weekly.

(9) "Negative reserve" means a negative value of the terminal reserve, which occurs when the values of the benefits are decreasing with advancing age or duration.

(10) "Preliminary term reserve method" means the method of valuation in which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. At the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(11) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

(12) "Terminal reserve" means the reserve at the end of a contract year equal to the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(13) "Unearned premium reserve" means the reserve that values that portion of the premium paid or due to the insurer that is applicable to the period of coverage extending beyond the valuation date.

(14) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0220

Principles Governing Reserves

(1) When an insurer determines that health insurance reserves meeting the minimum standards specified in OAR 836-031-0200 to 836-031-0300 are inadequate, increased reserves shall be held and shall be considered the minimum reserves for that insurer.

(2) With respect to any block of contracts, or with respect to an insurer's health insurance business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation must take into account, for all contracts in force, including those in a claims status or in a continuation of benefits status on the valuation date, the present value as of the valuation date of the following:

(a) All expected benefits unpaid;

(b) All expected expenses unpaid; and

(c) All unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

(3) A gross premium valuation described in section (2) of this rule is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health insurance business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) by this standard shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under OAR 836-031-0200 to 836-031-0300.

(4) Whenever minimum reserves as defined in OAR 836-031-0200 to 836-031-0300 exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under OAR 836-031-0200 to 836-031-0300.

(5) Adequacy of an insurer's health insurance reserves is determined on the basis of all three categories of reserves, including claim reserves, premium reserves and contract reserves, combined.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0230

Claim Reserves

(1) The following provisions apply to claim reserves generally:

(a) An insurer must maintain claim reserves for all incurred but unpaid claims on all health insurance policies;

(b) An insurer must maintain appropriate claim expense reserves with respect to the estimated expense of settlement of all incurred but unpaid claims; and

(c) An insurer must test all such reserves for prior valuation years for adequacy and reasonableness using claim runoff schedules in accordance with the statutory financial statement, including consideration of any residual unpaid liability.

(2) The following minimum standards apply to claim reserves for disability income insurance:

(a) Interest. The maximum interest rate for claim reserves is specified in OAR 836-031-0280;

(b) Morbidity. Minimum standards with respect to morbidity are those specified in OAR 836-031-0270 except that at the option of the insurer:

(A) For claims with a duration from date of disablement of less than two years, reserves may be based on the experience of the insurer, if such experience is considered credible, or upon other assumptions that to place a sound value on the liabilities; and

(B) For group disability income claims with a duration from date of disablement of more than two years but less than five years, reserves may, with the approval of the Director, be based on the experience of the insurer. The request for such approval of a plan of modification to the reserve basis must include:

(i) An analysis of the credibility of the experience;

(ii) A description of how the experience of the insurer is proposed to be used in setting reserves;

(iii) A description and quantification of the margins to be included;

(iv) A summary of the financial impact that the proposed plan of modification would have had on the last filed annual statement of the insurer;

(v) A copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(vi) Any other information requested by the Director; and

(c) Duration of disablement. For contracts with an elimination period, the duration of disablement must be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(3) The following minimum standards apply to claim reserves for all other benefits:

(a) Interest. The maximum interest rate for claim reserves is specified in OAR 836-031-0280;

(b) Morbidity or other contingency. The reserve must be based on the experience of the insurer, if such experience is considered credible, or upon other assumptions that place a sound value on the liabilities.

(4) Any generally accepted or reasonable actuarial method or combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0240

Premium Reserves

(1) The following provisions apply to premium reserves generally:

(a) An insurer must maintain unearned premium reserves for all contracts with respect to the period of coverage beyond the date of valuation for which premiums, other than premiums paid in advance, have been paid;

(b) If premiums due and unpaid are carried as an asset, an insurer must treat such premiums as premiums in force, subject to unearned premium reserve determination for which premiums, other than premiums paid in advance, have been paid. An insurer must carry the value of unpaid commissions, premium taxes and the cost of collection associated with due and unpaid premiums as an offsetting liability;

(c) The gross premiums paid in advance for a period of coverage commencing after the next premium due date that follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve that would otherwise be required as a minimum.

(2) The following are minimum standards for unearned premium reserves:

(a) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date. Such premium must be determined on the basis of:

(A) The valuation net modal premium on the contract reserve basis applying to the contract; or

(B) The gross modal premium for the contract if no contract reserve applies;

(b) Notwithstanding subsection (a) of this section, the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements shall not be less than the gross modal unearned premium reserve on all such contracts as of the date of valuation. Such sum shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(3) An insurer may employ suitable approximations and estimates, including but not limited to groupings, averages and aggregate estimation in computing premium reserves. Such approximations or estimates must be tested periodically to determine their continuing adequacy and reliability.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0250

Contract Reserves

(1) The following provisions apply to contract reserves gen erally:

(a) Unless otherwise specified in subsection (b) of this section (1), an insurer must maintain contract reserves for:

(A) All individual and group contracts with which level premiums are used; or

(B) All individual and group contracts with respect to which, owing to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of future valuation net premiums at that time.The values specified in this paragraph (B) of this subsection shall be determined on the basis specified in section (2) of this rule;

(b) Contracts that cannot be continued after one year from issue do not require a contract reserve;

(c) The contract reserve is in addition to claim reserves and premium reserves;

(d) The methods and procedures for contract reserves must be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

(2) The following are minimum standards for contract reserves:

(a) Morbidity or other contingency. Minimum standards with respect to morbidity are those set forth in OAR 836-031-0270. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. Contracts for which tabular morbidity standards are not specified in OAR 836-031-0270 shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the Director;

(b) Interest. The maximum interest rate is specified in OAR 836-031-0280;

(c) Termination rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in OAR 836-031-0290, except provided in this subsection. When a morbidity standard specified in OAR 836-031-0270 is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and are subject to prior approval by the Director. Total termination rates that exceed the specified mortality table rates may be used for the following benefits, but the total termination rates used may still not exceed the lesser of 80 percent of the total termination rate used in the calculation of the gross premiums or eight percent. The specified benefits are as follows:

(A) Contracts for which premium rates are not guaranteed;

(B) For return of premium; or

(C) Other deferred cash benefits;

(d) Reserve method:

(A) For insurance, excepting long-term care insurance and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term reserve method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary;

(B) For long-term care insurance, the minimum reserve is the reserve calculated on the one-year full preliminary term reserve method; and

(C) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(i) On the one year preliminary term reserve method if such benefits are provided at any time before the 20th anniversary;

(ii) On the two year preliminary term reserve method if such benefits are provided only on or after the 20th anniversary;

(iii) The preliminary term reserve method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis;

(e) Negative reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(3) The following provisions apply with regard to alternative valuation methods and assumptions generally:

(a) If the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified in sections (1) and (2) of this rule, an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency; and

(b) Subject to subsection (a) of this section, an insurer may employ methods other than the methods stated in sections (1) and (2) of this rule in determining a sound value of its liabilities under such contracts. The methods may include but are not limited to the following:

(A) The net level premium method;

(B) The one-year full preliminary term reserve method;

(C) Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

(D) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms;

(E) The computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and

(F) The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(4) The following apply with regard to tests for adequacy and reasonableness of contract reserves:

(a) Annually, an insurer shall make an appropriate review of the prospective contract liabilities of the insurer on contracts valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves, giving consideration to future gross premiums. Subject to the minimum standards of section (2) of this rule, the insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate.

(b) In the event an insurer has a contract or a group of related similar contracts for which future gross premiums will be restricted by contract, insurance department regulations or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfall in the aggregate.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0260

Reinsurance

Increases to or credits against reserves held that arise because of reinsurance assumed or reinsurance ceded must be determined in a manner consistent with OAR 836-031-0200 to 836-031-0300 and also with all applicable provisions of the reinsurance contracts that affect the liabilities of the insurer.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0270

Specific Standards for Morbidity

The following standards apply to morbidity:

(1) Minimum morbidity standards for valuation of specified benefits provided in individual health insurance policies are as follows:

(a) For disability income benefits due to accident or sickness:

(A) Contract reserves:

(i) Contracts issued on or after January 1, 1965 and prior to January 1, 1987: The 1964 Commissioners Disability Table (64 CDT) or, at the option of the insurer, a more recent table approved by the Director;

(ii) Contracts issued on or after January 1, 1995: the **1985 Commissioners Individual Disability Tables A (85CIDA**) or the **1985 Commissioners Individual Disability Tables B (85CIDB)**. Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. An insurer may, however, elect to use the other tables with respect to any subsequent statement year;

(iii) Contracts issued during 1987 through 1994: Optional use of either the 1964 Table or the 1985 Tables as provided in paragraph (ii) of this subsection;

(B) Claim reserves: The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.

(b) For hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only):

(A) Contract reserves:

(i) Contracts issued on or after January 1, 1955, and before January 1, 1982: The **1956 Intercompany Hospital-Surgical Tables**; and

(ii) Contracts issued on or after January 1, 1982: The **1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX**, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: **Development of the 1974 Medical Expense Benefits, Houghton and Wolf**;

(B) Claim reserves: No specific standard. See subsection (e) of this section;

(c) Cancer expense benefits (Scheduled benefits or fixed time period benefits only):

(A) Contract reserves: Contracts issued on or after January 1, 1986: The **1985 NAIC Cancer Claim Cost Tables**;

(B) Claim reserves: No specific standard. See subsection (e) of this section;

(d) Accidental death benefits:

(A) Contract reserves: Contracts issued on or after January 1, 1965: The **1959 Accidental Death Benefits Table**.

(B) Claim reserves: Actual amount incurred.

(e) Other individual contract benefits:

(A) Contract reserves: For all other individual contract benefits, morbidity assumptions are to be determined by using tables established for reserve purposes by a qualified actuary and acceptable to the Director;

(B) Claim reserves: For all benefits other than disability, claim reserves are to be determined by using tables established for reserve purposes by a qualified actuary and acceptable to the Director.

(2) Minimum morbidity standards for valuation of specified benefits for group health insurance policies are as follows:

(a) For disability income benefits due to accident or sickness:

(A) Contract reserves:

(i) Contracts issued prior to January 1, 1995: Use of the **87CGDT** is optional; and

(ii) Contracts issued on or after January 1, 1995: The **1987 Commissioners Group Disability Income Table (87CGDT)**; and

(B) Claim reserves:

(i) For claims incurred on or after January 1, 1995: The 1**987 Commissioners Group Disability Income Table (87CGDT)**; and

(ii) For claims incurred prior to January 1, 1995: Use of the **87CGDT** is optional; and

(b) Other group contract benefits:

(A) Contract reserves: For all other group contract benefits, morbidity assumptions are to be determined by using tables established for reserve purposes by a qualified actuary and acceptable to the Director;

(B) Claim reserves: For all benefits other than disability, claim reserves are to be determined by using tables established for reserve purposes by a qualified actuary and acceptable to the Director;

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0280

Specific Standards for Interest

(1) For contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

(2) For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

(3) For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0290

Specific Standards for Mortality

(1) Except as provided in section (2) of this rule, the mortality basis used shall be according to any table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract.

(2) Other mortality tables adopted by the NAIC and also adopted by the Director may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the Director. The request for such approval must include the proposed mortality table and the reason that the standard specified in section (1) of this rule is inappropriate.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

836-031-0300

Reserves for Waiver of Premium

(1) Waiver of premium reserves involves several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are not reserves on active lives but rather are reserves on contracts in force. This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

(2) Reserves using any of the tables described in section (1) of this rule shall value reserves on the following basis:

(a) Claim reserves must include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived;

(b) Premium reserves must include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived; and

(c) Contract reserves must include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

Stat. Auth.: ORS 731.244 & 733.080

Stats. Implemented: ORS 733.080

Hist.: ID 7-1995, f. & cert. ef. 11-15-95

Accounting

(ORS 733.010 to 733.230)

Investments and Accounting Generally

836-031-0400

Allowed Assets

For the purpose of applying investment limitations and prohibitions in ORS Chapter 733 that are based upon percentages, the allowed assets of an insurer shall be those allowed assets described in ORS 733.010 that are shown in the financial statement filed by the insurer for the period immediately preceding the period for which the most recent financial statement was filed.

Stat. Auth.: ORS 731.244, 733.010 & 733.695

Stats. Implemented: ORS 733.010 & 733.510 - 733.780

Hist.: ID 5-1992, f. & cert. ef. 3-26-92

Standard Valuation Law; Actuarial Opinions and Memoranda

836-031-0600

Purpose

The purpose of OAR 836-031-0600 to 836-031-0690 is to prescribe:

(1) Guidelines and standards for statements of actuarial opinion to be submitted in accordance with ORS 733.304 and for memoranda in support thereof;

(2) Guidelines and standards for statements of actuarial opinion that are to be submitted when a company is exempt from ORS 733.304(2); and

(3) Rules applicable to the appointment of an appointed actuary.

Stat. Auth.: ORS 731.244 & 733.304

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92

836-031-0610

Authority

OAR 836-031-0600 to 836-031-0690 are adopted pursuant to ORS 733.300 to 733.322 generally and ORS 733.304 specifically. OAR 836-031-0600 to 836-031-0690, including amendments thereto effective July 30, 1993, first apply with respect to annual statements reflecting valuation of actuarial assets and liabilities and related actuarial items for the year ending on December 31, 1992.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92; ID 1-1993(Temp), f. & cert. ef. 2-4-93; ID 4-1993, f. 7-27-93, cert. ef. 7-30-93

830-031-0620

Scope

(1) OAR 836-031-0600 to 836-031-0690 apply to all life insurers transacting insurance in this state and to all life insurers that are authorized to reinsure life insurance, annuities or health insurance business in this state. Except with respect to companies that are exempt pursuant to OAR 836-031-0650, a statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with OAR 836-031-0670 and a memorandum in support thereof in accordance with OAR 836-031-0680 are required each year. Any company so exempted must file a statement of actuarial opinion pursuant to OAR 836-031-0660.

(2) Notwithstanding section (1) of this rule, the Director may require any company otherwise exempt pursuant to OAR 836-031-0600 to 836-031-0690 to submit a statement of actuarial opinion and to prepare a memorandum in support thereof in accordance with OAR 836-031-0670 and 836-031-0680 if, in the opinion of the Director, asset adequacy analysis is necessary with respect to the company.

Stat. Auth.: ORS 731.244 & 733.304

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92

836-031-0630

Definitions

As used in OAR 836-031-0600 to 836-031-0690:

(1) "Actuarial Opinion" means:

(a) With respect to OAR 836-031-0670, 836-031-0680 or 836-031-0690, the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy test in accordance with OAR 836-031-0670 and with currently accepted actuarial standards;

(b) With respect to OAR 836-031-0660, the opinion of an appointed actuary regarding the calculation of reserves and related items, in accordance with OAR 836-031-0660 and with those currently accepted actuarial standards that specifically relate to that opinion.

(2) "Actuarial Standards Board" is the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(3) "Annual Statement" means that statement required by ORS 731.574 of the **Insurance Code** to be filed by the

company with the Director annually.

(4) "Appointed Actuary" means any individual who is appointed or retained in accordance with the requirements set forth in OAR 836-031-0640(3) to provide the actuarial opinion and supporting memorandum as required by ORS 733.304.

(5) "Asset Adequacy Analysis" means an analysis that meets the standards and other requirements referred to in OAR 836-031-0640(4). It may take many forms, including, but not limited to, cash flow testing, sensitivity testing or applications of risk theory.

(6) "Company" means a life insurance company or reinsurer subject to the provisions of OAR 836-031-0600 to 836-031-0690.

(7) "Non-Investment Grade Bonds" are bonds designated as Classes 3, 4, 5 or 6 by the Securities Valuation Office of the National Association of Insurance Commissioners.

(8) "Qualified Actuary" means any individual who meets the requirements set forth in OAR 836-031-0640(2).

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92; ID 1-1993(Temp), f. & cert. ef. 2-4-93; ID 4-1993, f. 7-27-93, cert. ef. 7-30-93

836-031-0640

General Requirements

(1) The following provisions apply to submission of the statement of actuarial opinions:

(a) There is to be included on or attached to page 1 of the annual statement for each year beginning with 1992 the statement of an appointed actuary, entitled "Statement of Actuarial Opinion", setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with OAR 836-031-0670. However, any company exempted pursuant to OAR 836-031-0650 from submitting a statement of actuarial opinion in accordance with OAR 836-031-0670 shall include on or attach to page 1 of the annual statement a statement of actuarial opinion rendered by an appointed actuary in accordance with OAR 836-031-0660;

(b) If in the previous year a company provided a statement of actuarial opinion in accordance with OAR 836-031-0660 and in the current year fails the exemption criteria of OAR 836-031-0650(3)(a),(b) or (e) to again provide an actuarial opinion in accordance with OAR 836-031-0660, the Director may require that the statement of actuarial opinion in accordance with OAR 836-031-0670 be provided not later than August 1 following the date of the annual statement. In this instance, the company shall provide a statement of actuarial opinion in accordance with OAR 836-031-0660 with appropriate qualification noting the intent to subsequently provide a statement of actuarial opinion in accordance with OAR 836-031-0670;

(c) In the case of a statement of actuarial opinion required to be submitted by a foreign or alien company, the Director may accept the statement of actuarial opinion filed by such company with the insurance supervisory regulator of another state if the Director determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(d) Upon written request by the company, the Director may grant an extension of the date for submission of the statement of actuarial opinion.

(2) For purposes of OAR 836-031-0600 to 836-031-0690, a "qualified actuary" is an individual who:

(a) Is a member in good standing of the American Academy of Actuaries;

(b) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(c) Is familiar with the valuation requirements applicable to life and health insurance companies; and

(d) Has not been found by the Director, or if so found has subsequently been reinstated as a qualified actuary, following appropriate notice and hearing to have:

(A) Violated any provision of, or any obligation imposed by, the Insurance Code or other law in the course of the qualified actuary's dealings as a qualified actuary;

(B) Been found guilty of fraudulent or dishonest practices;

(C) Demonstrated incompetency, lack of cooperation or untrustworthiness to act as a qualified actuary;

(D) Submitted to the Director during the past five years, pursuant to OAR 836-031-0600 to 836-031-0690, an actuarial opinion or memorandum that the Director rejected because it did not meet the provisions of OAR 836-031-0600 to 836-031-0690, including standards set by the Actuarial Standards Board; or

(E) Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(e) Has not failed to notify the Director of any action taken by any insurance regulator of any other state similar to that under subsection (d) of this section.

(3) For purposes of OAR 836-031-0600 to 836-031-0690, an "appointed actuary" is a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by OAR 836-031-0600 to 836-031-0690, either directly by or by the authority of the board of directors through an executive officer of the company. The company shall give the Director timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in such notice that the person meets the requirements set forth in section (2) of this rule. Once notice is furnished, no further notice is required with respect to this person if the company gives the Director timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in section (2) of this rule. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

(4) This section establishes standards for asset adequacy analysis. The asset adequacy analysis required by OAR 836-031-0600 to 836-031-0690:

(a) Shall conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and acceptable to the Director, and on any additional standards under OAR 836-031-0600 to 836-031-0690, which standards are to form the basis of the statement of actuarial opinion in accordance with OAR 836-031-0670; and

(b) Shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board and acceptable to the Director.

(5) The following apply to liabilities to be covered:

(a) Under authority of ORS 733.304, the statement of actuarial opinion shall apply to all in force business on the statement date regardless of when or where issued, e.g., reserves of **Exhibits 8, 9,** and **10**, and claim liabilities in **Exhibit 11, Part I** and equivalent items in the separate account statement or statements;

(b) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in ORS 733.312, 733.314, 733.320 and 733.322, the company shall establish such additional reserve;

(c) For years ending prior to December 31, 1994, the company may, in lieu of establishing the full amount of the additional reserve in the annual statement for that year, set up an additional reserve in an amount not less than the following:

(A) December 31, 1992, the additional reserve divided by three;

(B) December 31, 1993, two times the additional reserve divided by three.

(d) Additional reserves established under subsection (b) or (c) of this section and deemed not necessary in subsequent years may be released. Any amount released must be disclosed in the actuarial opinion for the applicable year. The release of such reserves is not to be deemed an adoption of a lower standard of valuation.

Stat. Auth.: ORS 731.244 & 733.304

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92

836-031-0650

Required Opinions

(1) General. In accordance with ORS 733.304, every company doing business in this state shall annually submit the opinion of an appointed actuary as provided for by OAR 836-031-0600 to 836-031-0690. The type of opinion submitted shall be determined by the provisions of this rule and shall be in accordance with the applicable provisions in OAR 836-031-0600 to 836-031-0690.

(2) Company Categories. For purposes of OAR 836-031-0600 to 836-031-0690, companies shall be classified as follows, based on admitted assets as of the end of the calendar year for which the actuarial opinion is applicable:

(a) Category A shall consist of those companies whose admitted assets do not exceed $20 million;

(b) Category B shall consist of those companies whose admitted assets exceed $20 million but do not exceed $100 million;

(c) Category C shall consist of those companies whose admitted assets exceed $100 million but do not exceed $500 million; and

(d) Category D shall consist of those companies whose admitted assets exceed $500 million.

(3) Exemption Eligibility Tests. The following are eligibility tests for exemptions from the requirement that a company submit a statement of actuarial opinion:

(a) Any Category A company that, for any year beginning with 1992, meets all of the following criteria shall be eligible for exemption from submission of a statement of actuarial opinion in accordance with OAR 836-031-0670 for the year in which the criteria are met. The ratios in paragraphs (A), (B) and (C) of this subsection shall be calculated based on amounts as of the end of the calendar year for which the actuarial opinion is applicable. The criteria are as follows:

(A) The ratio of the sum of capital and surplus to the sum of cash and invested assets is at least equal to .10;

(B) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is less than .30;

(C) The ratio of the book value of the non-investment grade bonds to the sum of capital and surplus is less than .50;

(D) The Examiner Team for the National Association of Insurance Commissioners has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or the company has resolved the first or second priority status to the satisfaction of the Commissioner of the state of domicile and the Commissioner has so notified the chair of the NAIC Life and Health Actuarial Task Force and the NAIC Staff and Support Office.

(b) Any Category B company that, for any year beginning with 1992, meets all of the following criteria shall be eligible for exemption from submission of a statement of actuarial opinion in accordance with OAR 836-031-0670 for the year in which the criteria are met. The ratios in paragraphs (A), (B) and (C) of this subsection shall be calculated based on amounts as of the end of the calendar year for which the actuarial opinion is applicable. The criteria are as follows:

(A) The ratio of the sum of capital and surplus to the sum of cash and invested assets is at least equal to .07;

(B) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is less than .40;

(C) The ratio of the book value of the non-investment grade bonds to the sum of capital and surplus is less than .50;

(D) The Examiner Team for the National Association of Insurance Commissioners has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or the company has resolved the first or second priority status to the satisfaction of the Commissioner of the state of domicile and the Commissioner has so notified the chair of the NAIC Life and Health Actuarial Task Force and the NAIC Staff and Support Office.

(c) Any Category A or B company that meets all of the criteria set forth in subsection (a) or (b) of this section, whichever is applicable, is exempted from submission of a statement of actuarial opinion in accordance with OAR 836-031-0670 unless the Director specifically indicates to the company that the exemption is not to be taken;

(d) Any Category A or B company that, for any year beginning with 1992, is not exempted under subsection (c) of this section shall be required to submit a statement of actuarial opinion in accordance with OAR 836-031-0670 for the year for which it is not exempt;

(e) Any Category C company that, after submitting an opinion in accordance with OAR 836-031-0670, meets all of the following criteria shall not be required, unless required in accordance with subsection (f) of this section, to submit a statement of actuarial opinion in accordance with OAR 836-031-0670 more frequently than every third year. Any Category C company that fails to meet all of the following criteria for any year shall submit a statement of actuarial opinion in accordance with OAR 836-031-0670 for that year. The ratios in paragraphs (A), (B) and (C) of this subsection shall be calculated based on amounts as of the end of the calendar year for which the actuarial opinion is applicable. The criteria are as follows:

(A) The ratio of the sum of capital and surplus to the sum of cash and invested assets is at least equal to .05;

(B) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is less than .50;

(C) The ratio of the book value of the non-investment grade bonds to the sum of the capital and surplus is less than .50;

(D) The Examiner Team for the National Association of Insurance Commissioners has not designated the company as a

first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or the company has resolved the first or second priority status to the satisfaction of the Commissioner of the state of domicile and the Commissioner has so notified the chair of the NAIC Life and Health Actuarial Task Force and the NAIC Staff and Support Office..

(f) Any company that is not required by this rule to submit a statement of actuarial opinion in accordance with OAR 836-031-0670 for any year shall submit a statement of actuarial opinion in accordance with OAR 836-031-0660 for that year unless as provided for by OAR 836-031-0620(2) the Director requires a statement of actuarial opinion in accordance with OAR 836-031-0670.

(4) Large Companies. Every Category D company shall submit a statement of actuarial opinion in accordance with OAR 836-031-0670 for each year beginning with 1992.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92; ID 1-1993(Temp), f. & cert. ef. 2-4-93; ID 4-1993, f. 7-27-93, cert. ef. 7-30-93

836-031-0660

Statement of Actuarial Opinion Not Including an Asset Adequacy Analysis

(1) General Description. The statement of actuarial opinion required by this rule shall consist of:

(a) A paragraph identifying the appointed actuary and the qualifications of the qualified actuary;

(b) A regulatory authority paragraph stating that the company is exempt pursuant to OAR 836-031-0600 to 836-031-0690 from submitting a statement of actuarial opinion based on an asset adequacy analysis and that the opinion, which is not based on an asset adequacy analysis, is rendered in accordance with OAR 836-031-0660;

(c) A scope paragraph identifying the subjects on which the opinion is to be expressed and describing the scope of the appointed actuary's work; and

(d) An opinion paragraph expressing the appointed actuary's opinion as required by ORS 733.304.

(2) Recommended Language. The following provisions of this section are those that in typical circumstances would be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary must use language that clearly expresses the professional judgment of the appointed actuary. However, in any event the opinion shall retain all pertinent aspects of the language provided in this rule. The following provisions apply:

(a) The opening paragraph must indicate the appointed actuary's relationship to the company as follows:

(A) For a company actuary, the opening paragraph of the actuarial opinion must read as follows:

"I, (name of actuary), am (title) of (name of company) and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of the insurer to render this opinion as stated in the letter to the Commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health companies".

(B) For a consulting actuary, the opening paragraph of the actuarial opinion must contain a statement such as the following:

"I, (name and title of actuary), a member of the American Academy of Actuaries, am associated with the firm of (insert name of consulting firm). I have been appointed by, or by the authority of, the Board of Directors of (name of company) to render this opinion as stated in the letter to the Commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies".

(b) The regulatory authority paragraph must include a statement such as the following:

"The company is exempt pursuant to OAR 836-031-0650 of the Oregon Department of Insurance and Finance from submitting s statement of actuarial opinion based on an asset adequacy analysis. This opinion, which is not based on an asset adequacy analysis, is rendered in accordance with OAR 836-031-0660".

(c) The scope paragraph must contain a sentence such as the following:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, ( )".

The paragraph must list items and amounts with respect to which the appointed actuary is expressing an opinion. The list must include but need not be limited to:

(A) Aggregate reserve and deposit funds for policies and contracts included in **Exhibit 8**;

(B) Aggregate reserve and deposit funds for policies and contracts included in **Exhibit 9**;

(C) Deposit funds, premiums, dividend and coupon accumulations and supplementary contracts not involving life contingencies included in **Exhibit 10**; and

(D) Policy and contract claims -- liability end of current year included in **Exhibit 11, Part 1**.

(d) If the appointed actuary has examined the underlying records, the scope paragraph must also include the following:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic records and such test of the actuarial calculations as I considered necessary".

(e) If the appointed actuary has not examined the underlying records, but has relied upon listings and summaries of policies in force prepared by the company or a third party, the scope paragraph must include a sentence such one of the following:

"I have relied upon listing and summaries of policies and contracts and other liabilities in force prepared by (name and title of company officer certifying in force records) as certified in the attached statement. (See accompanying affidavit by a company officer.) In other respects my examination included review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary"; or

"I have relied upon (name of accounting firm) for the substantial accuracy of the in force records inventory and information concerning other liabilities, as certified in the attached statement. In other respects may examination included review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary".

The statement of the person certifying must follow the form indicated by subsection (2)(j) of this rule.

(f) The opinion paragraph must include the following:

"In my opinion the amounts carried in the balance sheet on account of the actuarial items identified above:

(A) Are computed in accordance with those currently accepted actuarial standards that specifically relate to the opinion required under this rule;

(B) Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

(C) Meet the requirements of the Insurance Law and regulations of the state of (state of domicile) and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(D) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end with any exceptions as noted below; and

(E) Include provision for all actuarial reserves and related statement items which ought to be established.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Compliance Guidelines as promulgated by the Actuarial Standards Board, which guidelines form the basis of this statement of opinion".

(g) The concluding paragraph must document the eligibility for the company to provide an opinion as provided by this rule. It must include the following:

"This opinion is provided in accordance with OAR 836-031-0660 (see Section 7 of the NAIC Actuarial Opinion and Memorandum Regulation). As such it does not include an opinion regarding the adequacy of reserves and related actuarial items when considered in light of the assets that support them.

Eligibility for OAR 836-031-0660 (see Section 7 of the NAIC Actuarial Opinion and Memorandum Regulation) is confirmed as follows:

(A) The ratio of the sum of capital and surplus to the sum of cash and invested assets is (insert amount), which equals or exceeds the applicable criterion based on the admitted assets of the company (OAR 836-031-0650(3); see Section 6C of the NAIC Actuarial Opinion and Memorandum Regulation);

(B) The ratio of the sum of the reserves and liabilities for annuities and deposits to the excess of the total admitted assets is (insert amount), which is less than the applicable criteria based on the admitted assets of the company (OAR 836-031-0650(3); See Section 6C of the NAIC Actuarial Opinion and Memorandum Regulation);

(C) The ratio of the book value of the non-investment grade bonds to the sum of capital and surplus is (insert amount), which is less than the applicable criteria of .50;

(D) To my knowledge, the NAIC Examiner Team has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile;

(E) To my knowledge there is not a specific request from any Commissioner requiring an asset adequacy analysis opinion.

_____

Signature of Appointed Actuary

_____

Address of Appointed Actuary

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Telephone Number of Appointed Actuary"

(h) If there has been any change in the actuarial methods or assumptions from those previously employed, that change must be described in the annual statement or in a paragraph of the statement of actuarial opinion, and the reference in paragraph (2)(f)(D) of this rule to consistency must read as follows:

"...with the exception of the change described on Page ( ) of the annual statement (or in the preceding paragraph)".

The adoption for new issues or new claims or other new liabilities of an actuarial assumption which differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this subsection.

(i) If the appointed actuary is unable to form an opinion, the appointed actuary must refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, the appointed actuary must issue an adverse or qualified actuarial opinion explicitly stating the reason or reasons for the opinion. This statement must follow the scope paragraph and precede the opinion paragraph;

(j) If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of policies in force, there shall be attached to the opinion the statement of a company officer or accounting firm who prepared such underlying data similar to the following:

"I (name of officer), (title) of (name and address of company or accounting firm), hereby affirm that the listings and summaries of policies and contracts in force as of December 31, ( ), prepared for and submitted to (name of appointed actuary), were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

_____

Signature of the Officer of the Company

or Accounting Firm

_____

Address of the Officer of the Company

or Accounting Firm

_____

Telephone Number of the Officer of the

Company or Accounting Firm"

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92; ID 1-1993(Temp), f. & cert. ef. 2-4-93; ID 4-1993, f. 7-27-93, cert. ef. 7-30-93

836-031-0670

Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

(1) General Description. The statement of actuarial opinion submitted in accordance with this rule must consist of:

(a) A paragraph identifying the appointed actuary and the qualifications of the qualified actuary, as provided in subsection (2)(a) of this rule;

(b) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, as provided in subsection (2)(b) of this rule, and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(c) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios, as provided in subsection (2)(c) of this rule, supported by a statement of each such expert in the form prescribed by section (5) of this rule;

(d) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities, as provided in subsection (2)(f) of this rule; and

(e) One or more additional paragraphs, to be included in individual company cases as follows:

(A) If the appointed actuary considers it necessary to state a qualification of the appointed actuary's opinion;

(B) If the appointed actuary must disclose the method of aggregation for reserves of different products or lines of business for asset adequacy analysis;

(C) If the appointed actuary must disclose reliance upon any portion of the assets supporting the Asset Valuation Reserve (AVR), Interest Maintenance Reserve (IMR) or other mandatory or voluntary statement reserves for asset adequacy analysis;

(D) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for the appointed actuary's opinion;

(E) If the appointed actuary must disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release; and

(F) If the appointed actuary chooses to add a paragraph briefly describing the assumptions forming the basis for the actuarial opinion.

(2) Recommended Language. The following paragraphs must be included in the statement of actuarial opinion in accordance with this section. The following provisions of this section are those that in typical circumstances would be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary must use language that clearly expresses the professional judgment of the appointed actuary. However, in any event, the opinion must retain all pertinent aspects of the language provided in this section. The following provisions apply:

(a) The opening paragraph must indicate generally the appointed actuary's relationship to the company and qualifications of the appointed actuary to sign the opinion, as follows:

(A) For a company actuary, the opening paragraph of the actuarial opinion must read as follows:

"I, (name), am (title) of (insurance company name) and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of the insurer to render this opinion as stated in the letter to the Commissioner dated (insert date). I meet the Academy qualification standards for rendering the

opinion and am familiar with the valuation requirements applicable to life and health insurance companies".

(B) For a consulting actuary, the opening paragraph must contain a sentence such as:

"I, (name), a member of the American Academy of Actuaries, am associated with the firm of (name of consulting form). I have been appointed by, or by the authority of, the Board of Directors of (name of company) to render this opinion as stated in the letter to the Commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies".

(b) The scope paragraph must include a statement such as the following:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 19( ). Tabulated below are those reserves and related actuarial items that have been subjected to asset adequacy analysis". See Table 1 (Reserves and Liabilities).

(c) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph must include a statement such as the following:

"I have relied on (name), (title), for (e.g., anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios) and, as certified in the attached statement...";

or

"I have relied on personnel as cited in the supporting memorandum for certain critical aspects of the analysis in reference to the accompanying statement".

Such a statement of reliance on other experts must be accompanied by a statement by each of such experts on the form prescribed in section (5) of this rule.

(d) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph must also include the following:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary".

(e) If the appointed actuary has not examined the underlying records, but has relied upon listings and summaries of policies in force or asset records prepared by the company or a third party, or both the listings and summaries and the asset records, the reliance paragraph must include a statement similar to the following:

"I have relied upon listing and summaries (of policies and contracts, of asset records) prepared by (name and title of company officer certifying in-force records) as certified in the attached statement. In other respects my examination included such review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary";

or

"I have relied upon (name of accounting firm) for the substantial accuracy of the in-force records inventory and information concerning other liabilities, as certified in the attached statement. In other respects my examination included review of the actuarial assumptions and actuarial methods and tests of the actuarial calculations as I considered necessary".

Such a section must be accompanied by a statement by each person relied upon, in the form prescribed by section (5) of this rule.

(f) The opinion paragraph must include the following:

"In my opinion, the reserves and related actuarial values concerning the statement items identified above:

(i) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

(ii) Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

(iii) Meet the requirements of the Insurance Law and regulation of the state of (state of domicile) and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(iv) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below);

(v) Include provision for all actuarial reserves and related statement items that ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts, make adequate provision, according to currently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion that should be considered in reviewing this opinion; or

The following material change or changes that occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

The appointed actuary must choose one of the above two paragraphs, whichever is applicable.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____

Signature of Appointed Actuary

_____

Address of Appointed Actuary

_____

Telephone Number of Appointed Actuary"

(3) Assumptions for New Issues. The adoption, for new issues or new claims or other new liabilities, of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities

is not a change in actuarial assumptions within the meaning of this rule.

(4) Adverse Opinions. If the appointed actuary is unable to form an opinion, the appointed actuary must refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, the appointed actuary must issue an adverse or qualified actuarial opinion explicitly stating the reason or reasons for the opinion. Such a statement must follow the scope paragraph and precede the opinion paragraph.

(5) Reliance on Data Furnished by Other Persons. If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of policies in force or asset oriented information, there shall be attached to the opinion the statement of a company officer or accounting firm who prepared such underlying data similar to the following:

"I (name of officer), (title), of (name of company or accounting firm), hereby affirm that the listings and summaries of policies and contracts in force as of December 31, 19( ), and other liabilities prepared for and submitted to (name of appointed actuary) were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

_____

Signature of the Officer of the Company

or Accounting Firm

_____

Address of the Officer of the Company

or Accounting Firm

_____

Telephone Number of the Officer of the

Company or Accounting Firm"

or the following, or instead, both the preceding and the following statements:

"I, (name of officer), (title) of (name of company, accounting firm, or security analyst), hereby affirm that the listings, summaries and analyses relating to date prepared for and submitted to (name of appointed actuary) in support of the asset-oriented aspects of the opinion were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

_____

Signature of the Officer of the Company,

Accounting Firm or the Security Analyst

_____

Address of the Officer of the Company,

Accounting Firm or the Security Analyst

_____

Telephone Number of the Officer of the

Company, Accounting Firm or the

Security Analyst"

[ED. NOTE: Table 1 (Reserves and Liabilities) referenced in this rule is not printed in the OAR Compilation. Copies may be obtained from the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92; ID 1-1993(Temp), f. & cert. ef. 2-4-93; ID 4-1993, f. 7-27-93, cert. ef. 7-30-93

836-031-0680

Description of Actuarial Memorandum Including an Asset Adequacy Analysis

(1) General provisions. The following general provisions apply to actuarial memoranda that include an asset adequacy analysis:

(a) In accordance with ORS 733.304 (Standard Valuation Law), the appointed actuary shall prepare a memorandum to the Company describing the analysis done in support of the appointed actuary's opinion regarding the reserves under an opinion pursuant to OAR 836-0310-670. The memorandum must be made available for examination by the Director upon request of the Director but shall be returned to the company after such examination and not be filed with the Department;

(b) In preparing the memorandum, the appointed actuary may rely on, and include as a part of the appointed actuary's own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of OAR 836-031-0640(2), with respect to the areas covered in such memoranda, and so state in their memoranda;

(c) If the Director requests a memorandum and no such memorandum exists or if the Director finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of OAR 836-031-0600 to 836-031-0690, the Director may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Director;

(d) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Director. However, any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the Director and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the Director pursuant to the Standard Valuation Law. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to OAR 836-031-0600 to 836-031-0690 for any one of the current year or the preceding three years.

(2) Provisions relating to the Memorandum Section Documenting Asset Adequacy Analysis. When an actuarial opinion under OAR 836-031-0670 is provided, the memorandum shall demonstrate that the analysis has been done in accordance with standards for asset adequacy referred to in OAR 836-031-0640(4) and any additional standards under OAR 836-031-0600 to 836-031-0690. It must specify:

(a) For reserves:

(A) Product descriptions, including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(B) Source of liability in force;

(C) Reserve method and basis;

(D) Investment reserves; and

(E) Reinsurance arrangements.

(b) For assets:

(A) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

(B) Investment and disinvestment assumptions;

(C) Source of asset data; and

(D) Asset valuation bases.

(c) Analysis basis:

(A) Methodology;

(B) Rationale for inclusion and exclusion of different blocks of business and how pertinent risks were analyzed;

(C) Rational for degree of rigor in analyzing different blocks of business;

(D) Criteria for determining asset adequacy; and

(E) Effect of federal income taxes, reinsurance and other relevant factors.

(d) Summary of Results;

(e) Conclusion or conclusions.

(3) Conformity to Standards of Practice. The memorandum must include the following statement:

"Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum".

Stat. Auth.: ORS 731.244 & 733.304

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92

836-031-0690

Additional Considerations for Analysis

(1) Aggregation. For the asset adequacy analysis for the statement of actuarial opinion provided in accordance with OAR 836-031-0670, reserves and assets may be aggregated by either of the following methods:

(a) By aggregating the reserves and related actuarial items, and the supporting assets, for different products or lines of business, before analyzing the adequacy of the combined assets to mature the combined liabilities. The appointed actuary must be satisfied that the assets held in support of the reserves and related actuarial items so aggregated are managed in such a manner that the cash flows from the aggregated assets are available to help mature the liabilities from the blocks of business that have been aggregated;

(b) By aggregating the results of asset adequacy analysis of one or more products or lines of business, the reserves for which prove through analysis to be redundant, with the results of one or more products or lines of business, the reserves for which prove through analysis to be deficient. The appointed actuary must be satisfied that the asset adequacy results for the various products or lines of business for which the results are so aggregated:

(A) Are developed using consistent economic scenarios; or

(B) Are subject to mutually independent risks, i.e., the likelihood of events impacting the adequacy of the assets supporting the redundant reserves is completely unrelated to the likelihood of events affecting the adequacy of the assets supporting the deficient reserves;

(C) In the event of any aggregation, the actuary must disclose in the actuary's opinion that such reserves were aggregated on the basis of the method prescribed in subsection (a), paragraph (b)(A) or (b)(B) of this section, whichever is applicable, and describe the aggregation in the supporting memorandum.

(2) Selection of Assets for Analysis. The appointed actuary shall analyze only those assets held in support of the reserves that are the subject for specific analysis, hereafter called "specified reserves". A particular asset or portion thereof supporting a group of specified reserves cannot support any other group of specified reserves. An asset may be allocated over several groups of specified reserves. The annual statement value of the assets held in support of the reserves must not exceed the annual statement value of the specified reserves, except as provided in section (3) of this rule. If the method of asset allocation is not consistent from year to year, the extent of its inconsistency must be described in the supporting memorandum.

(3) Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve. An appropriate allocation of assets in the amount of the Interest Maintenance Reserve (IMR), whether positive or negative, must be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the Asset Valuation Reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support. The amount of the assets used for the AVR must be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum.

(4) Required Interest Scenarios. For the purpose of performing the asset adequacy analysis required by OAR 836-031-0600 to 836-031-0690, the qualified actuary must follow standards adopted by the Actuarial Standards Board and acceptable to the Director. However, the appointed actuary must also consider in the analysis the effect of at least the following interest rate scenarios:

(a) Level with no deviation;

(b) Uniformly increasing over ten years at a half percent per year and then level;

(c) Uniformly increasing at one percent per year over five years and then uniformly decreasing at one percent per year to the original level at the end of ten years and then level;

(d) An immediate increase of three percent and then level;

(e) Uniformly decreasing over ten years at a half percent per year and then level;

(f) Uniformly decreasing at one percent per year over five years and then uniformly increasing at one percent per year to

the original level at the end of ten years and then level; and

(g) An immediate decrease of three percent and then level.

(5) For purposes of section (4) of this rule:

(a) For these and other scenarios that may be used, projected interest rates for a five year Treasury note need not be reduced beyond the point where such five year Treasury Note yield would be at 50 percent of its initial level;

(b) The beginning interest rates may be based on interest rates for new investments as of the

valuation date similar to recent investments allocated to support the product being tested or be based on an outside index, such as Treasury yields, of assets of the appropriate length on a date close to the valuation date. Whatever method is used to determine the beginning yield curve and associated interest rates must be specifically defined. The beginning yield curve and associated interest rates must be consistent for all interest rate scenarios.

(6) Documentation. The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 733.304

Hist.: ID 10-1992, f. & cert. ef. 5-27-92; ID 1-1993(Temp), f. & cert. ef. 2-4-93; ID 4-1993, f. 7-27-93, cert. ef. 7-30-93

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 33

INVESTMENTS (ORS 733.510 TO 733.780)

836-033-0105

Statutory Authority; Purpose

OAR 836-033-0110 is adopted pursuant to ORS 733.550(3), which grants the Commissioner authority to prescribe standards to be applied to determine if obligations invested in by an insurer are "amply secured obligations" under the statutes regulating investments of insurers. The purpose of the section is to prescribe such standards.

Stat. Auth.: ORS Ch. 733

Stats. Implemented: ORS 733.550(3)

Hist.: IC 66, f. & ef. 6-4-76

836-033-0110

"Amply Secured Obligations" Defined

In addition to those obligations referred to in ORS 733.550(1) and (2), an "amply secured obligation" is one that is eligible for amortization within the requirements adopted by the Subcommittee on Valuation of Securities of the National Association of Insurance Commissioners and published in "**Valuations of Securities as of December 31, 1975**". An obligation that meets the requirements adopted by the Subcommittee on Valuation of Securities and set out in its most recent publication on **"Valuation of Securities"** will be considered within the requirements of this section.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS Ch. 733

Stats. Implemented: ORS 733.550(3)

Hist.: IC 66, f. & ef. 6-4-76

836-033-0120

Purpose and Authority; Definition

(1) OAR 836-033-0120 and 836-033-0130 implement ORS 733.695 by establishing which obligations are not of investment grade and regulating the acts and practices of insurers with respect to the concentration of such obligations.

(2) For purposes of this rule and OAR 836-033-0130, "obligation" has the meaning given that term in ORS 733.540.

Stat. Auth.: ORS 731.244, 733.010 & 733.695

Stats. Implemented: ORS 733.695

Hist.: ID 5-1992, f. & cert. ef. 3-26-92

836-033-0130

Investments in Medium Grade and Lower Grade Obligations

(1) An insurer may acquire or hold obligations that are not investment grade only as provided in this rule. For purposes of this rule, an obligation is not investment grade if the obligation is either of the following:

(a) A "medium grade obligation", which means an obligation that is rated three by the Securities Valuation Office of the National Association of Insurance Commissioners;

(b) A "lower grade obligation," which means an obligation that is rated four, five or six by the Securities Valuation Office of the National Association of Insurance Commissioners.

(2) An insurer shall not acquire, directly or indirectly, any medium grade or lower grade obligation of any person if, after given effect to the acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the insurer would exceed 20% of its allowed assets. For purposes of this section, the aggregate amount of medium grade and lower grade obligations shall be the aggregate value of the obligations as set forth in the most recent financial statement required by and filed with the Director.

(3) In addition to the prohibition in section (2) of this rule on the aggregate amount of medium grade and lower grade obligations, an insurer shall not acquire or hold:

(a) More than ten percent of its allowed assets in obligations rated four, five or six by the Securities Valuation Office of the National Association of Insurance Commissioners;

(b) More than three percent of its allowed assets in obligations rated five or six by the Securities Valuation Office of the National Association of Insurance Commissioners;

(c) More than one percent of its allowed assets in obligations rated six by the Securities Valuation Office of the National Asociation of Insurance Commissioners.

(4) Attaining the limit of any one category under section (3) of this rule does not preclude an insurer from acquiring or holding obligations in other categories, subject to the specific and multi-category limits of this rule.

(5) The following prohibitions apply to investments in lower grade obligations and medium grade obligations issued, guaranteed or insured by any one person:

(a) An insurer shall not acquire or hold more than an aggregate of one percent of its allowed assets in medium grade obligations issued, guaranteed or insured by any one person;

(b) An insurer shall not acquire or hold more than one-half of one percent of its allowed assets in lower grade obligations issued, guaranteed or insured by any one person;

(c) In addition to the prohibitions in subsections (a) and (b) of this section, an insurer shall not acquire or hold more than one percent of its allowed assets in any medium or lower grade obligations issued, guaranteed or insured by any one person.

(6) This rule does not prohibit an insurer from doing any of the following:

(a) Acquiring any obligation that the insurer committed prior to the effective date of this rule to acquire if the insurer would have been permitted to acquire the obligation when the insurer made the commitment;

(b) Acquiring an obligation as a result of a restructuring of a medium or lower grade obligation already held.

(7) An insurer may acquire a medium or lower grade obligation of a person in which the insurer already has one or more medium or lower grade obligations if the obligation is acquired in order to protect an investment previously made in the obligations of the person. All such acquired obligations, however, shall not exceed one-half of one percent of the insurer's allowed assets.

(8) The board of directors of a domestic insurer that acquires, hold or invests, directly or indirectly, more than two percent of its allowed assets in medium grade and lower grade obligations shall adopt a written plan for the making of such investments. The plan shall contain guidelines with respect to the quality of the issues invested in as well as diversification standards. The diversification standards shall at least include standards regarding the issuer, industry, duration, liquidity and geographic location.

(9) An insurer shall not acquire any lower grade or medium grade obligation that in whole or in part exceed the applicable limitation established in this rule. The requirement under this section does not apply to the acquisition of an obligation to which section (6) of this rule applies.

(10) On and after January 1, 1995, an insurer shall not claim as an allowed asset any portion of lower grade or medium grade obligations acquired by the insurer prior to the effective date of this rule or as authorized by subsection (6)(a) of this rule that exceed the applicable limitation established in this rule, except with the consent of the Director.

(11) If an obligation held by an insurer is of investment grade when acquired but subsequently becomes a medium grade or lower grade obligation, and that event causes the obligations of the insurer to exceed an applicable limit established under this rule, the insurer shall not count the excess as an allowed asset. An insurer shall not hold any excess ascribable to deterioration of an obligation as described in this section longer than a continuous period of three years during which the obligation is a medium or lower grade obligation, except with the consent of the Director.

(12) A foreign or alien insurer is subject to this rule as provided in ORS 733.510(2).

Stat. Auth.: ORS 731.244, 733.010 & 733.695

Stats. Implemented: ORS 733.695

Hist.: ID 5-1992, f. & cert. ef. 3-26-92

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 42

RATES AND RATEMAKING

836-042-0001

Statutory Authority; Purpose and Effective Date

(1) OAR 836-042-0001 to 836-042-0035 are adopted pursuant to the general rulemaking authority of the Commissioner in ORS 731.244.

(2) The purpose and applicability of these rules is to effectuate orderly administration of the 1981 amendments to ORS 737.205, 737.225, 737.265 and 737.320 requiring insurers to file their own workers' compensation insurance rates, rating plans, and rating systems and prohibiting rating organizations from filing workers' compensation insurance rating provisions for expenses, taxes, or profit.

(3) OAR 836-042-0001 to 836-042-0025 and 836-042-0035 become effective July 1, 1982. OAR 836-042-0030 becomes effective June 1, 1982.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.205(1)-(2), 737.225(1), 737.265, 737.310(1) &737.320(3)

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82

836-042-0005

Definitions

As used in OAR 836-042-0001 to 836-042-0035, unless the context requires otherwise:

(1) "Anniversary rating date" means the month and day that rates, rating plans and rating systems are initially applied to a policy in effect and each annual anniversary thereafter, unless a different date is established by the rating organization of which the insurer is a member.

(2) "Classification" means a grouping of insurance risks according to a classification system used by an insurer.

(3) "Classification System" means a schedule of classifications and a rule or set of rules used by an insurer for

determining the classifications applicable to an insured.

(4) "Insurer" means any insurer authorized to write workers' compensation insurance or the State Accident Insurance Fund Corporation.

(5) "Loss Cost" means a provision for claim payment

(6) "Premium" means the contractual consideration charged to an insured for insurance for a specified period of time regardless of the timing of actual charges.

(7) "Provision for Claim Payment" means an estimate expressed per unit of exposure basis for the monetary amount ultimately to be needed to pay workers' compensation insurance claims, excluding all loss adjustment or claim management expenses, other operating expenses, assessments, taxes, and profit or contingency allowances.

(8) "Rate" means a monetary amount applied to the units of exposure basis assigned to a classification and used by an insurer to determine the premium for an insured.

(9) "Rating Plan" means a rule or set of rules used by an insurer to calculate premium for an insured, and the parameter values used in such calculation, after application of classification premium rates to units of exposure.

(10) "Rating System" means a collection of rating plans to be used by an insurer, rules for determining which rating plans are applicable to an insured, a classification system, and other rules used by an insurer for determining contractual consideration for an insured.

(11) "Standard Premium at Company Rates" means Oregon premium determined on the basis of premium rates approved for an insurer and any applicable experience rating modification but does not include expense constants or additional premium charged to achieve minimum premium

(12) "Workers' Compensation Insurance" means insurance providing coverage for the obligations of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapter 656, similar laws of the United States, or agreements between states.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.205(1)-(2), 737.225(1), 737.265 & 737.320(3)

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82; ID 15-1992, f. & cert. ef. 11-16-92

836-042-0010

All Current Workers' Compensation Filings Disapproved as of July 1, 1982

All workers' compensation insurance rates, rating plans and rating systems filed with the Commissioner to become effective prior to July 1, 1982 shall not apply to insurance policies written to become effective on or after July 1, 1982. However, such rates, rating plans and rating systems as approved by the Commissioner shall continue to apply to workers' compensation insurance rating agreements or policies written to become effective prior to July 1, 1982. Multi-year workers' compensation insurance rating agree-ments or policies written to become effective prior to July 1, 1982 may be cancelled by the insurer on the subsequent anniversary rating date.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.205(1)-(2)

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82

836-042-0015

Workers' Compensation Filings -- Procedural Rules for Insurers and Rating Organizations

(1) Every workers' compensation insurer shall file with the Commissioner copies of the workers' compensation insurance premium rates to be used by it. An insurer may satisfy this requirement by authorizing the Commissioner to accept on its behalf the provisions for claim payment filed by a rating organization in accordance with section (4) of this rule, to the extent the insurer uses the classification system of the rating organization, and by specifying the factors by which every such provision shall be multiplied to make allowances for expenses, taxes or profit and a rule for rounding each such provision after multiplication.

(2) Workers' compensation insurance premium rates based on loss costs of a licensed rating organization filed by an insurer must each be accompanied by transmittal letters of the forms prescribed in **Exhibit 1** and **2**.

(3) Every filing of workers' compensation insurance premium rates, rating plans or rating systems by an insurer and every filing of workers' compensation insurance rating plans, rating systems or provisions for claim payment by a rating organization must be submitted to the Commissioner for review prior to becoming effective.

(4) The effective date of a workers' com-pensation insurance filing required by section (3) of this rule to be submitted to the Commissioner for review shall be the date specified therein but not earlier than the 30th day after the date the filing is received by the Commissioner, or the 30th day after the date of receipt of supporting information, whichever is later. If the Commissioner has reviewed the filing prior to expiration of the waiting period, the Commissioner may authorize an effective date prior to the expiration of the waiting period but not earlier than the date such written application and any required supporting information is received. The 30 day period may be extended to 60 days if the Commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the extended period is needed for consideration of such filing. A filing subject to this section shall be deemed to meet the requirements of ORS Chapter 737 unless disapproved by the Commissioner within the waiting period or extension thereof.

(5) An insurer may authorize the Commissioner to accept on its behalf the workers' compensation insurance rating plans or rating systems filed by a licensed rating organization of which it is a member when such filings have been approved by the Commissioner and to the extent such plans or systems are complete and usable without addition of allowances for expenses, taxes or profit. When such plans and systems are not complete and usable, an insurer may file for review by the Commissioner supplementary systems or values providing allowances for expenses, taxes or profit to be used in conjunction with such workers' compensation insurance rating plans and rating systems. An insurer may so adopt the rating plans and rating systems of a rating organization on part of the classifications of risks insured by it and may make its own filings as to other classifications.

(6)(a) Nothing in this section should be construed to require any insurer to adopt any rating plan or rating system filed by a rating organization and approved by the Commissioner nor to prohibit any insurer from filing any workers' compensation insurance rating plan or rating system which supplements or differs from any rating plans or rating systems filed by a rating organization; and

(b) Notwithstanding subsection (a) of this section, workers' compensation insurers shall adopt the experience rating plan established by the rating organization, or an alternative plan designed to promote worker safety approved by the Commis-sioner, to be applied on a uniform basis.

(7) A licensed rating organization may assist any member with filing workers' compensation insurance premium rates, rating plans or rating systems following instructions from such member as to the provisions for expenses, taxes and profit appropriate for its use.

(8) Every workers' compensation insurance filing submission to the Commissioner by an insurer shall also be simultaneously submitted to the rating organization of which the insurer is a member.

(9) Workers' compensation insurance policies shall be reviewed by the rating organization of which the insurer is a member to determine compliance with the insurer's filings. The rating organization shall review workers' compensation insurance policies issued by their members for compliance with **Insurance Code Chapter 737** and OAR 836-042-0035.

[Publications: The publication(s) and exhibit(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.205(1)-(2), 737.225(1), 737.265(2) & 737.320(2)-(3)

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82; ID 15-1992, f. & cert. ef. 11-16-92

836-042-0020

InsurersMustDemonstrateStatistical Reporting Ability

(1) Any insurer filing a workers' compensation insurance exposure base, classification or classification system, must demonstrate how statistical experience data will be converted for purposes of statistical reporting in accordance with the uniform statistical plan prescribed by OAR 836-042-0045.

(2) Any filing by an insurer of a workers' compensation insurance exposure base, classi-fication or classification system which does not meet the requirements of section (1) of this rule shall be determined not to satisfy the requirements of ORS Chapter 737 and shall be disapproved.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.325(1)-(2), (4) & 737.230

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82

836-042-0025

Workers' Compensation Filings Standards for Unfair Discrimination

(1) Except for revisions solely attributable to legislative enactments, changes in administrative rules or orders, or approved by the Director to prevent an impairment, or applying to state agencies, workers' compensation insurance rates, rating plans, rating systems or provisions for claim payment are unfairly discriminatory if either:

(a) Revision of a rate, rating plan or rating system is filed to become effective within six months of the effective date of a corresponding rate, rating plan or rating system previously established pursuant to OAR 836-042-0015 by the filing insurer; or

(b) The rating system does not contain rules specifying that a revision of a rate, rating plan or system shall not apply to an insured until an anniversary rating date at least 11 months and 16 days subsequent to the earlier of the preceding anniversary rating date or the preceding policy effective date established for an insured unless approved by the Director to apply to all policies in force on a common date; or

(c) Premium rates are based on provisions for claim payment filed by a licensed rating organization which are not the provisions most recently approved or premium rates are determined by multiplying superseded provisions by a factor; or

(d) Provisions for claim payment to be used by an insurer as a basis for premium rates are revised to be effective on a date other than the date of a revision approved for a licensed rating organization.

(2) Workers' compensation insurance rating plans or rating systems are presumed to be unfairly discriminatory, unless demonstrated otherwise, if either:

(a) A rating plan or rating system which produces only credit modifications to an insured's premiums is offered at the option of the insurer;

(b) The modification of the premium or premium rates applicable to an insured cannot be quantitatively determined by the Commissioner except for the uncertainty of estimated exposures; or

(c) An insurer has filed two or more schedules of premium rates without providing a clear rule for deciding which schedule is to be applied to an insured.

(3) Premiums are unfairly discriminatory if differentials between insureds fail to reasonably reflect the differences in expected losses and expenses to the insurer attributable to the insureds. Workers' compensation insurance rates, rating plans or rating systems are not unfairly discriminatory when different premiums result or different rates apply to insureds if:

(a) Differences in loss exposures, expense factors or investment income opportunity to an insurer can be attributed to the insureds; and

(b) The differences are reasonably reflected by the rates, rating plan or rating system.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.310

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82; IC 12-1982(Temp), f. 6-29-82, ef. 7-1-82; IC 14-1982, f. 12-17-82, ef. 12-29-82; ID 15-1992, f. & cert. ef. 11-16-92; ID 15-1996, f. & cert. ef. 11-12-96

836-042-0030

Rating Organization Report of Investment Income

(1) Not later than the first day of October of each year, each workers' compensation rating organization shall file with the Commissioner a report of investment income derived by its members during the preceding calendar year from the investment or deposit of premiums and all forms of assets invested and held to cover reserves for liabilities resulting from workers' compensation insurance transacted in this state.

(2) A rating organization may satisfy the investment income reporting requirement imposed by ORS 737.320(3) by referring to the report filed as required by section (1) of this rule for the preceding October 1.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.320(3)

Hist.: IC 4-1982, f. 1-27-82, ef. 6-1-82; IC 6-1983, f. 7-21-83, ef. 8-1-83

836-042-0035

Workers' Compensation Policy Forms Filings by Insurers

Workers' compensation insurance must be written using policy forms filed by the rating organization of which the insurer is a member except that if the insurer files a rating plan or rating system requiring a policy provision or

endorsement for which the rating organization has made no usable filing then the insurer may file its own policy forms needed to implement its rating plans or systems. Such policy form filings are subject to ORS Chapter 743.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.265(2) & 737.320(3)

Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82

836-042-0040

Statutory Authority; Purpose and Effective Date

(1) OAR 836-042-0040 through 836-042-0045 are adopted by the Insurance Commissioner pursuant to the requirements of ORS 737.225(4).

(2) The purpose and applicability of these rules is to prescribe a uniform statistical plan for workers' compensation insurance statistics as required by ORS 737.225(4).

(3) OAR 836-042-0040 through 836-042-0045 apply to all reporting of workers' compensation insurance statistics, as therein defined and prescribed, on or after July 1, 1982, provided that nothing contained herein shall restrict the reporting of statistical, financial, or accounting data necessary to fulfill the requirements of ORS Chapter 737.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.225(4)

Hist.: IC 3-1982, f. 1-27-82, ef. 7-1-82

836-042-0043

Definition

As used in OAR 836-042-0040 through 836-042-0045, unless the context requires otherwise: "Workers' compensation insurance" means insurance providing coverage for the obligation of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapter 656, similar laws of the United States or agreements between states.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.225(4)

Hist.: IC 3-1982, f. 1-27-82, ef. 7-1-82

836-042-0045

Uniform Workers' Compensation Statistical Plan

(1) The **Unit Statistical Plan, Edition of December 1, 1978 as revised through January 3, 1983, filed by the National Council on Compensation Insurance and approved by the Commissioner to become effective March 1, 1983**, is prescribed as the statistical plan for workers' compensation insurance.

(2) The State Accident Insurance Fund Corporation and each insurer transacting workers' compensation insurance in this state shall report statistics for such business to the workers' compensation rating organization of which it is a member according to the statistical plan prescribed by section (1) of this rule.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.225(4)

Hist.: IC 3-1982, f. 1-27-82, ef. 7-1-82; IC 10-1982, f. 6-23-82, ef. 7-1-82; IC 2-1983, f. 3-16-83, ef. 4-1-83; IC 5-1983, f. 6-30-83, ef. 7-1-83; IC 4-1984, f. 9-28-84, ef. 10-1-84

836-042-0050

Statutory Authority; Purpose and Applicability

(1) OAR 836-042-0050 to 836-042-0060 are adopted pursuant to the general rulemaking authority of the Insurance Commissioner in ORS 731.244 and the specific authority of ORS 737.310, which authorizes the Insurance Commissioner to prescribe by rule the conditions under which a division of payroll between different classifications is permitted for purposes of calculating workers' compensation insurance premiums.

(2) The purpose and applicability of these rules is to improve parity in the workers' compensation insurance market by prescribing a uniform set of rules for division of a single employee's payroll between assigned classifications and a necessary clarification of the definition of payroll to effectuate these rules.

(3) OAR 836-042-0050 to 836-042-0060 apply to all workers' compensation insurance policies written to become effective January 15, 1982 or after by any insurer.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.310

Hist.: IC 1-1981(Temp), f. & ef. 11-2-81; IC 2-1982, f. & ef. 1-15-82; ID 15-1996, f. & cert. ef. 11-12-96

836-042-0055

Definitions

(1) As used in OAR 836-042-0050 to 836-042-0060, unless the context requires otherwise:

(a) "Classification" means a grouping of insurance risks according to a classification system used by an insurer.

(b) "Classification System" means a schedule of classifications and a rule or set of rules used by an insurer for determining the classification applicable to risks insured by it.

(c) "Insurer" means any insurer authorized to write workers' compensation insurance or the State Accident Insurance Fund Corporation.

(d) "Interchange of Labor" means an employee or employees at different times perform duties described by two or more classifications assigned to an employer according to the classification system used by the insurer.

(e) "Overtime Work", unless more extensively defined within the rating system used by the insurer, means work beyond

the time worked on a regular basis in a day or a week and work on days not worked on a regular basis such as Sundays or holidays but does not include time or days worked on a regular basis according to the contract of employment whether or not any increased rate of pay is applied.

(f) "Payroll" means money or substitutes for money payable to workers for their services and which are specified or defined by the rating system used by the insurer except that payroll may not include vacation pay, incremental pay recorded for overtime work, and payments excluded as provided in section (2) of this rule.

(g) "Workers' Compensation Insurance" means insurance providing coverage for the obligations of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapter 656, similar laws of the United States, or agreements between states.

(2) An insurer shall include a payment in or exclude a payment from workers' compensation premium basis of an employer as follows:

(a) An unanticipated bonus payment to an individual employee shall be excluded. A bonus payment is otherwise subject to inclusion in the premium basis if the payment is anticipated. A bonus payment is unanticipated or anticipated as follows:

(A) A bonus payment is unanticipated if all of the following conditions are met:

(i) The payment is paid as an arbitrary and gratuitous disbursement; and

(ii) The payment is not part of an oral or written employment agreement.

(B) A bonus payment is anticipated if made under one or more of the following circumstances:

(i) The payment is made to any one employee more frequently than twice in a policy period and at the same times as payments made in the preceding year;

(ii) The payment is made to offset a pay cut or reduction in wages;

(iii) The payment is made in lieu of a raise in wages;

(iv) The payment is made to corporate officers who are directors with a substantial ownership in the corporation, as "substantial ownership" is defined in OAR 436-050-0050(2)(g);

(v) The payment is made to limited liability company members who have a substantial ownership interest in the company;

(vi) The payment is related to meeting or exceeding preestablished production goals; or

(vii) The payment is related to absenteeism or attendance.

(b) A safety bonus shall be excluded from or included in the premium basis as follows:

(A) A safety bonus shall be excluded if all of the following conditions apply with respect to the payment:

(i) The payment is anticipated;

(ii) The payment is distributed in accordance with a written plan; and

(iii) The payment is tied strictly to safe working practices.

(B) A safety bonus shall be included if the safety bonus is paid to offset pay cuts or a reduction of wages.

(c) A profit sharing payment shall be excluded from the premium basis if all of the following conditions apply with respect to the payment:

(A) The payment is anticipated;

(B) The payment is distributed from net realized profits; and

(C) The payment is distributed in accordance with a written plan that creates a legal obligation for the employer to disburse funds in accordance with the plan.

Stat. Auth.: ORS 731.244 & 737.310

Stats. Implemented: ORS 737.310

Hist.: IC 1-1981(Temp), f. & ef. 11-2-81; IC 2-1982, f. & ef. 1-15-82; ID 17-1996, f. & cert. ef. 12-16-1996

836-042-0060

Conditions for Division of Payroll of Individual Employees

(1) When there is an interchange of labor, the payroll of an individual employee shall be divided and allocated among the classification or classifications that may be properly assigned to the employer, provided verifiable payroll records of the employer disclose a specific allocation for each such individual employee, in accordance with the standards for rebilling set forth in OAR 836-043-0190.

(2) When there is an interchange of labor without verifiable records, the entire payroll of employees who interchange shall be assigned to the classification representing any part of their work that carries the highest authorized premium rate, in accordance with the standards for rebilling set forth in OAR 836-043-0190.

(3) The payroll of any individual employee used by an insurer to compute workers' compensation insurance premium must be determined in a manner consistent with the definition of "overtime work" and "payroll" in sections (5) and (6) of OAR 836-042-0055.

(4) The amendments to this rule that are effective July 27, 1995, apply to policies issued on or after July 1, 1991, except that the amendments do not apply with respect to any policy that is or has been subject to judicial review on the issue of division of payroll.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.310(10)

Hist.: IC 1-1981(Temp), f. & ef. 11-2-81; IC 2-1982, f. & ef. 1-15-82; ID 5-1995(Temp), f. 7-26-95, cert. ef. 7-27-95; ID 2-1996, f. & cert. ef. 1-26-96

Workers' Compensation Large Deductible Provisions

836-042-0070

Statutory Authority and Purpose

OAR 836-042-0070 to 836-042-0090 are adopted pursuant to the general rulemaking authority of the Director of the

Department of Consumer and Business Services in ORS 731.244 to specify for insurers offering large deductible provisions of workers' compensation insurance policies requirements for rates, rating plans, and rating systems which may be approved according to ORS Chapter 737.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS Ch. 737, 737.310 & 741.001 - 742.007

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-042-0075

Definitions

As used in OAR 836-042-0070 to 836-042-0090:

(a) "Insurer" means any insurer authorized to write workers' compensation insurance and includes the State Accident Insurance Fund Corporation.

(2) "Director" means the Director of the Department of Consumer and Business Services.

(3) "Large Deductible" means a provision in a workers' compensation policy, or added by endorsement thereto, which allows a policy holder to be financially responsible for claims incurred under the policy up to a percentage of premium, a stated amount per claim, or other limit specified in the provision in exchange for a prospective premium reduction.

(4) "Workers' Compensation Insurance" means insurance providing coverage for the obligations of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapters 654 and 656, similar laws of the United States, or agreements between states.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS Ch. 737, 737.310 & 741.001 - 742.007

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-042-0080

Rate Filing Requirements and Standards

An insurer that issues a policy for worker's compensation insurance including a large deductible provision must use a provision which satisfies requirements of OAR 836-054-0210 and has been approved by the Director and must file rating plans for determining premium credits or rating modifications with the Director according to ORS 737.320 and OAR 836-042-0001 to 836-042-0045 and which satisfy these additional requirements:

(1) Such rating plans must be based on actuarial assumptions and methods similar to and not circumventing the design of retrospective rating plans approved by the Director.

(2) A deductible credit or rating modification must be the final rating step so that the insurer may distinguish the amount of credit or modification premium and the policy premium prior to the credit or modification. An insurer may compute premium discounts based on premium amounts after deductible credits if the insurer can demonstrate that greater premium equity is achieved and that data distinguishing the various premium elements will be maintained.

(3) Such rating plans may not contain provisions which cannot be approved under the unfair discrimination provisions

of OAR 836-042-0025.

(4) A deductible credit or rating modification must recognize expenses which vary with net earned premium after such credits or modifications

(5) Prospective experience rating plans based on prior claims experience must use losses valued on a gross basis prior to deductible provisions.

(6) Large deductible rating plans may not be applied to rating groups approved under OAR 836-042-0201 to 836-042-0225.

(7) Minimum eligibility for a large deductible provision must be not less than $750,000 estimated country-wide annual premium prior to large deductible credits or premium credits based on premium size. The minimum deductible limit per claim for each injury or illness may not be less than $75,000. An aggregate limit for deductible amounts for all claims may be specified but may not be less than the deductible limit per claim.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS Ch. 737, 737.310 & 741.001 - 742.007

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-042-0085

Statistical Data Maintenance and Reporting Requirements.

An insurer that issues a policy for worker's compensation insurance including a large deductible provision must:

(1) Maintain policy premium data distinguishing credit or modification premium for large deductible provisions;

(2) Report policy unit statistical data with losses valued on a gross basis prior to deductible provisions; and

(3) Separately report financial experience data to a licensed rating organization including premium prior to credits or modifications for large deductible provisions and loss valued on a gross basis prior to deductible provisions.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS Ch. 737, 737.310 & 741.001 - 742.007

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-042-0090

Trade Practices Found Injurious to the Insurance-Buying Public

(1) Failure of an insurer to comply with OAR 836-042-0080, 836-042-0085 or 836-054-0210 constitutes an unfair trade practice under ORS 746.240.

(2) Failure of an insurer to delete a large deductible provision following discovery that an insured employer has on three or more occasions during the policy period known of a workers' compensation insurance claim for five (5) days or longer but has not reported the claim to the insurer or has on any occasion within the policy period made direct payment of claim costs constitutes an unfair trade practice under ORS 746.240.

(3) Failure of an insurer to include amounts of premium credits or modifications for large deductible provisions in the base for the assessment imposed by the Director pursuant to ORS 656.612 and to pay the assessment on those amounts constitutes an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 746.240

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-042-0201

Statutory Authority; Purpose; Effective Date

(1) OAR 836-042-0201 to 836-042-0225 are adopted under the general rulemaking authority of the Insurance Commissioner in ORS 731.244 and the specific authority relating to workers' compensation insurance rating groups in ORS 737.316.

(2) The purpose of OAR 836-042-0201 to 836-042-0225 is to provide an orderly procedure for insurers to combine the workers' compensation insurance experience of a group of employers for rating purposes.

(3) OAR 836-042-0201 to 836-042-0225 become effective October 14, 1983.

Stat. Auth.: ORS 731.244 & 737.316

Stats. Implemented: ORS 737.316

Hist.: IC 2-1984, f. 1-18-84, ef. 2-1-84; ID 18-1992(Temp), f. 12-21-92, cert. ef. 1-2-93; Suspended by ID 2-1993(Temp), f. & cert. ef. 4-1-93; ID 10-1993, f. 10-1-93, cert. ef. 10-2-93; ID 15-1996, f. & cert. ef. 11-12-96

836-042-0205

Definitions

As used in OAR 836-042-0201 to 836-042-0225 unless the context requires otherwise:

(1) "Anniversary Rating Date" means the month and day that a rating plan is initially applied to a policy and each annual anniversary thereafter, unless a different date is established by the rating organization to which the insurer belongs.

(2) "Combined Experience" means the sum of workers' compensation insurance premium, claims, and payroll or other exposure measures used by an insurer to rate individual members of a group of employers. Data from all members of the group are included in the sum without further modification or adjustment.

(3) "Experience Rating" means any prospective modification of workers' compensation insurance premium based on previous workers' compensation experience data for an individual employer or a group of employers.

(4) "Group Anniversary Rating Date" means the month and day the combined experience of a group of employers is initially used to rate individual members of the group and each annual anniversary thereafter, unless a different date is established with the approval of the Insurance Commissioner.

(5) "Insurer" means any person authorized to write workers' compensation insurance in this state and includes the State Accident Insurance Fund Corporation.

(6) "Modification Factor" means the numerical result of an experience rating calculation. Insurance premiums are multiplied by this number to adjust for past experience of an employer or a group of employers.

(7) "Premium" means the contractual amount charged to an insured for insurance for a specific period of time, regardless of the timing of actual charges.

(8) "Premium Discounting" means the modification of workers' compensation insurance premium according to a rating plan used by an insurer based solely upon a gradation of expense provisions according to the amount of premium.

(9) "Rating Plan" means any set of rules and values filed with the Insurance Commissioner and used by an insurer to calculate premiums.

(10) "Retrospective Rating" means adjustment of workers' compensation insurance premium for the policies of a group of employers after the policies have expired using the combined experience from those policies according to the insurer's rating plan.

(11) "Workers' Compensation Insurance" means insurance covering the obligations of an employer arising from workers' illness or injury, whether an obligation is imposed by ORS Chapter 656, similar laws of the United States, or agreements between states.

Stat. Auth.: ORS 731.244 & 737.316

Stats. Implemented: ORS 737.316

Hist.: IC 2-1984, f. 1-18-84, ef. 2-1-84; ID 18-1992(Temp), f. 12-21-92, cert. ef. 1-2-93; ID 10-1993, f. 10-1-93, cert. ef. 10-2-93

836-042-0210

Rating Plans for Which Employers May be Combined; Retrospective Rating Deposit Required; When Group Rating May be Applied

(1) An insurer may use the combined experience of a group of employers for experience rating, retrospective rating, or premium discounting of workers' compensation insurance premiums for the employers in the group. An insurer may also apply other factors approved by the Insurance Commissioner which are not adequately reflected in experience rating, retrospective rating, or premium discounting and which satisfy the requirements of section (6) of this rule.

(2) If the combined experience of a group of employers is used for experience rating, a modification factor to supplement the modification factors of individual employers shall be calculated and distributed by a licensed rating organization according to the Experience Rating Plan of the National Council on Compensation Insurance filed with the Insurance Commissioner. Limitations or other data adjustments shall be applied only to the experience data of individual group members. The rating organization shall provide such service to an insurer upon request and may charge a reasonable fee.

(3) The premiums of a group of employers may be combined for premium discounting if the group can reasonably justify the combination by showing savings in acquisition, premium collection, policy issuance or other insurance administrative expenses or insurance services provided by an organization of which employers in the group are members.

(4) The premiums of a group of employers may be combined for retrospective rating either to enhance volume and reduce insurance charges or to realize expense savings as would be allowed for premium discounting.

(5) Rating modifications based on the combined experience of a group of employers shall apply to individual members of the group as of the individual member's first anniversary rating date on or after the group anniversary rating date.

(6) An insurer may file a group rating plan for applying factors not adequately recognized and reflected by experience rating, retrospective rating, or premium discounting. The effective date of a proposed plan shall be the date specified in the filing, but not sooner than 30 days after the filing is received by the Insurance Commissioner. The Commissioner may approve an earlier effective date not preceding the date the filing was received. If, within the 30-day period, the Commissioner finds the proposal does not meet the standards and requirements of ORS Chapter 737 and this section, the Commissioner shall notify the insurer that the proposal has been disapproved, stating the basis for such action, and the proposal shall not become effective. If, following the 30-day period, the commissioner finds the proposal does not satisfy the requirements and standards of ORS Chapter 737, the commissioner may proceed according to ORS 737.336(2), 737.215, and 737.045 to disapprove the plan. The Commissioner shall not approve a plan for applying rating factors unless:

(a) All factors can be objectively evaluated and are consistently and uniformly applied and evidence thereof maintained by the insurer;

(b) Premium modifications for each factor are supported by actuarial evidence;

(c) The insurer captures and maintains statistical data demonstrating the rating equity of applying premium modifications; and

(d) The application of a rating factor does not inappropriately duplicate the recognition of experience used in other rating factors.

Stat. Auth.: ORS 731.244 & 737.316

Stats. Implemented: ORS 737.316

Hist.: IC 2-1984, f. 1-18-84, ef. 2-1-84; ID 18-1992(Temp), f. 12-21-92, cert. ef. 1-2-93; Suspended by ID 2-1993(Temp), f. & cert. ef. 4-1-93; ID 10-1993, f. 10-1-93, cert. ef. 10-2-93

836-042-0215

Consent to Group Rating Required Before Policy Issuance; Provision Required in Consent Form; Contents of Consent Form

(1) An insurer intending to combine the experience of a group of employers for rating purposes may not issue a policy to a member of the group unless it has secured a signed consent to group rating from each group member.

(2) The form used by the insurer to secure consent to group rating must be approved by the Insurance Commissioner. The form must include the following wording, or substantially equivalent wording approved by the Insurance Commissioner: **"The premium you must pay for this insurance will be determined in part by the consolidated experience of all members of the group in which you participate"**.

(3) The consent to group rating form must include the following:

(a) Name and address of the group member;

(b) Name, title and signature of the person giving consent;

(c) Name of the organization to which employers in the group belong;

(d) Specific description of how the combined experience of the group will be used for rating the group member; and

(e) The period covered by policies to be used for deriving the combined experience of group members.

Stat. Auth.: ORS 731.244 & 737.316

Stats. Implemented: ORS 737.316

Hist.: IC 2-1984, f. 1-18-84, ef. 2-1-84; ID 18-1992(Temp), f. 12-21-92, cert. ef. 1-2-93; Suspended by ID 2-1993(Temp), f. & cert. ef. 4-1-93; ID 10-1993, f. 10-1-93, cert. ef. 10-2-93

836-042-0220

Filing Requirements and Procedural Rules

(1) Before issuing any policies to group members which are to be rated by the combined experience of the group, the insurer must file the following with the Insurance Commissioner for each group:

(a) The name of the organization to which employers in the group belong;

(b) The number of employers in the organization;

(c) A listing of employers in the organization which have signed consent-to-group-rating forms;

(d) The number of covered workers employed by employers which have signed consent-to-group-rating forms;

(e) An explanation of how the grouping of employers is likely to improve accident prevention and claims handling and reduce expenses;

(f) A specific description of how the combined experience of the group will be used for rating group members; and

(g) The initial group anniversary rating date.

(2)(a) If the combined experience of a group of employers is used for experience rating, the supplemental modification factor shall be calculated 90 days in advance of the group anniversary rating date using the experience of employers that participated in the group during the experience rating base period. The experience to be combined is the experience of the individual employers for the policy year or years that they participated in the group plan. The employers participating in the group during the base period which also are participating at the time of the supplemental rating calculation must be at least 50 percent of the current participants;

(b) The group must also meet at least one of the following conditions at the time of the supplemental rating calculation:

(A) Total annual standard premium prior to the supplemental modification of $250,000 or greater; or

(B) At least 50 participating employers.

(c) Notwithstanding subsections (a) and (b) of this section, any approved experience rating group in force as of August 15, 1993, may be experience rated as otherwise provided by this rule for each group rating plan incepting before August 15, 1995. Thereafter, such a group must meet all requirements of the rule;

(d) Any approved experience rating group in force as of October 2, 1993, that did not have a group rating plan during any portion of the base period will have a group supplemental modification factor calculated using the experience during the experience rating base period of employers participating at the time of the supplemental rating calculation;

(e) The group supplemental modification factor for an organization with an Insurance Division approved experience rating group in force as of October 2, 1993 shall not change from the supplemental factor applicable to the group as of October 1, 1993, by more than 20 percent of the complement of the 1993 modification each ensuing year. A factor greater than 1.00 shall not be applied prior to October 2, 1999. Once a group no longer remains eligible in accordance

with this section, this transition program shall no longer be applicable.

(3) If the combined experience of a group of employers is used for premium discounting, the discount must be determined from the actual premium of all participating employers.

(4) The effective date of a proposal by an insurer to combine the experience of a group of employers shall be the date specified in the filing required under section (1) of this rule, but not sooner than 30 days after the filing is received by the Insurance Commissioner. The Commissioner may approve an earlier effective date, upon written request by the insurer, but the date shall not precede the date the filing was received. If, within the 30-day period, the Commissioner finds the proposal does not meet the standards and requirements of ORS Chapter 737, the Commis-sioner shall notify the insurer that the proposal has been disapproved, stating the basis for such action, and the proposal shall not become effective. If, following the 30-day period, the Commissioner finds the grouping proposal does not satisfy the requirements and standards of ORS Chapter 737, the Commissioner may proceed according to ORS 737.336(2), 737.215, and 737.045 to disapprove the group rating.

(5) Forty-five days before each group anniversary rating date after the initial effective date, the insurer must file with the Insurance Commissioner for review according to the preceding paragraph the following information for each grouping of employers:

(a) The number of employers in the organization;

(b) A listing of employers participating in the group;

(c) The number of covered workers employed by employers participating in the group; and

(d) A specific description of how the combined experience of the group will be used for rating group members.

Stat. Auth.: ORS 731.244 & 737.316

Stats. Implemented: ORS 737.316

Hist.: IC 2-1984, f. 1-18-84, ef. 2-1-84; ID 15-1990(Temp), f. & cert. ef. 7-3-90; ID 3-1991, f. & cert. ef. 4-18-91; ID 18-1992(Temp), f. 12-21-92, cert. ef. 1-2-93; Suspended by ID 2-1993(Temp), f. & cert. ef. 4-1-93; ID 10-1993, f. 10-1-93, cert. ef. 10-2-93

836-042-0225

Criteria for Grouping; Criteria for Substantially Similar Occupations Within Organization; Open Enrollment Required

An insurer may combine for rating purposes the experience of a group of employers which it covers for workers' compensation insurance only if:

(1) All employers in the group are members with full rights and privileges of the organization;

(2) The group satisfies all requirements of ORS 737.316.

Stat. Auth.: ORS 731.244 & 737.316

Stats. Implemented: ORS 737.316

Hist.: IC 2-1984, f. 1-18-84, ef. 2-1-84; ID 15-1990(Temp), f. & cert. ef. 7-3-90; ID 3-1991, f. & cert. ef. 4-18-91

836-042-0300

Statutory Authority; Purpose; Applicability; Effective Date

(1) OAR 836-42-300 to 836-042-0322 are adopted under the specific authority of the Insurance Commissioner in ORS 737.346, to make rules needed to allow mass marketing plans in personal lines casualty and property insurance.

(2) The purpose of these rules is to prevent abuses in connection with the sale of personal lines property-casualty insurance in this state under mass marketing plans, while preserving for consumers the potential benefits of this form of marketing. The rules also are to provide for an orderly procedure to carry out the provisions of ORS 737.346.

(3) OAR 836-042-0300 to 836-042-0322 apply only to insurance policies issued or renewed in this state after October 14, 1983, and is in addition to, and not instead of, other applicable requirements of the Insurance Code and Division rules. The requirements of OAR 836-042-0300 to 836-042-0322 do not apply to methods of marketing other than mass marketing plans.

(4) OAR 836-042-0300 to 836-042-0322 becomes effective October 14, 1983.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 737.346

Stats. Implemented: ORS 737.346

Hist.: IC 8-1983, f. & ef. 11-10-83; ID 15-1996, f. & cert. ef. 11-12-96

836-042-0302

Definitions

As used in OAR 836-042-0300 to 836-042-0322 unless the context requires otherwise:

(1) "Mass marketing plan" means a method of selling property-casualty personal lines insurance to members of a particular association which has agreed to or otherwise endorsed the sale of the insurance to its members.

(2) "Personal lines" means property and casualty insurance policies for personal, family or household purposes, and not for commercial or business purposes.

(3) "Property-casualty insurance" means insurance to which ORS 731.158 and 731.182 apply.

Stat. Auth.: ORS 731.244 & 737.346

Stats. Implemented: ORS 737.346

Hist.: IC 8-1983, f. & ef. 11-10-83; ID 15-1996, f. & cert. ef. 11-12-96

836-042-0304

Fictitious Arrangement Prohibited

(1) No insurer shall sell insurance under a mass marketing plan to members of any association without the approval of the Commissioner.

(2) The Commissioner will not approve any mass marketing plan unless it meets the requirements of ORS 737.346(3)(d).

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0306

Premium Rates

Premium rates under a mass marketing plan shall comply with the standards in the **Insurance Code** and shall not be excessive, inadequate, or unfairly discriminatory. Rates will not be deemed unfairly discriminatory when premiums differ between policy holders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates will not be deemed unfairly discriminatory if they are averaged broadly among persons insured under a mass marketing plan.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0308

Statistics

An insurer selling insurance under mass marketing plans shall maintain separate relevant statistics as to loss and expense experience.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0310

Producers

A person shall not act as an insurance agent in connection with a mass marketing plan for any kind of insurance unless such person is licensed as an agent to transact general lines insurance.

Stat. Auth.: ORS Ch. 731 & 744

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83; ID 3-1990, f. & cert. ef. 1-19-90

836-042-0312

Compulsory Participation Prohibited

No insurer shall sell insurance under a mass marketing plan if purchase under the plan is a condition of employment or of membership in any association, or if any employee or member would be subject to any penalty for non-participation.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0314

Tie-In Sales Prohibited

No insurer shall sell insurance under a mass marketing plan if:

(1) The purchase of insurance under the plan is contingent upon the purchase of any other insurance, product, or service; or

(2) The purchase or price of any other insurance, product, or service is contingent upon the purchase of insurance available under the plan. This provision does not prohibit the reasonable requirement of safety devices, such as heat detectors, lightning rods, theft prevention equipment and the like.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0316

Disclosure Required

Every insurer or agent selling insurance under a mass marketing plan shall, make full and fair disclosure to prospective insureds prior to sale of all features of the plan, whether favorable or unfavorable, including but not limited to premium rates, benefits, duration of coverage, policyholder services, conversion privileges available, and the financial interests in the plan, if any, of the association.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0318

Underwriting Standards

No insurer shall use substantially more restrictive underwriting standards for individual risk selection in a mass

marketing plan than the standards used by the insurer for individual risk selection in the sale in this state of the same kind of insurance under other plans. If the insurer does not sell the same kind of insurance in this state under other plans, its underwriting standards for individual risk selection in mass marketing plans shall not be substantially more restrictive than those standards used by its principal affiliate, if any.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0320

Cancellation and Non-Renewal

(1) For purposes of **Sections 743.905** and **743.916** of the **Insurance Code**, limiting the cancellation and non-renewal of insurance policies, the failure of an association, to remit premiums when due for any reason (including but not limited to interruption or termination of employment or membership) shall not be regarded as "non-payment of premium" by any insured under a plan providing for remittance of premium by such association, unless the insured has been given written notice of the failure to remit and has not paid the premium by ten days after such notice, or the due date of the premium remittance under the mass marketing plan, whichever is later.

(2) Every mass marketing plan shall provide that an insured may maintain the policy in force in the same amount, for 60 days after termination of employment or membership or discontinuance of the plan. The member would pay the premium applicable to the class of risk to which the member would belong as an individual. The option to maintain the insurance in force must be exercised within 30 days following the date of termination. Any notice of cancellation or non-renewal of a policy under a mass marketing plan shall include a notice to the insured member that the insurer will allow the association, a reasonable opportunity to consult with the insurer and to present facts in opposition to cancellation or non-renewal.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0322

Compulsory Facilities

An insurer or agent selling insurance under a mass marketing plan shall help any members who apply for but are denied insurance under the plan to obtain insurance through some other appropriate insurance plan, such as the assigned risk plan or the FAIR Plan.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 737.346(3)(d)

Hist.: IC 8-1983, f. & ef. 11-10-83

836-042-0400

Statutory Authority; Purpose; Applicability; Effective Date

(1) OAR 836-042-0400 to 836-042-0430 are adopted under the authority of ORS 737.346, as amended by Section 71, Chapter 774, Oregon Laws 1987, which requires the Director to make rules necessary for implementation of ORS 737.346.

(2) OAR 836-042-0430 is adopted to enable the Department to:

(a) Regulate the sale of casualty insurance in this state on commercial risks under group policies as authorized under ORS 737.346(3)(f);

(b) Regulate the sale of all forms of insurance subject to ORS 737.035 to day care facilities under group policies as authorized under ORS 737.346 (3)(g).

(3) OAR 836-042-0400 to 836-042-0430 become effective on adoption.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(f)-(g)

Hist.: ID 7-1987, f. & ef. 12-11-87

836-042-0405

Definitions

As used in OAR 836-042-0400 to 836-042-0430:

(1) "Casualty Insurance" as defined in ORS 731.158 and as used in ORS 836-042-0400 to 836-042-0430 means liability or casualty insurance as used in ORS 737.346(3)(f).

(2) "Rating System" means a collection of rating plans to be used by an insurer, rules for determining which rating plans are applicable to an insured, a classification system and other rules used by an insurer for determining contractual consideration for an insured.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(f)-(g)

Hist.: ID 7-1987, f. & ef. 12-11-87

836-042-0410

Commercial Risks; Prohibition; Requirements; Filing

(1) An insurer may not sell casualty insurance on commercial risks under a group policy to members of a group unless:

(a) The insurer has satisfied the filing requirements of this rule with respect to that policy; and

(b) The Director has approved the policy as meeting the requirements of ORS 737.346(3)(f).

(2) An insurer shall file the following with the Director with respect to each group policy of casualty insurance that the insurer proposes to sell:

(a) The name of the group and the common element among its members;

(b) The name of each member;

(c) A copy or a specific explanation of the risk management plan for the group;

(d) A specific explanation of the means by which the policy provides for reduced or returned premiums for members of the group;

(e) A specific description of the rating system to be used for rating group members.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(f)

Hist.: ID 7-1987, f. & ef. 12-11-87

836-042-0415

Day Care Facilities; Prohibition; Requirements; Filing

(1) An insurer may not sell insurance under a group policy to members of a group of day care facilities unless:

(a) The insurer has satisfied the filing requirements of this rule with respect to that policy; and

(b) The Director has approved the policy as meeting the requirements of OAR 836-042-0400 to 836-042-0430.

(2) An insurer shall file the following with the Director with respect to each group policy for day care facilities that the insurer proposes to sell:

(a) The name of the group;

(b) The name of each day care facility in the group;

(c) A description of the kind or class of insurance provided to the group;

(d) A copy or a specific explanation of the risk management plan for the group;

(e) A specific explanation of the means by which the policy provides for reduced or returned premiums for members of the group;

(f) A specific description of the rating system to be used for rating group members.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(g)

Hist.: ID 7-1987, f. & ef. 12-11-87

836-042-0420

Anniversary Filings

Not later than the 45th day before each anniversary of the effective date of each policy of insurance issued to a group under OAR 836-042-0400 to 836-042-0430, the insurer must file with the Director a statement whether premiums have been reduced or returned to the members in the group policy during the prior year.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(f)-(g)

Hist.: ID 7-1987, f. & ef. 12-11-87

836-042-0425

Statistics

(1) An insurer selling casualty insurance on commercial risks to groups shall maintain separate relevant statistics as to loss and expense experiences of the groups insured.

(2) An insurer selling insurance under group policies to members of groups of day care facilities certified under ORS 418.805 to 418.885 shall maintain separate relevant statistics as to loss and expense experiences of the groups insured. If the insurer also sells insurance under group policies to members of groups of days are facilities not required to be certified under ORS 418.805 to 418.885, the insurer shall maintain similar statistics for the groups of such day care facilities but shall maintain those statistics separate from the statistics for groups of certified day care facilities.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(f)-(g)

Hist.: ID 7-1987, f. & ef. 12-11-87

836-042-0430

Disclosure Required for Day Care Facilities

Every insurer selling insurance under a group policy for day care facilities shall make full and fair disclosure to prospective insureds, prior to sale, of all features of the plan, whether favorable or unfavorable, including but not limited to pricing and policyholder services.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.346(3)(g)

Hist.: ID 7-1987, f. & ef. 12-11-87

Rates and Ratemaking

836-042-0501

Statutory Authority; Purpose; Applicability; Effective Date

(1) OAR 836-042-0501 to 836-042-0520 are adopted pursuant to:

(a) The general rulemaking authority of the Director in ORS 731.244 as an aid to the effectuation of ORS 737.320(6) which enables the Director to require that filed rates, rating plans and rating systems be submitted to the Director for review prior to becoming effective; and

(b) The specific authority of the Director under ORS 737.207 to specify the markets of commercial liability insurance in which insurers and rating organizations must submit rate filings before they become effective if the average annual rate level increase or decrease for each market exceeds 15 percent.

(2) The purpose of OAR 836-042-0501 to 836-042-0520 is to moderate the sharp cyclical swings in the availability and affordability of commercial liability insurance. Such moderation is accomplished by requiring that insurers and rating organizations submit to the Director their filings of rates, rating plans and rating systems for a specified commercial liability insurance market for review before such filings become effective, if the average annual rate level increase or decrease for that market exceeds 15 percent.

(3) OAR 836-042-0501 to 836-042-0520 apply to all commercial liability insurance filings.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.207 & 737.320

Hist.: IC 4-1986(Temp), f. & ef. 4-21-86; IC 7-1986, f. 11-7-86, ef. 11-10-86; ID 4-1988(Temp), f. & cert. ef. 2-26-88; ID 14-1988, f. & cert. ef. 8-24-88; ID 15-1996, f. & cert. ef. 11-12-96

836-042-0505

Definitions

As used in OAR 836-042-0501 to 836-042-0520, unless the context requires otherwise:

(1) "Anniversary Rating Date" means the month and day that rates, rating plans and rating systems are initially applied to a policy in effect and each annual anniversary thereafter.

(2) "Annual Rate" means the total limits base rate per unit exposure.

(3) "Classification" means a grouping of insurance risks according to a classification system used by an insurer.

(4) "Classification System" means a schedule of classifications and a rule or set of rules used by an insurer for determining the classification applicable to an insured.

(5) "Commercial Liability Insurance" has the meaning set forth in ORS 731.074.

(6) "Premium" means the contracted consideration charged to an insured for insurance for a specific period of time regardless of the timing of actual charges.

(7) "Rating Plan" means a rule or set if rules used by an insurer to calculate premium for an insured, and the parameter values used in such calculation, after application of total limits base rates to units of exposure.

(8) "Rating System" means a collection of rating plans to be used by an insurer, rules for determining which rating plans are applicable to an insured, a classification system and other rules used by an insurer for determining contractual consideration for insured.

(9) "Total Limits Base Rate" means a monetary amount applied to the units of exposure basis assigned to a classification

and used by an insurer to determine the total limits premium for an insured, prior to any adjustment or adjustments resulting from the application of any rating plan.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.207(2) & 737.320(6)

Hist.: IC 4-1986(Temp), f. & ef. 4-21-86; IC 7-1986, f. 11-7-86, ef. 11-10-86; ID 4-1988(Temp), f. & cert. ef. 2-26-88; ID 14-1988, f. & cert. ef. 8-24-88

836-042-0510

Rates, Rating Plans System -- Prior Review

(1) An insurer or rating organization shall submit to the Director its filing of rates, rating plans and rating systems for a commercial liability insurance market specified in OAR 836-042-0512 prior to the effective date of the rates, rating plans and rating system if the average annual total limits rate level increase or decrease for such market exceeds 15 percent because of changes in any:

(a) Total limits base rates;

(b) Rating basis;

(c) Rating plans;

(d) Manual rules;

(e) Territorial definitions; or

(f) Combination of such rating system components, described in this section, or the compounding series of such changes applied at a date other than the anniversary rating date of a policy.

(2) Nothing in this rule applies to annual rate increases or decreases from:

(a) Change in hazard of the insured's operation;

(b) Change in magnitude of the exposure basis for the insured, (such as changes in payroll or sales, or other matters); or

(c) Application in parameter values provided for in a rating plan approved by the Director, including those approved prior to August 24, 1988.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.207(2) & 737.320(6)

Hist.: IC 4-1986(Temp), f. & ef. 4-21-86; IC 7-1986, f. 11-7-86, ef. 11-10-86; ID 4-1988(Temp), f. & cert. ef. 2-26-88; ID 14-1988, f. & cert. ef. 8-24-88

836-042-0512

Specified Commercial Liability Markets

The conditions for a prior review in OAR 836-042-0510 apply to:

(1) Average annual rate level increases greater than 15 percent for the following commercial liability markets:

(a) Products liability;

(b) Medical professional liability;

(c) Professional liability other than medical professional liability;

(d) Liquor law liability;

(e) Child care liability;

(f) Directors and officers liability;

(g) Recreational liability;

(h) Non-profit philanthropic and civic activity liability;

(i) Commercial automobile long haul trucking liability;

(j) Municipal liability;

(k) Public official liability.

(2) Average annual rate level decreases greater than 15 percent for all commercial liability markets except for commercial automobile policies and package insurance policies (such as commercial multi-peril and business owners policies).

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.207(1)-(2) & 737.320(6)

Hist.: ID 4-1988(Temp), f. & cert. ef. 2-26-88; ID 14-1988, f. & cert. ef. 8-24-88

836-042-0515

Commercial Liability Filings -- Procedural Rules for Insurers and Rating Organizations

(1) Each filing of a commercial casualty insurance premium rate, rating plan or rating system that is certified by a member of the American Academy of Actuaries or by an executive officer of the entity making the filing as not being subject to OAR 836-042-0510(1) shall become effective on the date specified in the filing but not earlier than the date the filing is received by the Director.

(2) Each filing of commercial liability insurance rate, rating plan or rating system that does not satisfy the condition of section (1) of this rule and the requirements of OAR 836-042-0520 and each filing subject to OAR 836-042-0510(1) must be submitted to the Director for review prior to becoming effective.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.207(3) & 737.320(6)

Hist.: IC 4-1986(Temp), f. & ef. 4-21-86; IC 7-1986, f. 11-7-86, ef. 11-10-86; IC 1-1986, f. & ef. 1-21-87; ID 4-1988(Temp), f. & cert. ef. 2-26-88; ID 14-1988, f. & cert. ef. 8-24-88

836-042-0520

Supporting Data

Supporting actuarial data shall accompany every filing of a commercial liability insurance rate, rating plan and rating system. The data shall be in sufficient detail to:

(1) Demonstrate compliance with ORS 737.207; and

(2) Demonstrate the statistical significance of differences or correlations relevant to rating plan definitions and rate differentials.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.207(4) & 737.320(6)

Hist.: IC 4-1986(Temp), f. & ef. 4-21-86; IC 7-1986, f. 11-7-86, ef. 11-10-86; ID 4-1988(Temp), f. & cert. ef. 2-26-88; ID 14-1988, f. & cert. ef. 8-24-88

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 43

RATING AND RATING ORGANIZATIONS (WORKERS'

COMPENSATION INSURANCE ASSIGNED RISK PLAN -- ORS CHAPTER 737)

836-043-0001

Statutory Authority; Purpose;

(1) OAR 836-043-0001 to 836-043-0091 are adopted by the Insurance Commissioner pursuant to the authority and requirements of ORS 656.427, 656.730 and 731.244 for the purpose of implementing ORS 656.427, 656.730 and 737.265, and may be cited as the Oregon Workers' Compensation Insurance Plan (the "Plan" or "WCIP").

(2) The Oregon Workers' Compensation Insurance Plan provides for the equitable apportionment among workers' compensation insurers of employers who are in good faith entitled to workers' compensation insurance, but who are unable to procure such insurance in a regular manner.

(3) The Plan applies to all authorized workers' compensation insurers and the State Accident Insurance Fund Corporation, their agents and the Plan Administrator.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: IC 1-1979(Temp), f. & ef. 10-12-79; IC 1-1980, f. & ef. 1-15-80; IC 1-1982, f. 1-15-82, ef. 7-1-82; ID 10-1989(Temp), f. & cert. ef. 11-3-89; ID 7-1990, f. 4-30-90, cert. ef. 5-1-90; ID 18-1990(Temp), f. & cert. ef. 8-6-90; ID 1-1991, f. & cert. ef. 2-19-91; ID 13-1992, f. & cert. ef. 8-12-92; ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0005

Definitions for the Workers' Compensation Insurance Plan

As used in OAR 836-043-0001 to 836-043-0091:

(1) "Affiliated insurer" or "affiliate" means an insurer that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, another insurer, and is required to participate in the Plan pursuant to OAR 836-043-0009. For purposes of this definition, the term "control" means possession, direct or indirect,

of the power to direct or cause the direction of the management and policies of an insurer, whether through the ownership of voting securities, by contract or otherwise. Control shall be deemed to exist if any person or business enterprise, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing ten percent or more of the voting securities of any other insurer.

(2) "Articles of Agreement" or "Articles" means the National Pool reinsurance mechanism that is filed with and approved by the Insurance Commissioner and that is authorized under this Plan to provide reinsurance to the servicing carriers on employers assigned to them under the Plan.

(3) "Assigned carrier" means the insurer that has been assigned to provide coverage to an employer who has applied for workers' compensation insurance pursuant to a Plan in a state other than Oregon.

(4) "Client" means any person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(5) "Employer" means any business organization or enterprise that has a statutory right to maintain workers' compensation insurance in this state. The term shall include any business organization or enterprise that is affiliated as a result of common management or ownership. The term includes a client business of a worker leasing company as established in ORS 656.850.

(6) "Insurer" includes the State Accident Insurance Fund Corporation.

(7) "National Council on Compensation Insurance, Inc." and "NCCI" mean a rating organization that is licensed in this state to make and file rates, rating values, classifications and rating plans for workers' compensation insurance, and is an organization that authorized workers' compensation insurers may be members for the purpose of satisfying ORS 737.560.

(8) "National Workers' Compensation Reinsurance Pool" or "National Pool" means the nonprofit unincorporated association of insurers that serves as a reinsurance facility for workers' compensation insurance in a number of states and that is administered by the National Council on Compensation Insurance, Inc.

(9) "Net premiums written" means the gross direct premiums charged less all premiums (except dividends and savings refunded under participating policies) returned to insureds for all workers' compensation and occupational disease insurance, exclusive of premiums for employers subject to the Plan, and for employers written under the National Defense Projects Rating Plan and under excess policies.

(10) "Plan" means the Oregon Workers' Compensation Insurance Plan.

(11) "Plan Administrator" means the organization designated in OAR 836-043-0017, and its agents.

(12) "Servicing carrier" means an insurer, including the State Accident Insurance Fund Corporation, approved by the Insurance Commissioner that has been assigned to provide coverage to an eligible employer who has applied for workers' compensation insurance pursuant to the Plan.

(13) "Undisputed premium obligation" means a workers' compensation insurance premium obligation that is not the subject of a bona fide dispute pursuant to ORS 737.318 or ORS 737.505 or by a judicial action, and for which there is no written payment plan in effect between an insurer and employer.

(14) "Workers' compensation insurance" means:

(a) Statutory workers' compensation and occupational disease liability insurance, including insurance for liability under the Longshore and Harbor Workers' Compensation Act, as amended, and the Federal Coal Mine Health and Safety Act of 1969, as amended;

(b) Employers liability insurance written in connection with a workers' compensation insurance policy; and

(c) Such additional coverages as determined by the Plan Administrator and approved by the Commissioner.

(15) "Workers' Compensation Rating System Review and Advisory Committee" means the committee established pursuant to OAR 836-043-0200 to hear employer grievances pursuant to ORS 737.505.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: IC 1-1979(Temp), f. & ef. 10-12-79; IC 1-1980, f. & ef. 1-15-80; IC 1-1982, f. 1-15-82, ef. 7-1-82; ID 10-1989(Temp), f. & cert. ef. 11-3-89; ID 7-1990, f. 4-30-90, cert. ef. 5-1-90; ID 18-1990(Temp), f. & cert. ef. 8-6-90; ID 1-1991, f. & cert. ef. 2-19-91; ID 13-1992, f. & cert. ef. 8-12-92; ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0009

Participation by Insurers and Agents

(1) All insurers authorized to transact workers' compensation insurance in this state are required to participate in the Plan and subscribe to the Articles of Agreement for this state.

(2) Failure of an insurer to comply with the Plan is grounds for revocation of the insurer's certificate of authority to transact workers' compensation insurance.

(3) Each agent who is authorized to transact the class of general lines insurance is authorized to transact workers' compensation insurance offered by the Plan. The Insurance Commissioner may terminate an agent's authority under this section for cause.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; Renumbered from 836-043-0016

836-043-0017

Plan Administrator

(1) The Plan Administrator is a rating organization for workers' compensation insurance in this state that is designated as the plan administrator by the Insurance Commissioner. The Plan Administrator shall continue to serve from the effective date of the Plan unless the Plan Administrator resigns. The Plan Administrator must give advance written notice of its resignation to the Insurance Commissioner at least one year in advance of the effective date of resignation.

(2) The Plan Administrator has the following duties and responsibilities in addition to any others set forth in the Plan and the Articles of Agreement:

(a) Administering, managing and enforcing the Plan, subject to the rules governing the Plan;

(b) Determining the methodology and formula for making assignments to servicing carriers pursuant to OAR 836-043-0060 and securing the necessary information in order to make the assignments;

(c) Processing assigned risk applications, determining eligibility for coverage and binding coverage pursuant to the requirements of the Plan;

(d) Establishing eligibility criteria for servicing carriers and selecting servicing carriers, subject to approval by the Commissioner;

(e) Establishing written performance requirements for servicing carriers, subject to approval by the Commissioner, including, but not limited to:

(A) Verification of ongoing Plan eligibility of the employer;

(B) Issuance of policies and endorsements;

(C) Filings with administrative agencies;

(D) Maintenance of premiums on policies, consistent with manual rules, rates, rating plans, and classifications;

(E) Completion and billing of final audits;

(F) Collection of premium;

(G) Claim services, including investigation, disability management and medical cost control;

(H) Loss control services and safety information to encourage employers to make safety a part of their business;

(I) Payment of agent fees;

(J) Issuance of renewal proposals and non-renewal notices;

(K) Assurance of insured and insurer compliance with all terms and conditions of the policy contract;

(L) Resolution of complaints and response to insured and agent inquiries; and

(M) Reporting financial and statistical data;

(f) Monitoring servicing carrier performance and enforcing performance requirements and incentives;

(g) Administering the dispute resolution mechanism as provided in OAR 836-043-0070;

(h) Developing and implementing assigned risk operating rules and forms to the extent necessary to carry out the purposes of the Plan;

(i) Informing the Insurance Commissioner of any insurer that is not participating in this Plan; and

(j) Monitoring the performance and operation of the Plan and initiating amendments thereto as appropriate.

(3) The Plan Administrator shall also publish and make available to all affected insurers and agents, upon request and at no charge, both the necessary information for placement in the Plan and the listings of all employers that have been placed into the Plan. The listings shall include each employer's name, address, policy expiration date, latest experience modification, if applicable, the ARAP factor and the governing class code.

(4) The Plan Administrator shall monitor compliance by servicing carriers with occupational safety and health consultative service requirements of ORS 731.480. The Plan Administrator shall file with the Insurance Commissioner by May 1 of each year a report regarding such compliance for the preceding calendar year. The Plan Administrator shall also determine the expenses for operation of the Plan, not including the Plan Administrator's expenses incurred in connection with responsibilities it has under the Articles, and shall assess each insurer participating in the Plan for those expenses on an equitable basis as determined by the Plan Administrator.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; Renumbered from 836-043-0030

836-043-0021

Servicing Carriers

(1) The Plan Administrator shall establish written requirements that insurers must meet in order to be eligible to act as a servicing carrier. From among those insurers that are eligible and have applied to act as a servicing carrier, and subject to approval by the Insurance Commissioner, the Plan Administrator shall select a sufficient number of servicing carriers that are needed to handle the assignments made pursuant to the Plan. Subject to approval by the Insurance Commissioner, the Plan Administrator may terminate the servicing carrier status of any insurer that fails to meet the servicing carrier requirements on a continuing basis.

(2) Each servicing carrier shall provide a report to the Plan Administrator in such a format and for such a period as determined by the Plan Administrator, but not less than semiannually. This report, among other things, shall provide information on the servicing carrier's operations related to Plan business in the following areas: underwriting, auditing, claims, loss control, premium collection and customer service. A summary of such reports shall be provided to the Commissioner.

(3) The Plan Administrator shall establish written minimum levels of acceptable performance for servicing carriers and shall establish procedures for measuring servicing carrier performance. Servicing carriers shall manage losses in compliance with the performance standards established hereunder. The Plan Administrator shall also establish the compensation for servicing carriers which shall take into consideration, among other things, provisions for:

(a) Rewarding servicing carriers for positive action targeted at reducing losses and costs;

(b) Disincentives for inefficiencies and poor service; and

(c) Servicing carrier capacity.

(4) Monitoring and enforcement are subject to the following provisions:

(a) The Plan Administrator shall monitor and review servicing carrier performance by:

(A) Reviewing the operations reports;

(B) Requiring and reviewing self-audits;

(C) Conducting on-site audits; and

(D) Reviewing any other information available that relates to the servicing carrier;

(b) The Plan Administrator shall require servicing carriers to maintain desired performance levels and shall take appropriate remedial action where necessary including, but not limited to, establishment and administration of a progressive discipline program which may lead to terminating an insurer's servicing carrier status;

(c) Termination of an insurer's servicing carrier status is subject to Insurance Commissioner approval;

(d) Any formal action taken by the Plan Administrator under this rule shall be the exclusive remedy and in lieu of any other penalty or sanction that may apply under the Plan;

(e) Any action taken by the Plan Administrator under this provision is subject to review under OAR 836-043-0070; and

(f) In order to fulfill its responsibilities under this Plan, the Plan Administrator shall have the right, itself or through authorized representatives, at all reasonable times during regular business hours, to audit and inspect the books and records of any servicing carrier with respect to any policies, claims, or related documents coming within the purview of the Plan, or the Articles.

Stat.Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96, Renumbered from 836-043-0040

836-043-0024

Right to apply

(1) An employer may apply to the Plan Administrator for workers' compensation insurance under the Plan as provided in this rule if the employer is unable to obtain an offer of workers' compensation insurance in a regular manner from an insurer who is authorized to transact and is actively transacting workers' compensation insurance in this state, and if the employer is eligible for coverage under the Plan.

(2) An employer seeking coverage under the Plan must apply to the Plan Administrator not later than the 60th day after the date on which the employer is declined coverage as provided in section (1) of this rule. The right of an employer to apply to the Plan Administrator does not apply when the employer is declined coverage by the insurer providing workers' compensation insurance to the employer at the time of application to the Plan Administrator.

(3) For purposes of section (1) of this rule, the offer of insurance with premium determined by any rating plan approved for use in this jurisdiction is an offer of insurance in a regular manner.

(4) For purposes of section (1) of this rule, an employer is presumed to be eligible in the absence of clear and convincing evidence to the contrary. An employer is not eligible if any of the following circumstances exists at the time of application or thereafter:

(a) At the time of application, the employer is a self-insured employer and is aware of pending bankruptcy proceedings, insolvency, cessation of operations or conditions that will probably result in occupational disease or cumulative injury claims from exposures incurred while the employer was self-insured;

(b) The employer, while insurance issued under the Plan is in force, knowingly refuses to meet reasonable health, safety or loss control requirements, does not allow the servicing carrier reasonable access for audit or inspection under the policy or does not comply with any other policy obligation;

(c) The employer has an outstanding workers' compensation insurance premium obligation or other monetary policy obligation on previous workers' compensation insurance that is not subject to a bona fide dispute; or

(d) The employer or its agent knowingly makes a material misrepresentation on the application by omission or otherwise, including but not limited to estimated payroll, offers of workers' compensation insurance, nature of business, name or ownership of business, premium insurance history, or an outstanding workers' compensation insurance premium obligation or other monetary policy obligation of the employer.

(5) An employer may apply to the Plan Administrator for coverage by electronic transmission or telephone, as provided by OAR 836-043-0028, or by United States mail or a private overnight mail delivery company as provided by OAR 836-043-0032. An application must be made on the forms and according to the directions prescribed in Exhibits 1, 2 and 3 to this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0028

Application by Electronic Transmission or Telephone

(1) An application made by electronic transmission or telephone must be completed in full and must be signed. The signature may be submitted by facsimile transmission. The application may include a requested date for the coverage to become effective pursuant to OAR 836-043-0044.

(2) Upon receiving an application, the Plan Administrator shall review the application for completeness and determine whether the employer is eligible for coverage under the Plan. If the employer is ineligible, the Plan Administrator shall so inform the employer. If the employer is eligible, the Plan Administrator shall calculate the initial premium and inform the employer or its agent of the applicable premium and the submission options identified by the Plan Administrator. The Plan Administrator shall refer to the Oregon State Instruction page of the application (Exhibit 3 to OAR 836-043-0024) for the minimum deposit percentage, and the percentage determined shall be the initial premium.

(3) The employer or its agent must submit the total required initial premium to the Plan Administrator by electronic funds transfer, mail-in check or verbal check. A portion of the deposit premium may be satisfied with an authorized surety's financial guaranty bond, but the cash portion shall be no less than either the minimum premium or 25 percent of the required premium, whichever is greater. The applicant may select any minimum deposit percentage listed in the Oregon State Instructions page (Exhibit 3 to OAR 836-043-0024) and post a bond for the premium difference between that percentage and the minimum deposit percentage otherwise applicable. If the application is otherwise complete and the Plan Administrator determines that the employer is eligible for coverage, in order for coverage to be bound on the effective date requested under section (1) of this rule, the initial premium must be received by the Plan Administrator not later than the fifth business day after the Plan Administrator notifies the employer or its agent of the amount of the initial premium.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0032

Nonelectronic Application

(1) An application made by United States mail or a private overnight mail delivery company must be completed in full and must be signed. The application must include the deposit premium as calculated by the employer or its agent. The application may include a requested date for the coverage to become effective. A portion of the deposit premium may be satisfied with an authorized surety's financial guaranty bond, but the cash portion shall be no less than either the minimum premium or 25 percent of the required premium, whichever is greater. The applicant may select any minimum deposit percentage listed in the Oregon State Instructions page (Exhibit 3 to OAR 836-043-0024) and post a bond for the premium difference between that percentage and the minimum deposit percentage otherwise applicable.

(2) The employer or its agent shall refer to the Oregon State Instruction page (Exhibit 3 to OAR 836-043-0024) of the

application for the minimum deposit percentage for the purpose of determining the amount of the deposit premium to be submitted by the employer.

(3) Upon receiving an application, the Plan Administrator shall review the application for completeness and determine whether the employer is eligible for coverage under the Plan. If the employer is ineligible or the application incomplete, the Plan Administrator shall so inform the employer or its agent.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0036

Facsimile Transmission

Until July 1, 1997, in addition to the application methods authorized in OAR 836-043-0024(5), an employer may apply to the Plan Administrator for coverage by facsimile transmission. An application by facsimile transmission:

(1) Must be made on the forms and according to the directions prescribed in Exhibits 1, 2 and 3 to OAR 836-043-0024; and

(2) Is subject to the provisions of OAR 836-043-0028 and 836-043-0044.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0037

Operative Dates for Transmission Methods

(1) An employer may apply to the Plan Administrator for coverage by telephone on and after July 1, 1996.

(2) An employer may apply to the Plan Administrator for coverage by electronic transmission on and after November 1, 1996.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0041

Application Review

(1) For the purpose of reviewing an application, the Plan Administrator may request additional information to establish eligibility, to assign appropriate classification codes, to calculate applicable premiums and to otherwise appropriately

process the application. Information may include tax documentation, ownership information, contracts, prior policy information including claims and audits, corporate charters, D and B reports, signed financial statements and signed letters of explanation.

(2) The employer or its agent shall provide information and documentation requested by the Plan Administrator or provide an acceptable explanation for failure to provide the requested items not later than the second business day after the request or upon the mutually agreed-upon date.

(3) The Plan Administrator may return an incomplete application to the employer or its agent for completion or, with notice to the employer or its agent, the Plan Administrator may retain the application pending receipt of further information. The Plan Administrator may reject an application if the employer fails to comply in a timely manner with a request from the Plan Administrator

(4) An employer or its representative shall maintain on record for the policy period the name of the insurer that declined the employer, and the contact person, address, phone number and date of contact, and make such information available to the Plan Administrator or servicing carrier upon request.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0044

Binding Coverage

(1) The Plan Administrator shall bind coverage for an employer if the Plan Administrator determines that the employer is eligible for coverage, the application is complete and signed and the initial premium or deposit premium is paid.

(2) The effective date of coverage of an employer applying for coverage by electronic transmission or telephone, other than an employer that was self-insured, is the later of the following dates but in any event must not be later than the 60th day after the date of application:

(a) 12:01 a.m. on the date following receipt by the Plan Administrator of a complete application;

(b) The date of expiration of existing coverage; or

(c) A date requested by the employer.

(3) The effective date of coverage of an employer applying for coverage by nonelectronic means, other than an employer that was self-insured, is the later of the following dates but in any event must not be later than the 60th day after the date of application:

(a) 12:01 a.m. on the day following the date of the postmark or equivalent receipt date on the envelope in which the application and check for the deposit premium is mailed;

(b) The date of expiration of existing coverage; or

(c) A date requested by the employer.

(4) The effective date of coverage of an employer applying for coverage by nonelectronic means, other than an employer that was self-insured, when there is no postmark or equivalent receipt date, is the later of the following dates, but in any event must not be later than the 60th day after the date of application:

(a) 12:01 a.m. on the date following receipt by the Plan Administrator of a complete application;

(b) The date of expiration of existing coverage; or

(c) A date requested by the employer.

(5) Subject to the review by the servicing carrier, an employer that was self-insured may request and obtain an effective date that is not later than 12:01 a.m. of the 60th day after the date on which the Plan Administrator receives a complete application.

(6) If the Plan Administrator fails to issue a binder to an eligible employer by the 14th day after receiving a completed application and the total initial or deposit premium, coverage is bound at 12:01 a.m. on the later of the dates specified in section (2) of this rule.

(7) The Plan Administrator shall send the binder as authorized under ORS 742.043(3), to the employer, the agent, the Compliance Section of the Workers' Compensation Division of the Department of Consumer and Business Services and the servicing carrier to which the Plan Administrator assigned the coverage. The binder remains in effect until canceled or a policy is issued.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0046

Rates and Forms, Policy Term, Additional Coverages and Other Provisions

(1) An insurer issuing a policy to an employer to which the Plan applies shall write the policy according to the classifications, forms, rates and rating plans recommended by the Plan Administrator and approved by the Commissioner, and required in ORS 737.265 (2). Each policy must be in writing and must be issued prior to expiration of the binder.

(2) The policy information page and all endorsements must be properly identified as a WCIP or AR (Assigned Risk) policy, and policy information submitted on hard copy must show the WCIP or AR indicator directly above the policy number on the Information Page. The Policy Information Page and all endorsements must be filed with the Plan Administrator or its designee on or before the date and in the format established by the Plan Administrator.

(3) The servicing carrier shall issue a policy and related guaranty contract, if any, for a term of at least one year, unless insurance for a shorter term has been requested. A short-term policy may be obtained only once within a 12-month period unless otherwise agreed by the servicing carrier.

(4) The servicing carrier may make additional coverages described in the Supplement to the Plan available to an employer, as shown in the WCIP Supplement at the end of the Plan for the coverages available in each state.

(5) The servicing carrier shall affix to each policy issued under the Plan the "Amendment to Coverage B Endorsement--Oregon" (NCCI form filing effective August 1, 1976).

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0048

Additional States' Coverage

Except as shown on the binder or verification page, all assignments under the plan are to be made on an intrastate basis. An employer seeking information for operations in one or more states other than the state covered by its servicing carrier may request its servicing carrier to furnish insurance in the additional states in accordance with OAR 836-043-0050 and the Interstate Assignments section of the Plan.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0050

Interstate Assignments

(1) A request by an employer for workers' compensation insurance in one or more other states is subject to the following provisions:

(a) Any employer assigned under this Plan and desiring workers' compensation insurance for operations in states other than that covered by the Plan may request its servicing carrier to furnish such insurance in such additional states. Workers' compensation insurance in such additional states may be written by the servicing carrier on a voluntary basis and in accordance with the law, rates, rules, classifications, and regulations applicable to the voluntary workers' compensation market in those states;

(b) If the servicing carrier does not wish to provide the insurance on a voluntary basis, such servicing carrier may provide assigned risk coverage in such additional states subject to the following:

(A) Workers' compensation insurance may be provided only in accordance with OAR 836-043-0001 to 836-043-0091 in those states that have a Workers' Compensation Insurance Plan that is similar to this Plan and that allows employers applying for coverage under those Plans to obtain coverage for operations in this state;

(B) A servicing carrier providing such insurance shall collect all premiums due on operations located in such other states. The effective date of such insurance in such additional states shall be the day after premium is received; however, in the event coverage in such additional states is on an "if any" basis, the effective date of such coverage shall be the day following receipt of an acceptable request for such insurance by the servicing carrier. A copy of the policy Information Page and all endorsements, properly identified as a WCIP or AR (Assigned Risk) policy, shall be submitted to the appropriate Plan Administrator having jurisdiction in the state where the coverage is effected;

(C) The rates, rating plans, classifications, and policy forms used to provide coverage in such additional states shall be those applicable to residual market and are on file and have been approved by the regulators in those additional states and authorized for use in the residual market by the Plan Administrator;

(D) The servicing carrier must be a signatory to an agreement providing reinsurance for residual market employers similar to the Articles of Agreement in each state where the coverage shall be provided; and

(E) A servicing carrier unwilling or unable to provide insurance for an employer in additional states either on a voluntary basis or in accordance with paragraph (A) of this subsection shall refer the request to the Plan Administrator.

(2) Multistate policy procedure at the time of application:

(a) An employer who applies for workers' compensation insurance under another state's Workers' Compensation Insurance Plan may purchase coverage for operations in this State without meeting the application requirements of this Plan, provided:

(A) The employer qualifies for such insurance under the other state's Plan;

(B) The employer is in good faith entitled to insurance under this Plan;

(C) The other state's Plan is similar to this Plan;

(D) That Plan also provides for interstate assignments; and

(E) The payroll for the employer's operation in this state is not greater than the payroll in the other state;

(b) The rates, rating plans, classifications and policy forms used to provide coverage in this state shall be those that are applicable to residual market risks in this state and are on file and have been approved by the Insurance Commissioner and authorized for use in the residual market by the Plan Administrator;

(c) The administrator of the other Plan is authorized to assign employers with operations in this State to the other Plan's assigned carriers, subject to the following conditions:

(A) The assigned carrier must be a signatory to the Articles of Agreement in this state. In addition, if the payroll for the employer's operation in this state is greater than $250,000, the assigned carrier must also be a servicing carrier in this state. If there is no eligible servicing carrier in this state that is also an insurer in the state of assignment, then the Plan Administrator may remove the payroll limitation or may require the employer to submit a separate application for coverage in this state; and

(B) The other state's Plan must give the Plan Administrator in this State similar authority to make interstate assignments; and

(d) With regard to interstate assignments and policies, this Plan shall have jurisdiction over all disputes resulting from the application of rules, programs, and procedures that are specific to this state. Disputes regarding application requirements shall be under the jurisdiction of the state's Plan where the application was filed.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0053

Premium Obligations

(1) The Plan Administrator shall not knowingly make an assignment unless the employer has met all undisputed workers' compensation premium obligations on any previous insurance to any servicing carrier, direct assignment carrier or voluntary insurer. After policy issuance, if an employer does not meet all undisputed workers' compensation insurance premium obligations under the current policy or previous assigned risk or voluntary policies, the employer's present servicing carrier retains the right to cancel a policy currently in force under the plan.

(2) When an employer with a prior undisputed workers' compensation premium obligation is a client of a worker leasing company as established in ORS 656.850 that is insured by the Plan, the servicing carrier may instruct the worker leasing

company to issue a client cancellation notice to the Workers' Compensation Division, with a copy to the client and a copy to the servicing carrier. Such a cancellation is effective on the 30th day after receipt of notice by the Workers' Compensation Division unless the client pays the prior premium debt or obtains coverage in the voluntary insurance market before the 30th day. When a worker leasing company fails to issue the requested client cancellation notice within 20 days of the request, the servicing carrier may cancel the worker leasing company policy.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0056

Insurer Termination of Guaranty Contracts or Surety Bonds

The following provisions of this rule govern when an insurer terminates a guaranty contract or surety bond:

(1) An insurer terminating coverage under ORS 656.427 for an employer who has an undisputed premium obligation not more than 30 days past due shall take the following actions:

(a) At the time the insurer gives notice of the termination, the insurer shall notify the employer of the right to placement in the Plan;

(b) Provide the employer, not later than the tenth day after the employer's contact for Plan coverage, an accurately filled-in "Request for Coverage" form, using the form prescribed in Exhibit 2 to OAR 836-043-0024; and

(c) The insurer shall date stamp the request for coverage identifying the insurer's name and forward the form to the Plan administrator with payment, not later than the fifth day after receiving the signed request form from the employer.

(2) An employer or its agent desiring Plan coverage, whose coverage is being terminated under ORS 656.427 and who does not have an undisputed premium obligation more than 30 days past due, shall:

(a) Give notice to the canceling or nonrenewing insurer, prior to the termination of coverage, that the employer intends to become an insured employer under the Plan; and

(b) Verify coverage elections and other information provided in the Request for Coverage form (Exhibit 2 to OAR 836-043-0024), and sign the request form and return the form with the deposit premium check to the canceling or nonrenewing insurer before termination of coverage or not later than the tenth day after the insurer issues the Request for Coverage form, if later.

(3) The Plan Administrator shall process the Request for Coverage form received with a deposit premium prior to the coverage termination date in the manner provided for a Plan application, except that the Plan Administrator shall bind coverage under the Plan for Request for Coverage upon the date of receipt of the form by the canceling or nonrenewing insurer in accordance with this rule or the termination date of previous coverage, if later.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0060

Assignment Formula

This rule describes the mechanism used to provide for the random and equitable distribution of employers under the Plan to servicing carriers. When participation under the Articles of Agreement is required by rule or by operation, distribution is based on each servicing carrier's share of the total net direct written premium of all insurers participating in the Plan in this state. When assigning an employer to an insurer, the Plan Administrator must consider the employer's prior Plan coverage, special requirements, such as additional states or federal coverage, and premium size. The Plan Administrator may override the random assignment process to ensure the availability of requested Plan coverages to the employer.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0062

Issuance and Continuation of Policy

A policy must be issued, renewed or reinstated without a lapse in coverage when premium is received by the carrier or postmarked by the United States Postal Service prior to the policy effective date or cancellation date.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0064

Renewal, Nonrenewal

Not later than the 45th day prior to the expiration date of insurance, the servicing carrier shall send a renewal proposal or notice of impending expiration of coverage to the insured, agent and the Plan Administrator. If this requirement conflicts with a state law or rule, the more stringent provision shall apply. Upon receipt of the required premium the policy shall be issued in the normal manner and a copy of such policy and all endorsements, properly identified as a WCIP or AR (Assigned Risk) policy, shall be furnished to the Plan Administrator or its designee within the time and in the format established by the Plan Administrator. Deposit premium paid by an employer in the Plan must be applied against the deposit required for a renewal policy, if any. If the servicing carrier assigned the renewal policy is different from the previous servicing carrier, then the previous servicing carrier shall promptly bill the employer for the final billing period, including any audit adjustments. If the final billing is not paid on or before the 30th day after the billing, the renewal servicing carrier may immediately issue a cancellation notice.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0066

Reassignment

(1) An employer who is dissatisfied with the servicing carrier may request reassignment to another insurer as provided in this rule. The employer must submit the request to the Plan Administrator not later than the 30th day and not earlier than the 60th day prior to the expiration of the current policy unless the Plan Administrator approves another request period. The employer must submit a new application for coverage in the Plan as provided in OAR 836-043-0028 or 836-043-0032. The employer must also provide the Plan Administrator with a reason or reasons for the request with appropriate documentation.

(2) The request for reassignment and the reason or reasons given for the request are subject to approval by the Plan Administrator. The reassignment shall be made on a random basis.

(3) A servicing carrier that is unwilling to renew an employer assigned to it shall notify the employer and the Plan Administrator not later than the 45th day prior to the date of expiration, or the number of days required by state statute if more stringent, giving a reason or reasons acceptable to the Plan Administrator.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0068

Cancellation

(1) The servicing carrier may cancel a policy after its issuance, with the approval of the Insurance Commissioner, for any of the reasons stated in this section. The servicing carrier must first provide an opportunity for cure and must file the reasons for cancellation with the Insurance Commissioner for necessary approval before issuance of the cancellation notice and inform the Plan Administrator of the reason for the cancellation. A proposed cancellation shall be deemed approved unless disapproved by the Insurance Commissioner on or before the 15th day after the servicing carrier filed the reasons for cancellation. The reasons for cancellation under this section are as follows:

(a) The employer has failed to comply with reasonable health, safety and loss control requirements; or

(b) The employer has violated any of the terms and conditions under which the insurance was issued.

(2) The servicing carrier may cancel a policy without the approval of the Insurance Commissioner when cancellation is for any of the following reasons:

(A) Nonpayment of Plan premium, except that a servicing carrier must provide a minimum of 30 days' notice of additional premium owed prior to the obligation becoming past due;

(B) Failure to complete, submit and pay a payroll report due the insurer, if the insurer has given the employer the following notice:

Important Notice:

This Policy is subject to periodic payroll reporting. Reports will be sent to you in accordance with the section entitled "Reporting Frequency" on the Information Page of your policy. Your failure to complete, submit and pay these reports to the insurance company when due may result in cancellation of your policy; or

(C) Nonpayment of a premium finance agreement, as defined in ORS 746.405 with notice pursuant to ORS 656.427.

(3) An insured employer whose coverage is canceled as provided in this rule must reestablish eligibility or must demonstrate entitlement to the Plan Administrator before any further assignment can be made under the Plan.

(4) If an employer fails or refuses to file any report of payroll required by the servicing carrier, the servicing carrier may estimate the payroll and make demand for premiums due thereon. If the required report and the premium due thereon are not received within ten days of actual notice of demand, the employer shall be considered in default of premium payment.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0070

Dispute Resolution Procedure

(1) Any person affected by the operation of the Plan including, but not limited to, participating insurers, employers, agents and assigned carriers, who has a dispute with respect to any aspect of the Plan, including any dispute arising under the Articles of Agreement or any dispute concerning the insuring of employers, may seek a review of the matter by the Plan Administrator by setting forth in writing with particularity the nature of the dispute, the parties to the dispute, the relief sought and the basis thereof. The Plan Administrator may secure additional information that it needs to make a decision.

(2) An appeal from an employer and insurer on a Plan matter regarding an individual employer dispute is subject to ORS 731.240, ORS 737.340 or 737.505 as applicable. Any other dispute shall be handled as follows:

(a) If the dispute relates to the general operation of the Plan, including the established classification, rates or rating data and excluding individual employer disputes, disputes arising under the Articles of Agreement, and disputes pertaining to the selection of servicing carriers, the Plan Administrator shall review the matter and render a written decision with an explanation of the reasons for the decision not later than the 30th day after receipt of all the information necessary to make the decision. Any party affected by a decision made by the Plan Administrator may seek binding arbitration for such purpose, or in the alternative, the party may seek a de novo review by the Insurance Commissioner by requesting such review, in writing, not later than the 30th day after the date of the decision; and

(b) Except as provided in section (3) of this rule, if the dispute arises under the Articles of Agreement, the Administrator designated under the Articles of Agreement shall first review the matter and render a written decision with an explanation of the reasons for the decision not later than the 30th day after receipt of all the information necessary to make the decision. Any party affected by the decision may seek a review by the Board of Governors established under the Articles by requesting such review, in writing, not later than the 30th day after the date of the decision by the Administrator under the Articles of Agreement. The Board of Governors may consider the matter and render its written decision pursuant to the procedures set forth in the Articles of Agreement, or waive its decision and offer the aggrieved party the option of appealing directly to the Commissioner or submitting the dispute to arbitration in accord with the terms and conditions established by the Board. Any party affected by a decision of the Board of Governors may seek a de novo review by the Insurance Commissioner by requesting such a review in writing not later than the 30th day after the date of the Board of Governors' decision.

(3) If the dispute relates to the expulsion of a participating insurer under the Articles of Agreement by the Board of Governors, an appeal may be taken directly to the Insurance Commissioner pursuant to ORS 737.360.

(4) In reviewing a dispute under section (3) of this rule, the Insurance Commissioner shall follow the procedures provided in ORS 737.360 and ORS 183.310 to 183.550 for contested cases.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0072

Voluntary Coverage

Notwithstanding OAR 836-043-0089, an insurer that wishes to insure an employer as voluntary business may do so at any time. If a servicing carrier wishes to insure voluntarily one of its plan accounts, the servicing carrier must provide written notice to both the Plan Administrator and the agent of the employer of its intent at least 30 days in advance of the effective date of the servicing carrier's voluntary coverage. If the insurer is not the servicing carrier, the servicing carrier shall cancel its policy pro rata and the assignment shall automatically terminate as of the later of the effective date of the voluntary insurer's policy or the date the voluntary insurer provides written notice to the servicing carrier of its coverage.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0076

Takeout Credit

(1) Each insurer participating in the Plan who removes an employer insured through the Plan is eligible for a take-out credit application against the premium used to calculate the Plan participation base of the insurer. An offer to take an employer out of the Plan must be made in writing to the named insured, stating the amount of the estimated annual premium, the amount of the down payment required and the amount of each installment, if available.

(2) An insurer may not receive credit for any policy removed from the Plan within one calendar year after the insurer or its affiliate wrote the policy in the voluntary market.

(3) An insurer, other than the last voluntary insurer of record, may remove a policy without any restriction on the length of time the policy resided in the residual market.

(4) For the purpose of the take-out credit program, the requirements of this rule apply to an insurer's affiliates as well as to the insurer.

(5) The kind and amount of coverage to be offered a voluntary employer shall not be less than those afforded by the policy being replaced unless the kinds and amounts of coverage are refused by the employer.

(6) The granting of credits is subject to the following provisions:

(a) An insurer who removes an employer from the residual market is eligible for a take-out credit application equal to the annual premium from the voluntary policy times a credit factor from the following schedule: Total Premium - $5,000 or Less -- Total Premium - Greater than $5,000:

(A) First Year -- 3.0 -- 1.0;

(B) Second Year -- 3.0 -- 1.0;

(C) Third Year -- 3.0 -- 1.0.

(b) Credits received under this rule are not subject to a maximum limit, except that the credits shall not reduce the participation base of an insurer below zero;

(c) When an insurer takes an employer out of the Plan, the insurer must report the individual employer credit on a form and in a manner prescribed by the Plan Administrator;

(d) An insurer shall receive a credit against the premium used to calculate its Plan participation base for the amount of verifiable annual premium reported in its financial statements for the respective calendar year. The reported premium must be stated on the same financial basis as the premiums that are reported for use in determining each insurer's Plan participation base and are subject to subsequent adjustments and audits. The definition of "net premiums written" in the WCIP Definitions section of the Plan shall govern the description of premium used to calculate the Plan participation base. As audit premiums, retrospective adjustments and other items are developed, an insurer shall receive a credit against its participation base for the amount of the premium adjustment in the calendar year in which the adjustment is reported in the direct earned premium for Oregon entry in the annual statement. Regardless of when an adjustment was made or reported in the direct earned premium for Oregon entry, the adjustment shall be allowed if related to the first, second or third year of voluntary coverage by the insurer;

(e) If an insurer keeps an employer out of the residual market for three years, the insurer shall receive credit for each of the three years. If the insurer does not write the insurance for three years, it shall receive credit only for the period of time that it covered the employer in the voluntary market. An insurer shall not receive any credit for an employer returned to the Plan within one policy year;

(f) An insurer must submit a request for credit annually during the three year period in order to qualify for the credit.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; Administrative Reformatting 1-15-98

836-043-0079

Notification of Outstanding Premium

A servicing carrier or its representative shall furnish information regarding outstanding assigned risk and voluntary workers' compensation insurance premium or other workers' compensation monetary policy obligations identified by the servicing carrier or its representative to the Plan Administrator or its designee in accordance with the appropriate performance standards or other state market conduct or regulatory requirements.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0082

Policyholder Services

A servicing carrier shall provide all of the following to each policyholder and its agent:

(1) Access to audit, loss control and safety services.

(2) Prompt, professional handling of claims, including investigation, resolution and communication.

(3) Fair and prompt responses to complaints and disputes.

(4) Access to appropriate information regarding the classification of the business and the factors influencing the policy premium.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0086

Agent Designation and Compensation

(1) An employer may designate a licensed agent, and with respect to any renewal of the assigned insurance, may change the designated agent by notice to the servicing carrier prior to the date of the renewal or, at any other time with the consent of the servicing carrier.

(2) A servicing carrier shall pay a fee to the agent designated by the employer on new and renewal policies upon payment and receipt of premium due under the policy. The fee shall be based on the state standard premium and paid at the rate of five percent on the first $1,000 of premium, three percent on the next $4,000 of premium, two percent on the next $95,000 of premium and one percent of premium in excess of $100,000.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0089

Confidentiality of Information

The servicing carrier shall keep in confidence and shall not disclose to any third party such detailed information as it may obtain by virtue of its position as the servicing carrier, except as directed by the insured or the agent of record, or as otherwise may be required by law or the Commissioner.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-043-0091

Self-Funded Plan

It is essential for maintaining the viability of the Plan to establish and maintain rates at a level that will permit the Plan to operate with no more than a reasonable subsidy required from voluntary insured employers. The NCCI shall maintain necessary ratemaking data in order to permit the actuarial determination of rates and rating plans appropriate for the business insured through the Plan. Each servicing carrier shall report its experience on business written under the Plan to the NCCI in a format prescribed by the NCCI. It is the responsibility of the NCCI to monitor both rate adequacy and Plan results. The NCCI shall notify the Insurance Commissioner if excessive losses are indicated to enable the Insurance Commissioner to take corrective action.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; Renumbered from 836-043-0080

Rating and Rating Organization Worker's Compensation Premium Audit Program System

836-043-0101

Statutory Authority; Purpose; Applicability

(1) OAR 836-043-0101 to 836-043-0170 are adopted by the Director of the Department of Insurance and Finance pursuant to the requirements of ORS 737.318.

(2) OAR 836-043-0101 to 836-043-0170 establish a premium audit program system for workers' compensation insurance for the following purposes:

(a) Achieving equitable premium charges to insureds and collecting credible ratemaking data;

(b) Prescribing minimum standards for a cost effective insurer audit program that focuses audit efforts on insureds with operation where accurate reporting may be difficult or where misreportings may be relatively likely, so that an adequate level of actual auditing of insurer's earned premium is achieved;

(c) Educating employers-insureds about the audit reporting function of the rating system;

(d) Establishing a continuing test audit program of all insurers;

(e) Providing an appeal process for employers to question the results of a premium audit.

(3) OAR 836-043-0101 to 836-043-0170 apply to all authorized workers' compensation insurers, the State Accident Insurance Fund Corporation and the National Council on Compensation Insurance, effective January 20, 1988.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.235, 737.318 & 737.505(4)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

836-043-0105

Definitions

As used in OAR 836-043-0101 to 836-043-0170, unless the context requires otherwise:

(1) "Bureau" means the licensed rating organization of this state for workers' compensation insurance.

(2) "Classification" means a grouping of insurance risks according to a classification system used by an insurer.

(3) "Classification System" means a schedule of classifications and a rule or set of rules used by an insurer for determining the classifications applicable to an insured.

(4) "Insurer" means any insurer authorized to write workers' compensation insurance or the State Accident Insurance Fund Corporation.

(5) "Payroll" means money or substitutes for money payable to workers for their services, that are specified or defined by the rating system used by the insurer subject to the limitations imposed in the definition of "payroll" in ORS 656.005.

(6) "Premium" means the contractual consideration charged to an insured for insurance for a specified period of time, regardless of the timing of actual charges.

(7) "Rate" means a monetary amount applied to the units of exposure basis assigned to a classification and used by an insurer to determine the premium for an insured.

(8) "Rating Plan" means a rule or set of rules used by an insurer to calculate premium for an insured, and the parameter values used in such calculation, after application of classification premium rates to units of exposure.

(9) "Rating System" means a collection of rating plans to be used by an insurer, rules for determining which rating plans are applicable to an insured, a classification system and other rules used by an insurer for determining contractual consideration for an insured.

(10) "Workers' Compensation Insurance" means insurance providing for the obligations of an employer arising from illness or insurance to workers whether such obligation is imposed by ORS Chapter 656, similar laws of the United States or agreement between states.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.235, 737.318 & 737.505(4)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

836-043-0110

Insurer Premium Audit Program

(1) The rates, rating plans and rating systems approved by and on file with the Insurance Division shall govern the audited payroll and the adjustment of premiums, subject to the provisions of this rule. An insurer shall make an actual audit of an employer's records for the purpose of determining the premium as follows:

(a) An insurer shall audit each policy producing an annual earned premium of $10,000 or more at least once annually;

(b) An insurer shall audit five percent of all policies that are issued by the insurer and produce an annual earned premium of less than $10,000 but more than $1,000. In each year when such a policy is not audited, the insurer shall obtain a signed payroll statement from the employer. If neither an audit nor a signed statement of payroll is obtained, the insurer shall give satisfactory reason therefore to the Division. Of the policies described in this subsection, the insurer

shall first select such policies that show multiple classifications, high rates or indications of contract labor, or any combination of such criteria.

(2) When an insurer increases premium for an employer based on a premium audit the insurer shall include in the final premium audit billing a notice to the employer:

(a) That the employer may appeal to the Director, as allowed by ORS 737.505; and

(b) That the written request required to initiate the appeal must be received by the Director not later than the 60th day after the employer receives the final premium audit billing.

(3) The final premium audit billing must be entitled "Final Premium Audit Billing" at the top of the front page. The notice required in section (2) of this rule shall include the following wording, or substantially equivalent wording approved by the Director, that is prominently displayed and in not less than 12-point type:

Notice: You, the employer, may appeal this final premium audit billing. You must initiate your appeal by submitting a written request for a hearing to the Director of the Department of Insurance and Finance, State of Oregon. Your request must be received by the Director not later than the 60th day after you received this billing.

Who may submit an employer's request?

1. If the employer is a sole proprietor, the employer or an attorney for the employer may submit the request.

2. If the employer is a partnership, an attorney for the partnership or any member of the partnership may submit the request.

3. If the employer is a corporation, association or organized group, an attorney for the corporation, association or organized group or an authorized officer or regular employee of the corporation, association or organized group may submit the request.

4. If the employer is a governmental authority other than a state agency, an attorney for the governmental agency or an authorized officer or employee of the governmental authority may submit the request.

Please state in your request the date on which you received your final premium audit billing.

The request for hearing must be sent to the following address:

Director, Department of Insurance and Finance

c/o Hearings Unit

Insurance Division

440 Labor and Industries Bldg.

Salem, OR 97310

After you submit your request for hearing, the Insurance Division will provide you a petition form. In the petition, you must state the reasons you believe your insurer billed you incorrectly and describe the actions you wish the Director to take to correct the matter.

You are entitled to a hearing only if the Director has received your completed petition and has determined that the Director has jurisdiction over the matter.

You may send a copy of your request for hearing to your insurer so that you may attempt to resolve the dispute with your insurer prior to a hearing. You may seek resolution up to the time set for the hearing, but please

remember:

1. The 60-day period for initiating your request continues to run even though you may be negotiating with your insurer.

2. Your request must be received at the address above not later than the 60th day after you received this billing.

You may wish to consult with an attorney about your case.

(4) In addition to the requirements of section (2) of this rule, if the premium audit billing is based in whole or part on a determination by the insurer that one or more persons are employees rather than an independent contractor, the insurer must also include in the notice with respect to each such person, an explanation of that determination. The explanation must name the person, designate or describe the position or tasks for which the person is determined to be an employee and give reasons for the determination.

(5) For purposes of this rule, the term "final premium audit billing" has the meaning given that term in OAR 836-043-0170.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318(1) & 737.505(4)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 13-1988(Temp), f. & cert. ef. 7-27-88; ID 15-1988(Temp), f. & cert. ef. 9-2-88; ID 4-1989, f. & cert. ef. 2-28-89; ID 9-1990, f. 5-10-90, cert. ef. 6-1-90; ID 6-1997(Temp), f. & cert. ef. 5-30-97

[ED. NOTE: The text of Temporary rules is not printed in the OAR Compilation. Copies may be obtained from the agency.]

836-043-0115

Insurer Audit Procedure Guide

Each insurer shall develop audit procedure guides that include all of the features described in this rule or, in place thereof, more comprehensive alternative procedures that will consistently achieve minimum standards as measured by the Oregon Test Audit Program under OAR 836-043-0125. The features are as follows:

(1) A pre-audit review by the auditor to ensure that all relevant information and materials, as enumerated in this section, have been provided or are available. The review must be accomplished by the use of a checklist. The following are the required relevant information and materials:

(a) The **Bureau Basic Manual**;

(b) Bureau Bulletins, "Scopes" on Classifications or similar Classifications and Rating Committee Minutes pertinent to classifications and auditing procedures;

(c) Copies of daily reports, which furnish a description of operations and a summary of payrolls by classification;

(d) Bureau Inspection Reports, which furnish a description of operations and summary of employees by classification;

(e) Bureau Experience Rating forms, which provide a history of payroll classifications and claims allocation;

(f) Claims data in sufficient detail for verification of classification assignments;

(g) Pertinent correspondence;

(h) Carrier inspection reports;

(i) Prior year's audit file if renewed, or copies of Insured's Report if on an interim reporting basis; and

(j) Credit reports, if available.

(2) A contact that must be made with a principal of the employer who is familiar with the employer's operation, in order to ensure that the employer is receiving the proper classifications allowable under **Manual** rules.

(3) A good field auditing practice requiring the following:

(a) Tabulating payrolls from the most complete and accurate records;

(b) Ascertaining proper payroll classifications, substantiated by a written description of the insured's operations;

(c) Making sufficient test checks for establishing the accuracy of the audit in compliance with Manual rules when summary type records are used as the payroll source;

(d) Reconciling the total payroll with records not used in the original tabulation; and

(e) Assisting the insured, if necessary, in setting up proper records to aid in future audits.

(4) A provision that an insured give particular attention to the following factors and circumstances:

(a) Type of entity. With respect to the type of entity being insured, the insurer shall include factors and circumstances as follows:

(A) If the entity is a corporation, the name, title, classification assignment and total remuneration for each executive officer must be shown separately. All other officers of the corporation also must be listed. The insurer shall designate as to each officer whether the officer is a subject employee under ORS Chapter 656, for purposes of ORS 656.027, exempting executive officers who are also directors with substantial ownership and those who are directors of family-owned farming corporations unless those officers elect to make themselves subject under the law;

(B) If the entity is a partnership, and one or more partners are included for coverage, the name, classification assignment and total remuneration must be shown separately. All partners must be listed and their status indicated as to inclusion or exclusion;

(C) Reference to corporate officers, partners and proprietors, when covered, must include a brief description of the duties of each. The internal audit reviewer must be able to verify the stipulated maximum and minimum, remuneration with respect to non-subject corporate officers who have elected coverage, and assumed wage for non-subject sole proprietors and partners who have elected coverage.

(b) Sources and reconciliation. The insurer shall indicate the source record used to conduct the audit and the record used for reconciliation purposes. The most commonly used records include the time book, payroll journal, individual earnings records, prepared summary, check book, cash book, petty cash book, general ledger, confidential ledger, job cost record and tax returns (Federal, Social Security/State Unemployment). The internal audit reviewer must be able to correlate the audit product with the source record and be certain that appropriate records have been examined to verify the inclusion of all payroll. When summary type records are used as the audit source, sufficient sampling of the original payroll records must be made to ensure the inclusion of all payroll. The insurer must be sure that the internal audit reviewer is able to check and list the dates (and amounts if readily available) of the opening and closing payroll period or periods (e.g., weekly and semi-monthly) in order to establish proper continuity from prior audits and for subsequent audits. This is also necessary for the purpose of proper audit review;

(c) Remuneration. The insurer shall investigate all possible sources of employee earnings, including that from uninsured contract employment. Certain types of remuneration other than normal salary and wages are subject to a premium charge under Manual rules. Among the most common additional forms of remuneration are: commissions, board, lodging and anticipated bonuses;

(d) Overtime. The insurer shall indicate whether overtime as paid and, if so, whether the records are maintained in such manner as to permit the exclusion of overtime remuneration from total payroll, as allowed by Manual rules. If overtime was paid but not properly recorded in the insured's records, the auditor shall inform the insured of the overtime rules and related records requirement so that credit can be allowed on subsequent audits. This action shall be documented on the auditor's worksheet;

(e) Out of state operation. The insurer shall determine if the employer is engaging in work outside Oregon and, if so, whether Oregon employees are utilized. Payroll for the latter is to be included in the basis of premium, based on protection provided through the extra-territorial provisions of Oregon law;

(f) Clerical employees, salesman and drivers. The insurer shall:

(A) Verify the proper use of Classifications 8810 -- Clerical Office Employee, 8742 -- Sales-men, Collectors or Messengers -- Outside, and Drivers, Chauffeurs and Their Helpers -- 7380. Because the use of these classifications is subject to specific restrictions, frequent reference to the Manual is essential;

(B) Show clerical, outside sales and drivers payroll analysis on work sheets, either for the entire audit period or for several payroll periods as a sampling.

(g) Classifications. The insurer shall determine the proper classifications. If different from those shown on the daily report or Bureau Inspection Report, the insurer shall provide an explanation. Final premium charges are subject to ORS 737.310 (11). A detailed description of the employer's operations shall be obtained. The most reliable source of information for classification purposes is the person or persons in the insured's organization best able to answer inquiries regarding the following:

(A) The service or product;

(B) The raw materials used;

(C) The process involved; and

(D) How the product is marketed.

(h) The employer's first reports of occupational injury or illness shall also be examined as an additional source of classification information, because these forms frequently will describe the duties and work classifications of injured workers. The insurer may use alternative claim review methods utilizing computer printouts listing relevant classification data from such employer first reports;

(i) Location. The insurer shall indicate any changes in location of the insured's operations. This information shall be reflected in the manner payrolls are extracted to assure that all locations have been included in the audit;

(j) Rate splits. The insurer shall determine the necessity of splitting payrolls to reflect rate changes or normal anniversary rating dates observed during the policy year;

(k) New construction or alteration. The insurer shall determine if structural alterations or new construction work on the insured's premises has been conducted by employees of the insured during the audit period. Payroll for these activities must be separately rated;

(l) New operations. The insurer shall indicate new operations, acquisitions or changes in operations. The insurer also shall advise its underwriting department of any changes in operations resulting in changes of classifications. The department in turn shall notify the Bureau of any such changes;

(m) United States Longshoremen and Harbor Workers operations. The insurer shall determine if the employer is engaged in operations subject to the United States Longshoremen's and Harbor Workers' Compensation Act and if such

operations are covered under the policy as evidenced by endorsement;

(n) Division of payroll. The insurer shall determine if there has been interchange of labor for which a division of payroll between different classifications may be allowed as provided for by OAR 836-042-0050 to 836-042-0060.

(5) A review of all audits by qualified personnel having an understanding of auditing procedures and a sound knowledge of **Manual** rules, classifications and rates. As in the case of the field auditor, the audit reviewer shall have the following materials available:

(a) **Bureau Basic Manual**;

(b) Relevant Bureau Bulletins, "Scopes" on classifications or similar Classifications and Rating Committee Minutes, or abstracts of them, pertaining to classifications and audit procedures;

(c) Copy of daily report, or its equivalent, and all endorsements;

(d) The Bureau Inspection Report or Classification Notice, if available, which provides the number of employees by classification;

(e) Bureau Experience Rating form, which provides the history of payroll classifications and claims allocation;

(f) Claims data in sufficient detail for verification of classification assignments;

(g) Pertinent correspondence;

(h) Carrier inspection reports; and

(i) Previous audit work sheets and premium invoice.

(6) An internal review for:

(a) Verification of arithmetical computations;

(b) Determination of completeness of audit work sheets;

(c) Verification of audit work sheets with items contained in the insurer's own **Audit Procedure Guide**;

(d) A review of audit in detail for compliance with:

(A) Audit procedure, including payroll reconciliation;

(B) Manual rules;

(C) Classification assignments and payroll allocations;

(D) Rates and proper application; and

(E) Special rules pertaining to the basis of premium or clerical office employees, salesmen, executive officers and partners.

(e) Determination that a complete description of operations is shown, including a sketch of the premises for more difficult classification assignments; and

(f) Confirmation of premium differences as a result of audit and the audit review process. The audit review process must be done expeditiously so that the insured can be advised as soon as possible the financial impact of the audit.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

836-043-0120

Minimum Standards of Employer Education Program

(1) At or before policy issuance, an insurer shall provide written reference materials to the employer-insured covering the following matters:

(a) Which workers are subject to the Workers' Compensation Law for whom premiums must be paid;

(b) What remuneration (or pay) is subject to premium charges;

(c) How to divide payroll between assigned classifications;

(d) The requirements for verifiable records;

(e) The existence and nature of premium audits and the appeal process afforded employers by ORS 737.505;

(f) The employer's responsibility to notify the insurer of changes in the business structure and operations;

(g) The classification notice requirements prescribed by OAR 836-043-0175 to 836-043-0185.

(2) When the insurer becomes aware of changes in the employer's business that affect the reporting of payroll or other exposure basis, the insurer shall provide additional appropriate instruction to the employer.

(3) When changes in statute, rules or rating system occur that affect reporting of payroll or other exposure basis, the insurer shall provide notification of such changes to employers as soon as reasonably possible.

(4) The Bureau shall conduct seminars for insured employers covering the audit fundamentals of section (1) of this rule. Such seminars shall be held at least semi-annually in Portland, Salem, Eugene, Medford, Coos Bay, Bend and Pendleton.

(5) The Bureau shall continuously disseminate to its member insurers beneficial information relevant to auditing procedures, training and materials.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318(3)(a)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

Test Audit Program

836-043-0125

Purpose

A Test Audit Program shall be conducted by the Bureau to carry out ORS 737.318. To perform this function, the Bureau shall maintain the test audit staff for examining pertinent records of at least 2,000 Oregon employers and insurers, or other appropriately credible audit levels as determined by the casualty actuary of the Insurance Division. The purposes of the test audit program are as follows:

(1) To initiate test audits for checking the accuracy and reliability of each insurer's audits, verifying the classifications assigned and assuring that the premiums charged are based upon rates, rating plans and rating systems on file with and approved by the Insurance Division;

(2) To establish minimum auditing standards and to develop a program for monitoring insurer performance toward the achievement of established standard; and

(3) To improve audit proficiency through the evaluation of insurer auditing practices.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 7-1997(Temp), f. & cert. ef. 5-30-97

[ED. NOTE: The text of Temporary rules is not printed in the OAR Compilation. Copies may be obtained from the agency.]

836-043-0130

Selection of Risks for Test Audit

(1) All insurers or insurer groups shall be test audited on a continuous basis. The Bureau shall send each quarter a list of policies that have been selected at random for test audit to the policy issuing office or offices designated by the insurer. This list shall include policies with expiration dates not less than 90 days prior to the date of selection. The Bureau shall complete the test audits within six months after receipt. Any test audit not completed within the six-month period must not be included in the insurer's result. However, the insurer shall submit a revised unit statistical report for any audits that would have constituted an error. The Bureau shall provide the Department of Consumer and Business Services a quarterly report of test audits that are not completed in a timely manner.

(2) The number of policies to be selected for each insurer shall be determined from **Exhibit 2** using the current policy premium distribution for the insurer and the error ratio from premium test audits of policies for the insurer. The policy premium distribution shall be based on estimated annual premium reported by insurers for policies subject to selection. The error ratio shall be the number of policies found to have audit errors divided by the total number of policies of the insurer that have been test audited during the latest six quarters. The error ratio shall be assigned credibility weight as described in **Exhibit 2** and the complement weight shall be assigned to the statewide error ratio of all insurers for the latest six quarters. The credibility weighted error rate for the insurer shall be used to determine the policy sample rates in **Exhibit 2**.

(3) The quarterly list of policies selected for test audit shall include both physical and voluntary audits. The list shall indicate, for each insurer or insurer group, the insured, the policy number, the issuing office (if available) and the policy dates. The list shall be sent to each Oregon policy issuing office of the insurer or insurer group.

(4) Within 30 working days after receipt of the selection list, each issuing office shall submit to the Bureau the following audit material on those risks for which it is responsible:

(a) If physically audited, a non-returnable copy of the auditor's work sheets and the premium invoice;

(b) Correspondence pertinent to proper completion of the audit;

(c) If the employer's voluntary payroll statement has been utilized and the policy has developed less than $6,000 of premium, a non-returnable copy of employer's payroll statement and the premium invoice;

(d) If the employer's voluntary payroll statement has been utilized and the policy will develop $6,000 or more in earned premium, a notification that the policy will be physically audited within 30 days and that the auditor's work sheet and premium invoice will be submitted at that time unless alternative auditing was approved under OAR 836-043-0110(2); and

(e) A non-returnable copy of the claim form of first report of injury for each compensable injury of $2,000 or more. The Bureau must receive at least the name of the injured employee and the date of accident, although the following information must also be submitted if available; job title, nature of injury, **Manual** classification to which claim is assigned, place of accident, claim file number and a brief description of what the employee was doing when the accident occurred. (See **Exhibit 2**.)

(5) No risk shall be test audited more than once in any four-year period except upon conditions established by the Insurance Division Administrator.

(6) When possible, risk selected from an insurer shall represent a cross section of that insurer's Oregon Workers' Compensation writings. A diversity of premium sizes, classifications and locations shall be included in the selection.

(7) Each test audit shall be for a completed policy period.

(8) The following must be obtained from Bureau files:

(a) A policy data sheet providing all necessary information shown on insurer's policy; and

(b) A copy of the latest Bureau inspection.

(9) Not later than ten days prior to an auditor's planned visit, the auditor must mail an appointment letter to the insured, advising auditor's planned date of call. (See **Exhibit 6**.)

[ED. NOTE:The publication(s) and exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 737.318

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 11-1994, f. 12-19-94, cert. ef. 1-1-95; ID 7-1997(Temp), f. & cert. ef. 5-30-97

[ED. NOTE: The text of Temporary rules is not printed in the OAR Compilation. Copies may be obtained from the agency.]

836-043-0135

Test Audits

(1) A Test Auditor's Analysis of Risk shall be completed on each test audit. (See **Exhibit 3**.)

(2) A brief interview shall be conducted with the insured or an authorized representative of the insured, in order to solicit the insured's cooperation and also to obtain all factual data necessary for proper completion of the test audit.

(3) If a current inspection is in the file, the test auditor shall verify data contained in that report.

(4) Each test audit, using the audit detail form, shall contain the following (see **Exhibit 7**):

(a) A reconciliation of payroll subject to premium charge, which must be made with the independent control records of the State Unemployment Insurance quarterly reports and FICA quarterly report;

(b) A review of the cash disbursements journal to develop the remuneration paid to contract labor and casual labor;

(c) A detailed review of at least one pay period to verify proper classification;

(d) A review of time cards to verify proper treatment of overtime remuneration;

(e) A review of original entry records to verify proper application of the "division of single employee's payroll" rules (OAR 836-042-0050 to 836-042-0060);

(f) A listing by name, duties and earnings of all persons assigned to the "standard exceptions" classifications. When size of the risk makes the listing impractical, spot checks must be made;

(g) A listing by name, title, duties and earnings of all covered executive officers, partners or individuals;

(h) A summary, by classification, of all chargeable payrolls;

(i) A summary of differences between the test audit and the carrier audit.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

836-043-0140

Test Auditor's Reports

A weekly production report that lists all test audits completed during the week must accompany the completed files.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

836-043-0145

Disposition of Test Audits

(1) Individual results of each test audit, including voluntary audits, must be submitted to the office or offices designated by the insurer as soon as the Bureau audit is completed.

(2) For those audits that do not develop a significant difference, defined as in excess of $300 in premium or in excess of one percent of the total earned premium, whichever is greater, the insurer must be notified by letter of the name of the insured, the policy number and the fact that the test audit was closed without change from the original audit.

(3) For those audits that do develop a significant difference, the insurer must be provided with a report explaining the difference and the effect of such difference upon the total premium. (See **Exhibits 3** and **4**.)

(4) Results of test audits of individual insurers shall be confidential data under ORS 731.264.

(5) Immediately upon receipt of the Bureau's report, the insurer shall determine whether it agrees with the Bureau's findings, making a re-audit if necessary. If there is agreement with the Bureau's findings, the insurer shall file such corrected information on the original or, if necessary, on a revised unit statistical report. When the net premium difference is not sufficient to qualify as an "error" but a single difference is sufficiently large to qualify as an error prior to any offsetting premium amounts, the insurer shall be advised of such differences by a "non-error" notice. Also, when individual claims have been assigned to an incorrect classification a "non-error" notice shall also be submitted to the insurer. Upon receipt of the "non-error" notice, the insurer shall report such payrolls or losses on the initial or, if necessary, a "C" (corrected) Unit Statistical Report. All test audit differences must be closed within sixty days of notification unless the insurer requests an extension and the request is approved by the Bureau.

(6) When classifications utilized by the insurer are found to be in error, the Bureau shall take the normal appropriate action to secure compliance.

(7) Findings resulting from test audits per se shall not be utilized in any action to enforce premium collections.

(8) If there is disagreement with the Bureau's findings, the insurer shall communicate with the manager of the National Council on Compensation Insurance office in Portland, Oregon to resolve areas of contention.

(9) When an insurer is unable to resolve test audit differences with the Bureau staff, the insurer may present an appeal to the Workers' Compensation Raging System Review and Advisory Committee.

(10) When an insurer is unable to resolve test audit differences with the Workers' Compensation Rating System Review and Advisory Committee, the insurer may present an appeal to the Insurance Division for final determination.

[ED. NOTE:The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 373.318

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 11-1994, f. 12-19-94, cert. ef. 1-1-95

836-043-0150

Summary of Test Audit Results

(1) Test audit results shall be summarized quarterly for the individual insurer or insurer group, as well as for the industry whole. The summary must include all prior quarters up to but not exceeding a total of six quarters. The summary must reflect separately the results of physical and voluntary audits. (See **Exhibits 5(a)** and **(b)**.)

(2) The summary of test audit results must be reported quarterly to the insurer's home office to the attention of the appropriate executive officer. If the carrier's home office is located outside Oregon, a copy of the summary results must also be forwarded to the Oregon branch or division office that reports directly to the home office. It shall be the insurer's responsibility to keep the Bureau advised of the responsible executive to whom the summary results should be directed.

(3) The Bureau shall meet with each insurer to review its results and when requested, may offer remedial suggestions when such action is indicated.

(4) Summarized quarterly and six quarterly audit results shall be furnished to the Workers' Compensation Rating System

Review and Advisory Committee, but not by individual insurers. Individual insurer data and all insurer data shall be furnished to the Insurance Division.

(5) The Bureau shall maintain sufficient records to permit accurate reporting to the insurer, Workers' Compensation Rating System Review and Advisory Committee and the Insurance Division.

(6) Copies of all individual insurer and summary reports shall be submitted to the Insurance Division upon completion.

[ED. NOTE**:** The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 737.318

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 11-1994, f. 12-19-94, cert. ef. 1-1-95

836-043-0155

Test Audit Standards

(1) An insurer who fails to achieve the *Minimum Standard* of the Test Audit Performance for six consecutive quarters shall meet with the Insurance Division Administrator, or the Administrator's designated representative, to provide a detailed explanation of the remedial measures the insurer is taking to restore overall audit proficiency to an acceptable level. An insurer meets the *Minimum Standard* when the insurer satisfies the requirement that the number of premium differences in excess of $300 or one percent of the insured's premium, whichever is greater, must not exceed the critical number shown in the Table of Minimum Standards (**Exhibit 1**).

(2) An insurer who still fails to achieve the *Minimum Standard* following examination by the Insurance Division Administrator shall be cited to the Director of the Department of consumer and Business Affairs for appropriate penalty including possible suspension of its certificate of authority.

[ED. NOTE:The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 737.318

Stats. Implemented: ORS 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 11-1994, f. 12-19-94, cert. ef. 1-1-95; ID 7-1997(Temp), f. & cert. ef. 5-30-97

[ED. NOTE: The text of Temporary rules is not printed in the OAR Compilation. Copies may be obtained from the agency.]

836-043-0165

Monitoring Audit Program System

(1) The Insurance Division shall examine every insurer at least once each three years for the purpose of determining its compliance with:

(a) The statistical reporting requirements of OAR 836-042-0045;

(b) The premium audit program requirements of OAR 836-043-0110 and 836-043-0115; and

(c) The minimum standards of employer education programs of OAR 836-043-0120.

(2) The Insurance Division shall continuously monitor the Bureau for the purpose of assuring its compliance with:

(a) The Test Audit Program requirements of OAR 836-043-0125 to 836-043-0155; and

(b) The Minimum Standards of Employers Education Program requirements of OAR 836-043-0120.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.235 & 737.318(3)(b)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88

836-043-0170

Premium Audit Hearings

(1) This rule establishes the procedure for an employer to appeal a final premium audit billing under ORS 737.505(4). An employer must first submit a written request to the Director for a hearing to review the results of a final premium audit billing. The request must be received by the Director not later than the 60th day after the employer received the billing. A request that is received by the Director not later than the 60th day after the employer received the billing satisfies the requirement under ORS 737.505 that an appeal be made within 60 days after receipt of the billing. The time period includes Saturdays and legal holidays, including Sundays. ORS 174.120 and 174.125 govern the computation of the time period.

(2) After submitting the written request for a hearing under section (1) of this rule, an employer must submit a petition to the Director, on a petition form provided by the Director, that states the reasons that the employer believes the insurer billed the employer incorrectly and describes the actions the employer wishes the Director to take in order to correct the matter.

(3) An employer is entitled to a hearing only when the Director has received the completed petition and has determined that the Director has jurisdiction over the matter.

(4) The Director shall give written notice of the hearing to the employer and the insurer, and also to the bureau if the statements in the petition of the employer address the use of the bureau rating system. The Director shall also forward the employer's petition to the insurer, and the bureau if applicable. The notice shall serve as a written request by the employer to the insurer, and the bureau, if applicable, to review the reasons that the employer is aggrieved. The Director may name the insurer or the rating bureau, if applicable, or both, as parties to the hearing.

(5) An employer may apply to the Director to stay the collection effort of an insurer on a final premium audit billing during the pendency of an appeal as provided in this section. The application must allege and show good cause as required in ORS 737.505(5) by stating the employer's contentions of error for which the Director would be authorized to provide relief if the contentions were proved at the hearing. The Director shall grant the stay after receipt of the petition from the employer if the Director determines that the Director has jurisdiction over the matter and that the application alleges and shows good cause.

(6) For the purpose of determining the date of receipt of a final premium audit billing delivered to the employer by mail, if the date is unknown to the employer, the date of receipt is considered to be the third day after the date of mailing except as otherwise provided in this section. If the third day after the date of mailing is a Saturday or a legal holiday, including Sunday, the date of receipt is considered to be the next day that is not a Saturday or a legal holiday.

(7) Subject to the exception provided in section (8) of this rule, for purposes of ORS 737.505, OAR 836-043-0110 and this rule, the final premium audit billing of an employer is the first document issued by the insurer to the employer after its audit of the employer that:

(a) Contains the results of the audit; and

(b) States the amount of the difference between the estimated standard premium reported by the employer for the entire policy period and the final standard premium calculated after the policy period is over as determined pursuant to the audit.

(8) If the insurer after an audit of an employer issues both a statement of the employer's account and a letter to the employer that explains the audit and states the amount of the difference:

(a) The insurer may provide the notice required in OAR 836-043-0110 either in the statement of account or in the letter;

(b) Whichever document contains the required notice is the final premium audit billing for purposes of the 60-day period within which the Director must receive the request for a hearing. If the statement of account and the letter both contain the notice, the 60-day period begins upon receipt by the employer of the later-received document.

(9) The Director may dismiss the appeal of an employer if the Director determines that the Director lacks jurisdiction in the matter or if the Director has not received the completed petition on or before the 180th day after the date on which the Director received the initial request from the employer for a hearing on the final premium audit billing.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.318 & 737.505(4)

Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 13-1988(Temp), f. & cert. ef. 7-27-88; ID 15-1988(Temp), f. & cert. ef. 9-2-88; ID 4-1989, f. & cert. ef. 2-28-89; ID 9-1990, f. 5-10-90, cert. ef. 6-1-90

Rating and Rating Organization Worker's Compensation

Insurance Classification Notice

836-043-0175

Statutory Authority; Purpose; Applicability

(1) OAR 836-043-0175 to 836-043-0190 are adopted by the Director of the Department of Insurance and Finance pursuant to the provisions of ORS 737.310.

(2) The purpose of these rules is to prescribe minimum standards for notice by insurers to insureds regarding approved rate classifications.

(3) These rules apply to all authorized workers' compensation insurers and the State Accident Insurance Fund Corporation effective January 20, 1988.

Stat. Auth.: ORS 731.244 & 737.310(12) & (13)

Stats. Implemented: ORS 737.310(12)

Hist.: ID 2-1988, f. & cert. ef. 1-20-88; ID 2-1992, f. 2-6-92, cert. ef. 2-15-92

836-043-0180

Definitions

As used in OAR 836-043-0175 to 836-043-0190 unless the context requires otherwise:

(1) "Bureau" means the National Council on Compensation Insurance (NCCI), the licensed rating organization of this state for workers' compensation insurance.

(2) "Classification" means a grouping of insurance risks according to a classification system used by an insurer.

(3) "Classification System" means a schedule of classifications and a rule or set of rules used by an insurer for determining the classifications applicable to an insured.

(4) "Insurer" means any insurer authorized to transact workers' compensation insurance or the State Accident Insurance Fund Corporation.

(5) "Reclassification" means an addition or removal of a classification by an insurer to a policy for an insured when the previous classification is improper or inadequate.

(6) "Workers' Compensation Insurance" means insurance providing for the obligations of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapter 656, similar laws of the United States or agreement between states.

Stat. Auth.: ORS 731.244 & 737.310(12) & (13)

Stats. Implemented: ORS 737.310(12)

Hist.: ID 2-1988, f. & cert. ef. 1-20-88; ID 2-1992, f. 2-6-92, cert. ef. 2-15-92

836-043-0185

Insurer Classification Notice

(1) When an insurer issues a workers' compensation insurance policy to an insured for the first time, an insurer shall provide each insured a written rate classification notice describing the work activities of each classification assigned.

(2) The rate classification notice shall include the following information:

(a) The complete description for each classification assigned as contained in the insurers' classification system filed with the Insurance Division;

(b) An adequate description of work activities for such classification as reviewed by the Insurance Division, such as that shown in the example in **Exhibit 1**;

(c) One or more publications that include basic ratemaking and classification information and necessary records and reporting procedures for the division of payroll of an individual employee among classifications assigned as provided for under OAR 836-042-0060, such as that shown in the example in **Exhibit 2**;

(d) An amendatory endorsement to the policy for reclassification assignments during the policy year as provided for under ORS 737.310(12).

(3) When an insurer provides the written rate classification notice required under ORS 737.310 (12) and (13), the notice must be given in the manner prescribed by section (2) of this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 737.310(12) & (13)

Stats. Implemented: ORS 737.310(12)

Hist.: ID 2-1988, f. & cert. ef. 1-20-88; ID 2-1992, f. 2-6-92, cert. ef. 2-15-92

836-043-0190

Insurer Reclassification Billings

If an insurer determines the workers' compensation insurance policy of an insured needs reclassification, the insurer:

(1) May bill additional premium for the revised classification after the insurer has provided the insured at least 60 days written notice of the reclassification.

(2) Shall bill retroactively to policy inception or date of change in insured's operations for any reclassification that results in a net reduction of premium.

(3) May, notwithstanding section (1) of this rule, retroactively bill an insured for reclassification during the policy year without prior notice of reclassification if:

(a) The insured knew or should have known that the employees were misclassified;

(b) The insured provided improper or inaccurate information concerning its operations; or

(c) The insured's operations changed after the date information on the employees is obtained from the insured.

Stat. Auth.: ORS 731.244 & 737.310(12) & (13)

Stats. Implemented: ORS 737.310(12)

Hist.: ID 2-1992, f. 2-6-92, cert. ef. 2-15-92

Rates and Rating Organizations Workers' Compensation

Rating System Review and Advisory Committee

836-043-0200

Statutory Authority; Purpose; Applicability

(1) OAR 836-043-0200 to 836-043-0240 are adopted by the Director pursuant to ORS 731.244, 737.310(13) and 737.526(1) to aid in the effectuation of insurer filings under ORS 737.205, the review of workers' compensation insurance filings under ORS 737.320 and the hearing process under ORS 737.505 for persons aggrieved by the application of the rating system.

(2) The purpose of these rules is to establish an Oregon Workers' Compensation Rating System Review and Advisory Committee by which the authorized workers' compensation rating organization for this state may:

(a) Exchange information and experience data with its members and the Director;

(b) Consult and cooperate with its members and the Director with respect to National Council on Compensation Insurance filings and to application of workers' compensation rating system; and

(c) Hear insured grievances regarding the application of its rating system.

(3) These rules apply to all authorized workers' compensation insurers, the State Accident Insurance Fund Corporation and the National Council on Compensation Insurance.

Stat. Auth.: ORS 731.244, 737.310(13) & 737.526(1)

Stats. Implemented: ORS 737.310(13) & 737.526

Hist.: ID 11-1992, f. 6-9-92, cert. ef. 6-15-92

836-043-0210

Definitions

As used in; OAR 836-043-0200 to 836-043-0240, unless the context requires otherwise:

(1) "Aggrieved Person" means any person adversely affected by application of a rating system or by any decision of the Committee.

(2) "Classification" means a grouping of insurance risks according to a classification system used by an insurer.

(3) "Classification System" means a schedule of classifications and a rule or set of rules used by an insurer for determining the classification applicable to an insured.

(4) "Committee" means the Oregon Workers' Compensation Rating System Review and Advisory Committee established by OAR 836-043-0200 to 836-043-0240.

(5) "Experience Rating" means modification of workers' compensation insurance premium according to the **Experience Rating Plan Manual** of the National Council on Compensation Insurance filed with the Director.

(6) "Hearing" or "Hearings" means an informal and reasonable means whereby any person aggrieved by the application of NCCI's rating system or an authorized representative of the person may be heard by the Oregon Workers' Compensation Rating System Review and Advisory Committee to review the manner in which such rating system has been applied in connection with the insurance afforded the person. This hearing does not constitute a contested case hearing within the meaning of ORS 183.310.

(7) "Insured" means an employer who has been issued a workers' compensation insurance policy by an insurer. An insured may designate, in writing, a representative to present their appeal before the Committee. The Small Business Ombudsman of the Department of Insurance and Finance may be a representative.

(8) "Insurer" means any insurer authorized to transact workers' compensation insurance and includes the State Accident Insurance Fund Corporation.

(9) "Member" means a member of the Oregon Workers' Compensation Rating System Review and Advisory Committee of the Director of the Department of Insurance and Finance.

(10) "National Council on Compensation Insurance" or "NCCI" is the rating organization that has been licensed by the Director for workers' compensation insurance, of which organization authorized workers' compensation insurers must be members pursuant to ORS 737.560.

(11) "Northwestern Division" or "NWD" is a branch of the National Council on Compensation Insurance providing related services for Oregon.

(12) "Premium" means the contractual consideration charged to an insured for insurance for a specific period of time regardless of the timing of actual charges.

(13) "Rate" means a monetary amount applied to the units of exposure basis assigned to a classification and used by an insurer to determine the premium for an insured, prior to any adjustment or adjustments resulting from the application of any rating plan.

(14) "Rating Plan" means a rule or set of rules used by an insurer to calculate premium for an insured, and the parameter values used in such calculation, after application of classification premium rates to units of exposure.

(15) "Rating System" means a collection of rating plans to be used by an insurer, rules for determining which rating plans are applicable to an insured, a classification system and other rules used by an insurer for determining contractual consideration for an insured.

(16) "Retrospective Rating" means a method of adjustment of workers' compensation insurance premium according to the insurer's rating plan for the policy of an insured based on losses incurred during the period covered by the policy.

(17) "Workers' Compensation Insurance" means insurance providing an employer coverage from the obligations of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapter 656 of this state, similar laws of the United States, or agreements between states.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 737.310(13) & 737.526(1)

Stats. Implemented: ORS 737.310(13) & 737.526

Hist.: ID 11-1992, f. 6-9-92, cert. ef. 6-15-92

836-043-0220

Committee Participation

(1) The Committee shall consist of seven voting and one nonvoting member as follows:

(a) Five voting members shall be insurers, one of which shall be the State Accident Insurance Fund Corporation. No two insurers that share common ownership or management so as to meet the definition of a controlled group under **Sections 851(c)(3) or 1563(a)** of the **Internal Revenue Code** shall serve together on the Committee;

(b) One voting member shall be an Oregon Workers' Compensation insured;

(c) One voting member shall be a "public body" as defined by ORS 192.410(1);

(d) The nonvoting member shall be the Director or the Director's designee.

(2) The Committee officers are as follows:

(a) Chairperson shall be the Director, or Director's designee;

(b) First Vice-chairperson and Second Vice-chairperson shall be elected by insurer voting members for annual terms provided that one of the vice-chairpersons be the State Accident Insurance Fund Corporation.

(c) Recording Secretary shall be a representative of the NCCI.

(3) Committee members shall be selected as follows:

(a) The Director shall appoint the insured member and public body members;

(b) The Director shall appoint the insurer members as follows:

(A) NCCI shall compile a list of nominees which the Director is to consider when making such appointments. The Director, however, is not required to appoint any of the nominees presented by NCCI;

(B) The list of nominees complied by NCCI shall contain no fewer than seven candidates, one of which shall be the State Accident Insurance Fund Corporation;

(C) The nominees presented by NCCI shall possess expertise in the application of the Oregon workers' compensation rating system;

(D) The nominees presented by NCCI shall, to the extent possible, represent on a written premium basis a balance between stock and non-stock insurers;

(E) NCCI shall provide the list of nominees to the Director 30 days prior to the date the Director is required to make the appointments;

(F) When an appointment is made, the Director will immediately notify NCCI regarding the identity of the insured member and public body members;

(G) In the event the Director fails to make any such appointment, the members serving on the Committee for the term immediately preceding shall continue to serve until such time as a new appointment is made.

(c) Each member appointed by the Director shall furnish to the Director, and to the NCCI the names, addresses, and telephone and facsimile numbers of the individuals which it has selected to serve as its representative and alternate on the Committee.

(4) Each insurer member's term on the Committee shall be for three years. The insurer members shall serve staggered terms. For the first term, two insurer members shall be selected for one year terms, two shall be selected for two year terms, and one shall be selected for a three year term.

(5) The insured member and public body members shall each serve for a one year term.

(6) Vacancies on the Committee shall be filled for the remainder of the unexpired term pursuant to section (3) of this rule. Newly appointed members shall be from the same class as the retiring member.

(7) Members shall be reimbursed by NCCI for the reasonable expenses connected with the Committee functions, including, but not limited to, travel expenses, food and lodging. Such reimburse-ment may be provided as a per diem allowance. Members shall receive no other compensation for their participation.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 737.310(13) & 737.526(1)

Stats. Implemented: ORS 737.310(13) & 737.526

Hist.: ID 11-1992, f. 6-9-92, cert. ef. 6-15-92

836-043-0230

Committee Operating Rules

(1) The term of each Committee shall commence on June 1 and expire on May 31 of the following year.

(2) The Committee shall meet either in person or by teleconference at the beginning of each term for purposes of electing the First Vice-chairperson and Second Vice-chairperson. The Chairperson shall be responsible for organizing the agenda of each meeting and each hearing, and for the conduct of each hearing. The First Vice-chairperson shall be responsible for arranging facilities, providing notice as required, and arranging for administrative support services. The Chairperson or Vice-chairperson, may delegate any of its administrative functions to other Committee officers.

(3) The Committee shall meet as needed and in accordance with the provisions of state law.

(a) Upon receipt of a grievance to the Recording Secretary, the Committee shall schedule a hearing to be convened within 90 days;

(b) Written notice of hearing shall be provided to the appellant, the insurer and the NWD within 20 days after receipt of the grievance, but not less than ten days prior to the hearing;

(c) The written notice of hearing shall contain notice of discovery rights pursuant to ORS 737.505 (1) and notice of the right to be represented by counsel or have other advisors present;

(d) Hearings shall not be held unless a quorum is present either in person or by teleconference. A quorum shall consist of a simple majority. The decision of the Committee shall be by majority vote of those voting members present at the hearing;

(e) If a member has a conflict of interest with respect to a hearing scheduled before the Committee, the member shall declare such conflict of interest and either abstain from voting, or obtain the agreement of the aggrieved party that such abstention is not required. A conflict of interest shall exist when:

(A) A member has a familial relationship with the aggrieved party; or

(B) An insured member is a direct competitor of the aggrieved party; or

(C) An insured member is a part of an affiliated group, any member of which is a direct competitor of the aggrieved party; or

(D) A member is associated with the aggrieved party and comes within the definition of a controlled group as specified in **Section 851(c)(3)** of the **Internal Revenue Code**; or

(E) A member has any other material conflicting interest which could call into question that member's ability to render an unbiased decision.

(f) A conflict of interest may be waived if, after full disclosure of the facts raising such a conflict, all parties to the appeal agree to such waiver;

(g) The NCCI representative(s) on the Committee shall not be deemed to have a conflict of interest with respect to any appeal brought before the Committee based solely upon such representa-tives' affiliation with NCCI.

(4) Each decision shall be provided in writing and shall state the reason(s) for the decision. The decision shall be sent within 30 days of the hearing to all parties and to the Director:

(a) The votes of each member shall not be recorded on the decision;

(b) This decision shall be prepared by the First Vice-chairman of the Committee;

(c) This decision shall provide conspicuous notice of the appeal rights to a de novo administrative law contested case hearing before the Director pursuant to ORS 737.505(3). The NCCI shall have the right to appeal this decision at such a contested case hearing.

(5) Review of decisions of the Committee shall be accorded pursuant to ORS 737.505.

(6) Except for executive sessions held to discuss appropriate issues, all Committee meetings shall be open to any NCCI member or subscriber, insured and the general public. Executive Sessions are open to any NCCI member.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 737.310(13) & 737.526(1)

Stats. Implemented: ORS 737.310(13) & 737.526

Hist.: ID 11-1992, f. 6-9-92, cert. ef. 6-15-92

836-043-0240

Committee Activities

The subject matter jurisdiction of the Committee shall include but not be limited to the following:

(1) Any insured or insurer grievance regarding the application of any part of the NCCI rating system adopted by the insurer, including but not limited to:

(a) A classification;

(b) Classification system;

(c) Experience rating system or component thereof; or

(d) Rating plans including the retrospective rating plans, component parts and tables.

(2) Except for voluntary market advisory loss cost and assigned risk plan advisory rate filings, proposed filings of the NCCI for subsequent submission to Director.

(3) The calling for an analysis of any special or

ordinary statistical data reports from the NCCI or its members.

(4) Special surveys or projects dealing with the rating system as may be initiated by the Director.

Stat. Auth.: ORS 731.244, 737.310(13) & 737.526(1)

Stats. Implemented: ORS 737.310(13) & 737.526

Hist.: ID 11-1992, f. 6-9-92, cert. ef. 6-15-92

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 50

GENERAL PROVISIONS

Assumption Reinsurance

836-050-0000

Purpose, Statutory Authority and Implementation

OAR 836-050-0000 to 836-050-0200 are adopted under the authority of ORS 731.244 and sections 5 and 6, chapter 30, Oregon Laws 1995, for the purpose of implementing sections 5 and 6, chapter 30, Oregon Laws 1995, relating to assumption reinsurance.

Stat. Auth.: ORS 731.244, Section 5 & 6, Ch. 30, Oregon Laws 1995

Stats. Implemented: Sections 5 & 6, Ch. 30, Oregon Laws 1995

Hist.: ID 4-1996, f. & cert. ef. 2-28-96

836-050-0010

Notice of Transfer

(1) An insurer transferring obligations or risks through an assumption reinsurance agreement subject to section 2, chapter 30, Oregon Laws 1995, shall provide or cause to be provided to each policyholder or certificate holder a notice of transfer by first-class mail, addressed to the last-known address of the policyholder or certificate holder or to the address to which premium notices or other policy documents are sent. For insurance business on which premiums are collected on a weekly or monthly basis by an agent of the insurer, the notice of transfer must be sent by personal delivery with acknowledged receipt. Notice of transfer must also be sent to the transferring insurer's agent or brokers of record on the affected policies.

(2) The notice of transfer must state or provide:

(a) The date the transfer and novation of the policyholder's policy or certificate holder's certificate are proposed to take place;

(b) The names, addresses and telephone numbers of the assuming insurer and the transferring insurer;

(c) That the policyholder or certificate holder may either consent to or reject the transfer and novation;

(d) The procedures and time limit for consenting to or rejecting the transfer and novation;

(e) A summary of any effect that consenting to or rejecting the transfer and novation will have on the policyholder's or certificate holder's rights;

(f) A statement that the assuming insurer is authorized to transact the type of insurance being assumed in the state in which the policyholder or certificate holder resides, or is otherwise authorized under sections 2 to 8, chapter 30, Oregon Laws 1995, to assume such insurance;

(g) The name and address of the representative of the transferring insurer to whom the policyholder or certificate holder should send its written statement of acceptance or rejection of the transfer and novation;

(h) The address and phone number of the insurance regulatory office of the state in which the policyholder or certificate holder resides so that the policyholder or certificate holder may write or call the office for further information regarding the financial information of the assuming insurer;

(i) A statement that the insurer will furnish to the policyholder or certificate holder, upon request, financial data for both insurers, including at a minimum the data described in section (3) of this rule; and

(j) An explanation of the reason for the transfer.

(3) The transferring insurer shall promptly furnish the following financial data for both insurers in response to a request for financial data by a policyholder or certificate holder or by an agent or broker of record of the transferring insurer with respect to the affected policies:

(a) Ratings for the previous year from two nationally recognized insurance rating services acceptable to the Director, including the rating service's explanation of the meaning of the ratings, and if ratings are unavailable for the year, the insurer shall so disclose;

(b) If the rating of either insurer furnished under subsection (a) of this section changed during the previous year, ratings for the year preceding from two nationally recognized insurance rating services acceptable to the Director, including the rating service's explanation of the meaning of the ratings, and if ratings are unavailable for the year preceding, the insurer shall so disclose;

(c) A balance sheet as of December 31 for the previous year if available and as of the date of the most recent quarterly statement; and

(d) A copy of the Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement.

(4) Notice in the form identical or substantially similar to **Exhibit 1** to this rule is considered to comply with the requirements of section (2) of this rule.

(5) The notice of transfer shall include a pre-addressed, postage-paid response card that a policyholder or certificate holder may return as its written statement of acceptance or rejection of the transfer and novation.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, Sections 5 & 6, Ch. 30, Oregon Laws 1995

Stats. Implemented: Sections 5 & 6, Ch. 30, Oregon Laws 1995

Hist.: ID 4-1996, f. & cert. ef. 2-28-96

836-050-0020

Notice of Rejection

A policyholder or certificate holder who elects to reject the transfer and novation of the policy under an assumption rensurance agreement to which section 2, chapter 30, Oregon Laws 1995, applied must give notice indicating rejection to the transferring insurer on a pre-addressed, postage-paid response card provided by the transferring insurer in the notice of transfer as required in OAR 836-050-0010 and **Exhibit 1** to that rule, or in another written notice by the policyholder or certificate holder.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, Sections 5 & 6, Ch. 30, Oregon Laws 1995

Stats. Implemented: Sections 5 & 6, Ch. 30, Oregon Laws 1995

Hist.: ID 4-1996, f. & cert. ef. 2-28-96

836-050-0105

Statutory Authority; Purpose; Applicability

(1) OAR 836-050-0105 to 836-050-0120 are adopted by the Director pursuant to ORS 743.028.

(2) The purpose of OAR 836-050-0105 to 836-050-0120 is to prescribe, as required by ORS 743.028, uniform health insurance claims forms that must be accepted by all insurers transacting health insurance in this state and by all state agencies that require health insurance claim forms for their records.

(3) OAR 836-050-0105 to 836-050-0120 do not apply to claims for vision care or drugs, or to benefits paid on other than an expense-incurred basis.

(4) "Insurer" as used in OAR 836-050-0105 to 836-050-0120 includes health care service contractors and state agencies that require health insurance claim forms for their records.

Stat. Auth.: ORS 731.244 & 743.028

Stats. Implemented: ORS 743.028

Hist.: IC 73, f. 2-25-77, ef. 3-1-77; IC 75, f. & ef. 5-27-77; ID 1-1995, f. 4-26-95, cert. ef. 8-1-95

836-050-0110

Uniform Claim Forms

(1) An insurer shall accept a properly completed claim submitted on the applicable uniform form prescribed by the exhibits to this rule, or on the substantially identical respective form approved by the American Medical Association's Council on Medical Services or the American Dental Association's Council on Dental Care Programs, as follows:

(a) **Exhibit 1** -- For claims other than dental care claims;

(b) **Exhibit 2** -- For dental care claims.

(2) If the information entered on the form is incomplete, the insurer may return the form to the provider for completion to the extent necessary.

(3) If additional information is essential to the insurer's proper handling of the claim, it may seek such information by letter, investigative inquiry, or other reasonable means of communication. These inquiries shall be kept to a minimum and shall not seek information duplicating what already is known to the insurer.

(4) An insurer may, at its option, accept a claim form different from the uniform form prescribed by this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 743.028

Stats. Implemented: ORS 743.028

Hist.: IC 73, f. 2-25-77, ef. 3-1-77; IC 75, f. & ef. 5-27-77; ID 1-1995, f. 4-26-95, cert. ef. 8-1-95

836-050-0115

Permitted Modifications to Uniform Forms

(1) An insurer may add to the face of the form its own identification and similar information, including insurer name and logo and policy identification by color coding or otherwise. The captions may be supplemented by instructions that merely facilitate the completion of the form.

(2) An insurer may add to the back of the form or, for **Exhibit 2**, to any blank area on the face of the form, an item whose purpose is the certification of the status of the patient as a person in the insured group or as a member of the family or dependent of a person in the insured group. In the case of a claim form required by a state agency, the back of the form may also contain such provider certification and acknowledgment language as is required or permitted by law.

(3) No alteration may be made to the format of the face of the form. No addition to the form may impose any additional requirement on any person, except for the certification item permitted by section (2) of this rule.

(4) An insurer may screen the portions of the uniform claim form that it does not require to be completed, if the screening is done in such a way as to leave these portions usable by others.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 743.028

Stats. Implemented: ORS 743.028

Hist.: IC 73, f. 2-25-77, ef. 3-1-77; IC 75, f. & ef. 5-27-77

836-050-0120

Effective Date; Temporary Provisions

(1) Except as provided in sections (2) and (3) of this rule, OAR 836-050-0105 and 836-050-0110 as amended are effective August 1, 1995, for claims other than dental care claims and for dental care claims.

(2) For claims other than dental care claims, an insurer shall accept until January 1, 1996, a properly completed claim submitted on either the **Exhibit 1** form of OAR 836-050-0110 in effect on July 31, 1995, or the **Exhibit 1** form of OAR 836-050-0110 effective as of August 1, 1995.

(3) For dental care claims, insurers shall accept until January 1, 1996, a properly completed claim submitted on either the **Exhibit 2** form of OAR 836-050-0110 in effect on July 31, 1995, or the **Exhibit 2** form of OAR 836-050-0110 effective as of August 1, 1995.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 743.028

Stats. Implemented: ORS 743.028

Hist.: IC 73, f. 2-25-77, ef. 3-1-77; IC 75, f. & ef. 5-27-77; ID 1-1995, f. 4-26-95, cert. ef. 8-1-95

Life and Health Insurance Benefit Provisions Relating to

HIV Infection

836-050-0200

Purpose, Scope and Definitions

(1) OAR 836-050-0200 to 836-050-0215 provide for equitable coverage under life and health insurance policies for conditions relating to HIV-infection, including AIDS and ARC. OAR 836-050-0200 to 836-050-0215 apply to all health insurance policies, including those of fraternal benefit societies and health care service contractors, issued or delivered for issue in Oregon. OAR 836-050-0200, 836-050-0205, 836-050-0207, and 836-050-0210 apply to all life insurance policies, including those of fraternal benefit societies, issued or delivered for issue in Oregon.

(2) For purposes of OAR 836-050-0200 to 836-050-0215:

(a) "AIDS" means Acquired Immunodeficiency Syndrome;

(b) "ARC" means AIDS Related Complex;

(c) "HIV" means Human Immunodeficiency Virus.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 742.003, 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

836-050-0205

Authority

(1) OAR 836-050-0200 to 836-050-0215 are adopted by the Director pursuant to the general rulemaking authority of the Director under ORS 731.244, for the purpose of carrying out the responsibilities of the Director under ORS 731.008 and 731.016, regarding the protection of the insurance-buying public, under 742.003 and 742.005, regarding approval of

forms, and under ORS 746.240, regarding definition of unfair practices in the transaction of insurance.

(2) OAR 836-050-0250 as amended effective October 13, 1997, applies to testing performed on and after August 15, 1997. An insurer must furnish the informational brochure in the exhibit to OAR 836-050-0250 as amended effective October 13, 1997, to applicants as required by OAR 836-050-0250 on and after January 1, 1998.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88; ID 1-1997(Temp), f. & cert. ef. 2-24-97; ID 12-1997, f. & cert. ef. 10-13-97

836-050-0207

Unfair Trade Practices

Failure of an insurer to comply with OAR 836-050-0210 and 836-050-0215 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

836-050-0210

General Exclusions

(1) All health insurance policies, other than those providing coverage only for specified diseases, shall cover HIV infection, including AIDS and ARC, as they would any other serious medical condition.

(2) All life insurance policies, other than those providing coverage for specific causes of death only, shall cover death from AIDS or ARC as they would death from any other cause.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

836-050-0215

Pre-existing Condition Exclusions; Health Insurance

With respect to health insurance policies:

(1) Asymptomatic HIV infection shall not be considered a preexisting condition with respect to subsequent claims related to AIDS or ARC. "Asymptomatic HIV infection" is that which is identified solely through use of a test for a virus or antibodies to the virus.

(2) The period of exclusion for HIV infection claims, when physical symptoms were present before the coverage date, shall be no longer than that for other pre-existing diseases.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88; ID 1-1997(Temp), f. & cert. ef. 2-24-97; ID 12-1997, f. & cert. ef. 10-13-97

Application Questions and Underwriting Practices Relating to HIV Infection

836-050-0230

Purpose, Scope and Definitions

(1) OAR 836-050-0230 to 836-050-0255 provide for fair standards of underwriting for risks relating to HIV infection and apply to all transactions of life and health insurance subject to the Oregon Insurance Code. Such transactions include the underwriting of applicants for coverage under individual and group life and health insurance, as well as the setting of group underwriting standards. OAR 836-050-0230 to 836-050-0255 apply to all insurers, including health care service contractors and fraternal benefit societies, and all insurance agents and insurance support organizations, that are engaged in the transaction of life and health insurance under the Oregon Insurance Code.

(2) For purposes of OAR 836-050-0230 to 836-050-0255:

(a) "AIDS" means Acquired Immunodeficiency Syndrome;

(b) "ARC" means AIDS Related Complex;

(c) "HIV" means Human Immunodeficiency Virus.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

836-050-0235

Rulemaking Authority

OAR 836-050-0230 to 836-050-0255 are adopted by the Director pursuant to the general rulemaking authority of the Director under ORS 731.244, for the purpose of carrying out the responsibilities of the Director under ORS 731.008 and 731.016, regarding the protection of the insurance-buying public, under 742.003 and 742.005, regarding approval of forms, and under ORS 746.240, regarding definition of unfair practices in the transaction of insurance; and for the purpose of assuring compliance by insurers with the requirements of ORS 433.045.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.005 & 746.240

Hist.: ID 5-1988(Temp), f. & cert. ef. 2-26-88; ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88; ID 18-1988, f. & cert. ef.

10-31-88; ID 1-1997(Temp), f. & cert. ef. 2-24-97; ID 12-1997, f. & cert. ef. 10-13-97

836-050-0237

Unfair Trade Practices

Failure of an insurer to comply with any provision of OAR 836-050-0240 or 836-050-0245, or the requirement in OAR 836-050-0250(2)(a) that testing for HIV infection be done only with the informed consent of the applicant for insurance, is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88; ID 18-1988, f. & cert. ef. 10-31-88

836-050-0240

General Principles

(1) No inquiry in an application for health or life insurance coverage, in an investigation conducted by an insurer, agent or insurance support organization in connection with an application for such coverage, shall be directed toward determining the applicant's sexual orientation.

(2) Sexual orientation shall not be used in the underwriting process or in the determination of insurability.

(3) Insurance support organization shall be directed by insurers not to investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary.

(4) Testing for or asking medical questions about HIV infection, including ARC and AIDS, is prohibited when not done in conjunction with testing for or asking medical questions about other health conditions. However, testing for HIV infection alone is permissible if the applicant has answered affirmatively that the applicant has tested positive in any HIV antibody test or has been diagnosed as having HIV infection, including AIDS or ARC.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

836-050-0245

Medical and Lifestyle Application Questions and Underwriting Standards

(1) No question shall be used that is designed to establish the sexual orientation of the applicant.

(2) The following provisions govern medical questions relating to HIV infection:

(a) Questions relating to the applicant's having or having been diagnosed as having HIV infection, including AIDS or ARC, and permissible if the questions are factual and designed to establish the existence of the condition. For example, insurer shall not ask such questions as "do you believe you may have...?", or "have you had any indications of...?", but

insurers may ask "have you been diagnosed or treated for...?";

(b) Questions relating to HIV infection, including AIDS and ARC, may be asked, but only if questions related to other high risk medical conditions are also asked. The questions must be presented and asked, and the answers used, in the same manner as other questions and their answers relating to other high risk medical conditions. Additional questions may be asked in a supplement but the supplement must be used in conjunction with medical questions on the application form.

(3) Questions relating to medical and other factual matters that are intended to reveal the possible existence of a medical condition are permissible if they are not used to establish the sexual orientation of the applicant and if the applicant is given opportunity to provide a detailed explanation for any affirmative answers given in the application. For example, insurers may ask such questions as, "Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands,...?" Such questions must pertain to a finite period of time preceding completion of the application, not to exceed ten years. The finite period does not apply to questions concerning prior diagnosis, treatment or testing.

(4) Questions relating to the applicant's having, or having been diagnosed as having, or having been advised to seek treatment for, a sexually transmitted disease are permissible.

(5) Neither the marital status, the "living arrangements", the occupation, the gender, the medical history, the beneficiary designation nor the zip code or other territorial classification of an applicant may be used to establish, or aid in establishing, the applicant's sexual orientation.

(6) For purposes of rating an applicant for health and life insurance, an insurer may impose territorial rates, but only if the rates are based on sound actuarial principles and are related to actual or reasonably anticipated experience.

(7) No adverse underwriting decision shall be based on information that the applicant has demonstrated AIDS, ARC or other HIV infection-related concerns by seeking counseling from health care professionals. This section does not apply to an applicant seeking treatment or diagnosis.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.005 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

836-050-0250

Testing for HIV Infection

(1) An insurer may not rate or deny coverage on the basis of test results unless the rating or denial is based on a test protocol consisting of two positive ELISA tests confirmed by a Western Blot test or another test or test series that the state epidemiologist finds to be no less accurate. This testing series may be performed on blood samples, or on oral specimens obtained and tested according to approval by the federal Food and Drug Administration. If the result of a Western Blot test is indeterminate, the insurer may postpone action on the application not longer than six months after the date of that Western Blot test in order to retest the applicant for conclusive Western Blot test results. The insurer may rate or deny coverage only if retesting produces the positive testing result or if the applicant declines the retesting or fails to respond to a request for retesting by the insurer.

(2) The following provisions apply to all testing for HIV infection and consent therefor:

(a) Testing may be done only with the informed consent of the applicant. Any test that helps an insurer determine the presence of HIV infection and is performed in conjunction with an insurance application shall have a signed consent by the applicant regarding the specific types of tests involved. This consent shall require the applicant to designate the person to whom final positive test results are to be reported. The applicant may designate a named physician, the county

health department or the applicant directly. An insurer may obtain the consent of the applicant at any time in the underwriting process prior to obtaining a sample or specimen;

(b) The consent form must be submitted to the Director for approval before use. A consent form may not be used unless the Director has approved the form as complying with OAR 836-050-0230 to 836-050-0255;

(c) An insurer shall disclose to the applicant when soliciting consent that the test is used for determining insurability;

(d) A copy of an informational brochure containing the information in Exhibit 1 shall be given to the applicant prior to or at the time of consent. The consent form and informational brochure may be combined in one form;

(e) A consent form signed by an applicant is valid for six months following the date that the consent form was signed. The consent form must so state. If after six months the test is not performed or retesting is needed, a new signed consent form must be obtained.

(3) All final positive HIV results shall be directly or indirectly disclosed to the applicant as provided in this section. Information about the results that an insurer acquires through required tests other than from a physician shall be disclosed to the applicant through the physician or county health department named by the applicant for that purpose, so that the physician or county health department may give further explanation of the results to the applicant. Such information may be disclosed directly to the applicant only if the applicant requested disclosure in the consent form and if the insurer, after receipt of positive HIV results confirmed through the protocol in section (1) of this rule, has given the applicant another opportunity to designate a physician or county health department. Direct disclosure to the applicant of final positive HIV results shall include a notice that gives the Oregon AIDS Hotline numbers for securing local assistance and advises the applicant to call the Oregon AIDS Hotline or consult a physician.

(4) An insurer may report only positive test results determined under section (1) of this rule to the person or person designated in the consent form and to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. For positive test results as defined in section (1) of this section, an insurer may also make a report of a nonspecific abnormality determined by the testing of blood or oral specimen to the Medical Information Bureau. An insurer may not make a report to the Medical Information Bureau when positive or inconclusive results occur only with respect to preliminary tests, even when the applicant fails to follow up with the required protocol.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.005 & 746.240

Hist.: ID 5-1988(Temp), f. & cert. ef. 2-26-88; ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88; ID 18-1988, f. & cert. ef. 10-31-88; ID 1-1997(Temp), f. & cert. ef. 2-24-97; ID 12-1997, f. & cert. ef. 10-13-97

836-050-0255

Inquiries Regarding Past Test Results

Insurers may ask whether an applicant has tested positive in any HIV antibody test, subject to the following restrictions:

(1) General questions asking only whether the applicant has taken such a test, regardless of outcome, are prohibited.

(2) Except as provided in this section, an insurer may not rate or deny coverage based merely on an affirmative response on the application to a questions about past test results. Before rating or denying coverage, the insurer must confirm a positive result to the full test protocol described in OAR 836-050-0250 through medical records or current retesting unless:

(a) The applicant fails to respond to a request by the insurer for the medical records or for retesting; or

(b) The insurer is informed that the applicant declines such further testing.

Stat. Auth.: ORS Ch. 433, 731, 743 & 746

Stats. Implemented: ORS 433.045(7), 742.00 & 746.240

Hist.: ID 6-1987(Temp), f. & cert. ef. 11-9-88; ID 10-1988, f. & cert. ef. 6-10-88

Group Policyholders

836-050-0275

Credit Unions as Associations; Group Life Insurance

A credit union organized under ORS chapter 723, a credit union authorized to conduct business as a credit union in this state under ORS 723.042 or a federal credit union the principal office of which is located in Oregon is considered to be maintained primarily for purposes other than the procurement of insurance. Such a credit union may qualify as an association for the purposes of being the policyholder of a group life insurance policy if:

(1) The credit union is authorized to provide insurance to its members under the laws under which the credit union is organized; and

(2) The Director determines that the credit union otherwise satisfies the requirements of ORS 743.351(1).

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.303 & 743.351

Hist.: ID 17-1990, f. & cert. ef. 7-25-90; ID 7-1994, f. & cert. ef. 6-3-94

836-050-0280

Credit Unions as Association; Group Health Insurance

A credit union organized under ORS chapter 723, a credit union authorized to conduct business as a credit union in this state under ORS 723.042 or a federal credit union the principal office of which is located in Oregon is considered to have a constitution and bylaws and to be maintained primarily for purposes other than the procurement of insurance. Such a credit union may qualify as an association for the purposes of being the policyholder of a group health insurance policy if:

(1) The credit union is authorized to be such a policyholder under the laws under which the credit union is organized; and

(2) The Director determines that the credit

union otherwise satisfies the requirements of ORS 743.522(2).

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.522 & 743.524

Hist.: ID 17-1990, f. & cert. ef. 7-25-90; ID 7-1994, f. & cert. ef. 6-3-94

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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1998 Compilation

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 51

LIFE, INDIVIDUAL AND GROUP; ANNUITIES

Life Disclosure Requirements

836-051-0005

Statutory Authority; Purpose; Applicability

(1) OAR 836-051-0005 to 836-051-0025 are adopted by the Director pursuant to general rulemaking authority in ORS 731.244, and specific authority in ORS 742.009 to issue rules requiring disclosures to prospective insurance purchasers.

(2) The purpose of these rules is to require insurers that are not electing to illustrate life insurance policies under OAR 836-051-0500 to 836-051-0600 to deliver to prospective buyers of life insurance guaranteed policy information that will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs, improve the buyer's understanding of the basic features of the policy that has been purchased or that is under consideration and improve the buyer's ability to evaluate the relative costs of similar plans of life insurance. These rules do not prohibit the use of additional material that is not in violation of these or other rules of the Director or provisions of the Insurance Code.

(3) These rules apply to all transactions of life insurance in this state except with respect to:

(a) Annuities;

(b) Credit life insurance;

(c) Group life insurance;

(d) Life insurance policies issued in connection with employee benefit plans as defined by Section 3(3) of the federal Employee Retirement Income Security Act of 1974 (ERISA) as amended from time to time; and

(e) Life insurance policies that comply with OAR 836-051-0500 to 836-051-0600.

Stat. Auth.: ORS 731.244 & 742.009

Stats. Implemented: ORS 742.009

Hist.: IC 3-1978, f. & ef. 6-9-78; ID 15-1996, f. & cert. ef. 11-12-96; ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0010

Definitions

As used in OAR 836-051-0005 to 836-051-0025:

(1) "Buyer's Guide" means a document that contains, and is limited to, the wording contained in **Exhibit 1** or other wording approved by the Commissioner.

(2) "Cash Dividend" means the currently illustrated dividend that can be applied toward payment of the gross premium.

(3) "Equivalent Level Annual Dividend" means the amount calculated by the following steps:

(a) Accumulate the annual cash dividends at five percent interest, compounded annually, to the ends of the 10th and 20th policy years;

(b) Divide each accumulation of step (a) by an interest factor that converts it into the equivalent level annual amount that, if paid at the beginning of each year, would accumulate to the value in step (a) over the respective period. If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

(c) Divide the results of step (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Equivalent Level Annual Dividend for each of the respective periods.

(4) "Equivalent Level Death Benefit" of a policy or term life insurance rider means the amount calculated by the following steps:

(a) Accumulate the guaranteed amount, that does not depend on the cause of death, payable upon death at the beginning of each policy year for 10 and 20 years at five percent interest, com-pounded annually, to the ends of the 10th and 20th policy years respectively;

(b) Divide each accumulation of step (a) by an interest factor that converts it into the equivalent level annual amount that, if paid at the beginning of each year, would accumulate to the value in step (a) over the respective period. If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

(5) "Generic Name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

(6) "Life Insurance Net Payment Cost Index" means the amount calculated in the same manner as the Life Insurance Surrender Cost Index except that the cash surrender value and any terminal dividend are set at zero.

(7) "Life Insurance Surrender Cost Index" means the amount calculated by the following steps:

(a) Determine the guaranteed cash surrender value, if any, available at the ends of the 10th and 20th policy years;

(b) For participating policies, add to the respective amount determined in step (a) the accumulation of the annual Cash Dividends at five percent interest, compounded annually, to the end of the period selected, and the respective terminal dividend, if any, payable upon surrender;

(c) Divide the result of step (b), or step (a) for guaranteed cost policies, by an interest factor that converts it into the equivalent level annual amount that, if paid at the beginning of each year, would accumulate to the value in step (b), or step (a) for guaranteed cost policies, over the period selected. If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

(d) Determine the equivalent level annual premium for each of the respective periods in step (a) by accumulating each annual premium payable for the basic policy or rider at five percent interest, compounded annually, to the end of the respective period and dividing the result by the respective period factor stated in step (c). (For a level premium plan, the result of this step equals the annual premium.);

(e) Subtract the result of step (c) from the result of step (d);

(f) Divide the result of step (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Life Insurance Surrender Cost Index.

(8) "Policy Summary" means a written statement describing the elements of the policy, including but not limited to items in subsections (a) to (k) of this section. The Policy Summary is a separate document. All information must be set out in such a manner as not to minimize or obscure any portion. Any amounts that remain level for two or more years of the policy may be represented by a single number if it is clearly indicated which amounts are applicable for each policy year. If more than one insured is covered under the policy or a rider, guaranteed death benefits shall be displayed separately for each insured, or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be expressed rather than being represented by a blank space:

(a) A prominently placed title as follows: **STATEMENT OF POLICY COST AND BENEFIT INFORMATION**;

(b) The name and address of the insurance agent or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Summary;

(c) The full name and home office or administrative office address of the insurer in which the life insurance policy is to be or has been written;

(d) The Generic Name of the basic policy and each policy rider;

(e) The following amounts, where applicable, on a total basis rather than on a per thousand or a per unit basis, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which Life Insurance Net Payment or Surrender Cost Indexes are displayed and at least one age from 60 through 65 or policy maturity, whichever is earlier:

(A) Annual premium for the basic policy;

(B) Annual premium for each optional rider;

(C) Guaranteed amount payable upon death at the beginning of the policy year, without regard to the cause of death other than suicide and other specific exclusions, that is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;

(D) Total guaranteed cash surrender values at the end of the year, with values shown separately for the basic policy and each optional rider;

(E) Cash Dividends payable at the end of the year, with values shown separately for the basic policy and each optional rider. (Dividends need not be displayed beyond the 20th policy year.);

(F) Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values above.

(f) If the policy contains a loan provision, the effective policy loan interest rate and the annual percentage interest rate applied in advance or in arrears, whichever is specified. If the policy loan interest rate is variable, the Policy Summary shall include the maximum effective and annual percentage rates;

(g) Life Insurance Net Payment and Surrender Cost Indexes for 10 and 20 years but in no case beyond the premium-

paying period. Separate Indexes shall be displayed for the basic policy and for each optional term life insurance rider. The Indexes need not be included for optional riders that are limited to such benefits as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits, nor for a basic policy or optional rider covering more than one life;

(h) The Equivalent Level Annual Dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations for which Life Insurance Net Payment and Surrender Cost Indexes are displayed;

(i) A statement, in the case of a Policy Summary that shows dividends, that dividends are based on the insurer's current dividend scale and are not guaranteed, and a statement in close proximity to the Equivalent Level Annual Dividend as follows: **"An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide"**;

(j) A statement in close proximity to the Life Insurance Net Cost and Surrender Cost Indexes as follows: **"An explanation of the intended use of these Indexes is provided in the Life Insurance Buyer's Guide"**;

(k) The date on which the Policy Summary is prepared.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 742.009(2)

Hist.: IC 3-1978, f. & ef. 6-9-78

836-051-0015

Disclosure Requirements

(1) An insurer shall provide to each prospective buyer of life insurance a Buyer's Guide and a Policy Summary prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision effective for at least ten days or unless the Policy Summary contains such an unconditional refund provisions, in either of which cases the Buyer's Guide and Policy Summary must be delivered with the policy or prior to delivery of the policy.

(2) An insurer shall provide a Buyer's Guide and a Policy Summary to any prospective buyer upon his request.

(3) In the case of policies for which the Equivalent Level Death Benefit does not exceed $5,000, the Policy Summary need include only the information described in the items in OAR 836-051-0010(8)(b), (c), (d), (e)(A), (e)(B), (e)(C), (f), (g), (j) and (k).

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 742.009(2)

Hist.: IC 3-1978, f. & ef. 6-9-78

836-051-0020

General Requirements

(1) An insurer shall maintain at its home office or principal office a complete file containing one copy of each document authorized by the insurer for use pursuant to OAR 836-051-0005 to 836-051-0025. Each such document shall be

retained in the file for at least three years following the date of its last authorized use.

(2) An agent shall inform a prospective buyer, prior to the beginning a life insurance sales presentation, that the agent is acting as a life insurance agent, and shall inform the prospective buyer of the full name of the insurer that he is representing to the buyer. In sales situations in which an agent is not involved, the insurers shall identify its full name.

(3) Such terms as "financial planner", "investment advisor", "financial consultant", or "financial counseling" shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sales, unless such is actually the case.

(4) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(5) A presentation that does not recognize through the use of appropriate interest adjustments the time value of money shall not be used for comparing the cost of two or more life insurance policies. Such a presentation may be used for the purpose of demonstrating the cash-flow pattern of a policy if it is accompanied by a statement disclosing that the presentation does not recognize that a dollar in the future has less value than a dollar today because of interest.

(6) A presentation of benefits shall not display guaranteed and non-guaranteed benefits as a single sum unless they are also shown separately in close proximity to the single sum.

(7) A statement regarding the use of the Life Insurance Net Cost and Surrender Cost Indexes shall include a explanation to the effect that the Indexes are useful only for the comparison of the relative costs of two or more similar policies.

(8) A statement of a Life Insurance Net Cost or Surrender Cost Index that reflects dividends, and an Equivalent Level Annual Dividend, shall be accompanied by a statement that it is based on the insurer's current dividend scale and is not guaranteed.

(9) For the purposes of OAR 836-051-0005 to 836-051-0025, the annual premium for a basic policy or optional rider for which the insurer reserves the right to change the premium shall be the maximum annual premium.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 742.009(2)

Hist.: IC 3-1978, f. & ef. 6-9-78

836-051-0025

Effective Date

OAR 836-051-0005 to 836-051-0020 shall apply to solicitations of life insurance that commence on or after January 1, 1979. Between the date these rules are filed with the Secretary of State (the "effective date") and January 1, 1979, compliance with these rules by an insurer will be an alternative to compliance with OAR 836-020-0065 to 836-020-0125. OAR 836-020-0065 to 836-020-0125 are repealed effective January 1, 1979.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 742.009(2)

Hist.: IC 3-1978, f. & ef. 6-9-78

Mortality Tables Authorized for Use in Determining

Nonforfeiture and Reserve Values

836-051-0101

Statutory Authority; Purpose; Applicability; and Effective Date

(1) OAR 836-051-0101 to 836-051-0115 are adopted pursuant to the general rulemaking authority of the Director in ORS 731.244, and specific authority of ORS 733.308 and 743.215 for approving mortality tables adopted by the National Association of Insurance Commissioners for use in determining minimum valuation and nonforfeiture standards.

(2) OAR 836-051-0101 to 836-051-0115 apply to policies of ordinary life insurance issued on the standard basis.

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: IC 5-1985, f. & ef. 11-20-85; ID 15-1996, f. & cert. ef. 11-12-96; ID 15-1997, f. & cert. ef. 10-29-97

836-051-0110

Life Insurance Nonforfeiture Standards for Men and Women

(1) Use of the blended tables procedure described in section (2) of this rule shall be limited to situations in which sex neutral benefits are required to comply with the decision of the United States Supreme Courts in **Arizona Governing Committee v. Norris, 463 U.S. 1073, 103 S. Ct. 3492, 77 1. Ed 2d 1236 (1983)**.

(2) In situations of section (1) of this rule, insurers may use the blended tables described in **NAIC Proposed Procedures for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insureds Under 1980 CSO and 1980 CET Mortality Tables**, **NAIC Proceedings, 1984 Volume I, pp. 426-428**, as amended in **Section 4** by **NAIC Proceedings, 1984 Volume 1, p. 395**. These procedures establish the method by which select factors are to be obtained for blended 1980 CSO Mortality Tables as described in **NAIC Proceedings, 1984 Volume I, p. 457**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 733 & 743

Stats. Implemented: ORS 733.306(1)-(2), (4)-(6)

Hist.: IC 5-1985, f. & ef. 11-20-85

836-051-0115

Smoker/Nonsmoker Mortality Tables

Insurers may use the tables as described in **Proposed NAIC Model Rule Permitting Smoker/Nonsmoker Mortality Rates for use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits. NAIC Proceedings, 1984 Volume I, pp. 458-460**. Nothing in this rule permits a company which has elected use of 1980 CSO for all new forms to revert to 1958 CSO for a subsequent form.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 733 & 743

Stats. Implemented: ORS 733.306(1)-(2), (4)-(6)

Hist.: IC 5-1985, f. & ef. 11-20-85

Annuity Mortality Tables

836-051-0200

Authority; Effective Date

OAR 836-051-0200 to 836-051-0250 are adopted by the Director of the Department of Consumer and Business Services pursuant to ORS 733.308.

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 15-1997, f. & cert. ef. 10-29-97

836-051-0210

Purpose

The purpose of OAR 836-051-0200 to 836-051-0250 is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts:

(1) The 1983 Table "a."

(2) The 1983 Group Annuity Mortality (1983 GAM) Table.

(3) The Annuity 2000 Mortality Table.

(4) The 1994 Group Annuity Reserving (1994 GAR) Table.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 15-1997, f. & cert. ef. 10-29-97

836-051-0220

Definitions

For the purpose of OAR 836-051-0200 to 836-051-0250, the following terms have the following meanings:

(1) "1983 Table 'a'" means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners. (See *1982 Proceedings of the NAIC II*, page 454.)

(2) "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners. (See *1984 Proceedings of the NAIC I*, pages 414 to 415.)

(3) "1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866-867 of Volume XLVII of the Transactions of the Society of Actuaries (1995).

(4) "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of Volume XLVII of the Transactions of the Society of Actuaries (1995).

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 15-1997, f. & cert. ef. 10-29-97

836-051-0230

Individual Annuity or Pure Endowment Contracts

(1) Except as provided in sections (2) and (3) of this rule, the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the insurer, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after October 4, 1977.

(2) Except as provided in section (3) of this rule, either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1998.

(3) Except as provided in section (4) of this rule, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1999.

(4) The 1983 Table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1, 1998, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(a) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(b) Settlements involving similar actions such as workers' compensation claims; or

(c) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 15-1997, f. & cert. ef. 10-29-97

836-051-0240

Group Annuity or Pure Endowment Contracts

(1) Except as provided in sections (1) and (2) of this rule, the 1983 GAM Table, the 1983 Table "a" and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the insurer, any one of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after October 4, 1977, under a group annuity or pure endowment contract.

(2) Except as provided in section (3) of this rule, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1998.

(3) The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 2000, under a group annuity or pure endowment contract.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 15-1997, f. & cert. ef. 10-29-97

836-051-0250

Application of the 1994 GAR Table

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows: $q_x^{1994+n} = qx^{1994} (1 - AA_x)^n$ where the q_x^{1994} and AA_xs are as specified in the 1994 GAR Table.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 15-1997, f. & cert. ef. 10-29-97

Accelerated Benefits Provision for Life Products

836-051-0300

Statutory Authority; Effective Date; Applicability

(1) OAR 836-051-0300 to 836-051-0380 are adopted pursuant to ORS 743.154.

(2) OAR 836-051-0300 to 836-051-0380 become effective on June 1, 1992.

(3) No life insurance policy, certificate or rider containing an accelerated benefit provision may be delivered or issued for delivery in this state on or after June 1, 1992, unless the provision complies with OAR 836-051-0300 to 836-051-0380.

(4) OAR 836-051-0300 to 836-051-0380 apply to individual and group life insurance policies and to riders and certificates issued thereunder. OAR 836-051-0300 to 836-051-0380 apply to all accelerated benefits provisions of life insurance policies except for provisions for advance payment of life insurance proceeds under OAR 836-052-0500 to 836-052-0645.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92; ID 1-1996, f. & cert. ef. 1-12-96

836-051-0310

Acknowledgement of Concurrence for Payout from Assignee or Beneficiary

Prior to payment of an accelerated benefit, an insurer shall obtain a signed acknowledgement of concurrence for payout as follows:

(1) From an assignee, when the amount of benefit that is accelerated exceeds the unassigned portion of the death benefit, unless the assignee is the insurer.

(2) From an irrevocable beneficiary, if there is an irrevocable beneficiary.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92

836-051-0320

Payment Options; Filing of Claims; Remaining Benefits

(1) An insurer shall include among payment options for the accelerated benefit an option that allows the policy owner or certificate holder to take the benefit as a lump sum. The insurer shall not make the benefit available as an annuity contingent upon the life of the insured.

(2) An insurer shall not impose any restriction on the use of the proceeds.

(3) If any death benefit remains after payment of an accelerated benefit, any accidental death benefit that is part of the policy shall not be affected by the payment of the accelerated benefit. Any other benefits in force at the time of acceleration shall not be affected by the payment of the accelerated benefit if premiums continue to be paid for those benefits.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92; ID 12-1993, f. & cert. ef. 11-19-93; ID 15-1996, f. & cert. ef. 11-12-96

836-051-0330

Disclosure

(1) An accelerated benefit provision shall include "accelerated benefit" or "accelerated death benefit" as part of the descriptive title. The policy, certificate or rider schedule must:

(a) Include one of the following:

(A) Any premium or cost of insurance charge designated for the accelerated benefit;

(B) The interest rate if fixed; or

(C) The method used by the insurer to establish the interest rate in OAR 836-051-0370(3); and

(b) Disclose any administrative expense charge associated with the exercise of the accelerated benefit.

(2) When a life insurance policy or certificate containing an accelerated benefit provision is applied for or delivered, or when an accelerated benefit rider to a life insurance policy is applied for, delivered or added, the insurer shall give or cause to be given a summary of coverage described in this section to the applicant for the policy, certificate or rider. The description must include all of the following:

(a) A brief summary of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefit;

(b) An explanation of any effect of the payment of an accelerated benefit on the cash value, accumulation account, death benefit, premium payments, any loans or liens.

(c) Disclosure of the basis for payment, whether a premium, cost of insurance charge, lien assessment or present value calculation;

(d) A statement that receipt of the accelerated benefit may be taxable and that assistance should be sought from a personal tax advisor.

(3) When an accelerated benefit option is exercised, the insurer shall provide the following to the policy holder or certificate holder and any irrevocable beneficiary:

(a) An illustration that:

(A) Numerically demonstrates any effect the payment of the benefit will have on the cash value, accumulation account, death benefit, premium payments, any loans or liens;

(B) Separately illustrates the loaned amount from the accelerated risk amount if the acceleration is based on a lien and the interest accrued on the two portions are not at the same rate; and

(C) Includes a statement that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, that benefits may be taxable and that assistance should be sought from a personal tax advisor.

(b) An amended schedule page showing any new, reduced in-force face amount and the continuing premium

requirements to keep the remaining coverage in force.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92; ID 12-1993, f. & cert. ef. 11-19-93

836-051-0340

Exercise of the Accelerated Benefit

(1) For conditions of eligibility resulting from accident, an accelerated benefit provision must be exercisable on or after the issue date of the accelerated benefit provision.

(2) For conditions of eligibility resulting from illness, an accelerated benefit provision must be exercisable not later than the 30th day after the issued date of the accelerated benefit provision.

(3) For the purpose of defining the qualifying event described in ORS 743.154(2)(c), an insurer shall not require a period of continuous confinement that is greater than 180 days.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92

836-051-0350

Waiver of Premium

(1) An insurer may offer a waiver of premium as part of the accelerated benefit provision in the absence of a regular waiver of premium provision.

(2) When an accelerated benefit is included in an individual term policy or an individually-paid group certificate, the accelerated benefit provision must include a waiver of premium provision for any remaining face amount.

(3) A term rider shall not be affected by the payment of the accelerated benefit if premiums continue to be paid for the rider.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92; ID 1-1996, f. & cert. ef. 1-12-96

836-051-0360

Discrimination

In the payment of accelerated benefits, an insurer shall not unfairly discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

An insurer shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider. An insurer who provides that its accelerated benefit provision is exercisable in the event of a medical condition to which ORS 743.154(2)(d) applies shall not limit exercise of the benefit to specific medical conditions.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92

836-051-0370

Minimum Benefit Standards

(1) For purposes of this rule, accelerated benefits consist of:

(a) The risk portion of the accelerated benefit, determined by deducting the cash values in the contract from the total accelerated benefit amount; and

(b) The portion of the accelerated benefit equal to the cash value in the policy at the time of acceleration. Any amount included in the accelerated benefit that is accessible through another policy provision is subject to that policy provision if more favorable to the policy holder or certificate holder. Such an amount must be separately identified.

(2) An insurer may require a premium charge or cost of insurance charge for the accelerated benefit provision. Such a charge shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be included in the experience rating.

(3) The following provisions apply to deferred financing options relating to an accelerated benefit provision:

(a) An insurer may pay a present value of the face amount or portion of the face amount being accelerated. The calculation must be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation must be based on sound actuarial principles and disclosed in the contract and actuarial memorandum;

(b) An insurer may accrue an interest charge on the amount of the accelerated benefit as part of a lien against the death proceeds. The interest rate or interest rate methodology used in the calculation must be based on sound actuarial principles and disclosed in the contract and actuarial memorandum;

(c) For purposes of subsections (a) and (b) of this section, the maximum interest rate used on the risk portion must not be greater than the greater of:

(A) The current yield on 90-day treasury bills; or

(B) The current maximum statutory adjustable policy loan interest rate. If a policy, certificate or rider does not have a loan provision, the maximum rate shall not be greater than the fixed statutory policy loan interest rate.

(d) For purposes of subsections (a) and (b) of this section, the interest rate used on the portion that is equal in amount to the cash value of the contract at the time of the benefit acceleration must not be more than the policy or certificate loan interest rate stated in the policy, certificate or rider.

(4) When an accelerated benefit is payable, not more than a pro rata reduction may be made in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.

(5) An insurer may consider the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest to be a lien against the death benefit of the policy, certificate or rider and may restrict the access to the cash value to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans may also be limited to any excess of the cash value over the sum of the lien any any other outstanding policy loans.

(6) When payment of an accelerated benefit results in a pro rata reduction in the cash value, the insurer may not apply the payment toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92; ID 12-1993, f. & cert. ef. 11-19-93

836-051-0380

Actuarial Disclosure and Reserves

(1) An insurer shall submit an actuarial memorandum with each filing that describes the accelerated benefit, the risks, the expected costs, the development of premiums, the bases used to calculate benefits payable and the calculation of statutory reserves.

(2) When an accelerated benefit is included as part of a policy, certificate or rider, an insurer shall determine reserves in accordance with the Standard Valuation Law. The actuary must follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate must be sufficient to cover:

(a) Policies upon which no claim has yet arisen; and

(b) Policies upon which an accelerated claim has arisen.

(3) Policy liens and policy loans, including accrued interest, represent assets of the insurer for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability, the excess must be held as a non-admitted asset.

Stat. Auth.: ORS 731.244 & 743.154

Stats. Implemented: ORS 743.154

Hist.: ID 8-1992, f. 5-26-92, cert. ef. 6-1-92

Life Insurance Illustrations

836-051-0500

Purpose; Authority

(1) The purpose of OAR 836-051-0500 to 836-051-0600 is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. OAR 836-051-0500 to 836-051-0600 provide illustration formats, prescribe standards to be followed when illustrations are used and specify the disclosures that are required in connection with illustrations. The goals of OAR 836-051-0500 to 836-051-0600 are to ensure that illustrations do not

mislead purchasers of life insurance and to make illustrations more understandable.

(2) Insurers shall, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

(3) OAR 836-051-0500 to 836-051-0600 are adopted pursuant to ORS 731.244 and 746.240 for the purpose of implementing ORS 746.075, 746.085, 746.100, 746.110 and 746.240.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0510

Applicability and Scope

(1) OAR 836-051-0500 to 836-051-0600 apply to all group life insurance policies and certificates and all individual life insurance policies except:

(a) Variable life insurance;

(b) Individual and group annuity contracts;

(c) Credit life insurance;

(d) Life insurance policies with an illustrated death benefit that does not exceed $10,000 on any individual; and

(e) Group term life insurance policies.

(2) OAR 836-051-0500 to 836-051-0600 apply to life insurance policies described in section (1) of this section that are sold on or after July 1, 1997. An insurer may conform its policies to the provisions of OAR 836-051-0500 to 836-051-0600 prior to that date.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0520

Definitions

For the purposes of OAR 836-051-0500 to 836-051-0600:

(1) "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(2) "Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

(3) "Currently payable scale" means a scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next 95 days.

(4) "Disciplined current scale" means a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer, that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

(a) Are consistent with all provisions of OAR 836-051-0500 to 836-051-0600;

(b) Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(c) Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(d) Do not permit assumed expenses to be less than minimum assumed expenses.

(5) "Generic name" means a short title descriptive of the policy being illustrated, such as "whole life," "term life" or "flexible premium adjustable life."

(6) "Guaranteed elements" and "non-guaranteed elements" have the following meanings:

(a) "Guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue;

(b) "Non-guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

(7) "Illustrated scale" means a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(a) The disciplined current scale; or

(b) The currently payable scale.

(8) "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years and that is one of the following three types:

(a) "Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements;

(b) "Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of OAR 836-051-0500 to 836-051-0600, and that may be presented in a format differing from the basic illustration, but may depict only a scale of non-guaranteed elements that is permitted in a basic illustration;

(c) "In force illustration" means an illustration furnished at any time after the policy that the illustration depicts has been in force for one year or more.

(9) "Illustration actuary" means an actuary meeting the requirements of OAR 836-051-0580 who certifies to illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

(10) "Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting as described in OAR 836-051-0500 to 836-051-0600, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five years and 100 percent policy persistency thereafter.

(11) "Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. An insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(a) Fully allocated expenses;

(b) Marginal expenses, except that marginal expenses may be used only if greater than a generally recognized expense table, and if no generally recognized expense table is approved, fully allocated expenses must be used; and

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the Director.

(12) "Non-term group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group when:

(a) Every plan of coverage was selected by the employer or other group representative;

(b) Some portion of the premium is paid by the group or through payroll deduction; and

(c) Group underwriting or simplified underwriting is used.

(13) "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

(14) "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

(15) "Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value must include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0530

Policies to be Illustrated

(1) An insurer shall identify each life insurance policy form filed with the Director on or after July 1, 1997, that will be marketed with an illustration. For informational purposes, the insurer shall file with the policy form filing a sample illustration in John Doe format to match a John Doe policy. Approval of a policy form filing will not be given until the Director has received the informational sample illustration. The insurer shall also identify in writing each policy form being actively marketed on July 1, 1997, with which an illustration is being or will be used. Any decision to market with an illustration or not may be changed by notice to the Director.

(2) If an insurer does not identify a policy form as one to be marketed with an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

(3) If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared

and delivered in accordance with OAR 836-051-0500 to 836-051-0600 is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

(4) Potential enrollees of non-term group life insurance subject to OAR 836-051-0500 to 836-051-0600 shall be furnished a quotation as described in this section with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of OAR 836-051-0500 to 836-051-0600, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0540

General Rules and Prohibitions

(1) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of OAR 836-051-0500 to 836-051-0600, be clearly labeled "life insurance illustration" and contain the following basic information:

(a) Name of insurer;

(b) Name and business address of the agent, if any;

(c) Name, age and sex of proposed insured, except when a composite illustration is permitted under OAR 836-051-0500 to 836-051-0600;

(d) Underwriting or rating classification upon which the illustration is based;

(e) Generic name of policy, the insurer product name, if different, and form number;

(f) Initial death benefit; and

(g) Dividend option election or application of non-guaranteed elements, if applicable.

(2) When using an illustration in the sale of a life insurance policy, neither an insurer nor its agent shall:

(a) Represent the policy as anything other than a life insurance policy;

(b) Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(c) State or imply that the payment or amount of non-guaranteed elements is guaranteed;

(d) Use an illustration that does not comply with the requirements of OAR 836-051-0500 to 836-051-0600;

(e) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than

that produced by the illustrated scale of the insurer whose policy is being illustrated;

(f) Provide an applicant with an incomplete illustration;

(g) Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

(h) Use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;

(i) Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported;" or

(j) Use an illustration that is not "self-supporting."

(3) If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0550

Standards for Basic Illustrations

(1) The format of a basic illustration shall conform to the following requirements:

(a) The illustration shall be labeled with the date on which it was prepared;

(b) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages");

(c) The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

(d) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

(e) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay;

(f) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

(g) If the illustration shows any non-guaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled non-guaranteed;

(h) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page one for guaranteed elements");

(i) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender;

(j) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable;

(k) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form;

(l) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(A) The benefits and values are not guaranteed;

(B) The assumptions on which they are based are subject to change by the insurer; and

(C) Actual results may be more or less favorable.

(m) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up;

(n) If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may show such use of dividends or policy values and the effect on future policy benefits and values.

(2) A basic illustration shall have a narrative summary, which shall include the following:

(a) A brief description of the policy being illustrated, including a statement that it is a life insurance policy;

(b) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

(c) A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

(d) Identification and a brief definition of column headings and key terms used in the illustration; and

(e) A statement containing in substance the following: "This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

(3) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. The following provisions apply to the numeric summary:

(a) For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five, ten and twenty and at age 70, if applicable, on the three bases shown in this subsection. For multiple life policies, the summary shall show policy years five, ten, twenty and thirty. The three bases are as follows:

(A) Policy guarantees;

(B) Insurer's illustrated scale;

(C) Insurer's illustrated scale used but with the non-guaranteed elements reduced as follows:

(i) Dividends at 50 percent of the dividends contained in the illustrated scale used;

(ii) Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(iii) All non-guaranteed charges, including but not limited to, term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(b) In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three bases.

(4) A basic illustration shall include the following tabular detail:

(a) A basic illustration shall include the following for at least each policy year from one to ten and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(A) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

(B) The corresponding guaranteed death benefit, as provided in the policy; and

(C) The corresponding guaranteed value available upon surrender, as provided in the policy.

(b) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium; and

(c) Non-guaranteed elements may be shown if described in the narrative. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

(5) Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in OAR 836-051-0500 to 836-051-0600.

(a) A statement to be signed and dated by the applicant or policy owner reading as follows: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."

(b) A statement to be signed and dated by the agent that reads as follows: "I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0560

Standards for Supplemental Illustrations

(1) A supplemental illustration may be provided so long as:

(a) It is appended to, accompanied by or preceded by a basic illustration that complies with OAR 836-051-0500 to 836-051-0600;

(b) The non-guaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(c) It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed; and

(d) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

(2) The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0570

Delivery of Illustration and Record Retention

(1) If a basic illustration is used by an agent in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with OAR 836-051-0500 to 836-051-0600, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant. If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall conform to the requirements of OAR 836-051-0500 to 836-051-0600, shall be labeled "Revised Illustration" and shall be signed and dated by the applicant or policy owner and agent no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

(2) If no illustration is used by an agent in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the agent shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application. If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

(3) If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this section shall be satisfied if the insurer can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be satisfied if the insurer includes in the mailing a self-

addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

(4) A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three years after the policy is no longer in force. A copy need not be retained if no policy is issued.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0580

Annual Report; Notice to Policy Owners

(1) In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(a) For universal life policies, the report shall include the following:

(A) The beginning and end date of the current report period;

(B) The policy value at the end of the previous report period and at the end of the current report period;

(C) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(D) The current death benefit at the end of the current report period on each life covered by the policy;

(E) The net cash surrender value of the policy as of the end of the current report period;

(F) The amount of outstanding loans, if any, as of the end of the current report period; and

(G) For fixed premium policies: If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(H) For flexible premium policies: If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

(b) For all other policies, when applicable:

(A) Current death benefit;

(B) Annual contract premium;

(C) Current cash surrender value;

(D) Current dividend;

(E) Application of current dividend; and

(F) Amount of outstanding loan.

(c) Insurers writing life insurance policies that do not build nonforfeiture values shall be required to provide only an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

(2) If the annual report does not include an in force illustration, it shall contain the following notice displayed prominently:

"**IMPORTANT POLICY OWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address] or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department."

The insurer may vary the sequential order of the methods for obtaining an in force illustration.

(3) Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of OAR 836-051-0540(1) and (2), and OAR 836-051-0550(1) and (5). No signature or other acknowledgment of receipt of this illustration shall be required.

(4) If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of that change shall be prominently displayed.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0590

Annual Certifications

(1) The board of directors of each insurer shall appoint one or more illustration actuaries.

(2) The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of OAR 836-051-0500 to 836-051-0600.

(3) The illustration actuary shall:

(a) Be a member in good standing of the American Academy of Actuaries;

(b) Be familiar with the standard of practice regarding life insurance policy illustrations;

(c) Not have been found by the Director, following appropriate notice and hearing to have:

(A) Violated any provision of, or any obligation imposed by, the Insurance Law or other law in the course of the actuary's dealings as an illustration actuary;

(B) Been found guilty of fraudulent or dishonest practices;

(C) Demonstrated the actuary's incompetence, lack of cooperation or untrustworthiness to act as an illustration actuary; or

(D) Resigned or been removed as an illustration actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards.

(d) Not fail to notify the Director of any action taken by a commissioner of another state similar to that under subsection (c) of this section (3);

(e) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in force policies are not consistent with the nonguaranteed elements actually being paid, charged or credited to the same or similar forms, this must be disclosed in the annual certification; and

(f) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(A) Fully allocated expenses;

(B) Marginal expenses; or

(C) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the Director.

(4)(a) The illustration actuary shall file a certification with the board and with the Director:

(A) Annually for all policy forms for which illustrations are used; and

(B) Before a new policy form is illustrated.

(b) If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the director promptly.

(5) If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the Director promptly of the actuary's inability to certify.

(6) A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

(a) That the illustration formats meet the requirements of OAR 836-051-0500 to 836-051-0600 and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(b) That the insurer has provided its agents with information about the expense allocation method used by the insurer in its illustrations and disclosed as required in section (3)(f) of this rule.

(7) The annual certification shall be provided to the Director each year by a date determined by the insurer. If the insurer decides to change the date for a subsequent year, the insurer must so notify the Director prior to the insurer's current elected date and include with the notification an explanation for the change. The first annual certification by an insurer is due on the date elected by the insurer during the calendar year beginning January 1, 1998.

(8) If an insurer changes the illustration actuary responsible for all or a portion of the insurer's policy forms, the insurer

shall notify the Director of that fact promptly and disclose the reason for the change.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

836-051-0600

Trade Practice Regulation

Violation of any provision of OAR 836-051-0500 to 836-051-0600 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 731.244 & 746.240

Stats. Implemented: ORS 746.075, 746.085, 746.100, 746.110 & 746.240

Hist.: ID 5-1997, f. 5-27-97, cert. ef. 7-1-97

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 52

INSURANCE POLICIES

Medicare Supplement Insurance

836-052-0103

Purpose

(1) OAR 836-052-0103 to 836-052-0194 are adopted in order to:

(a) Provide for the standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

(b) Facilitate public understanding and comparison of such policies;

(c) Eliminate provisions contained in such policies that may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

(d) Provide for full disclosures in the sale of accident and sickness insurance coverage to persons eligible for Medicare.

(2) OAR 836-052-0138, 836-052-0145 and 836-052-0151 are amended pursuant to the authority of ORS 743.683, in order to carry out the legislative intent of:

(a) Extending the opportunity for open enrollment for Medicare supplement insurance under OAR 836-052-0138 to all persons who enroll in Medicare Part B, regardless of age; and

(b) Providing that for rating purposes the pool of persons qualifying for Medicare by reason of disability is combined with the pool of persons qualifying by reason of age, so that premiums will be affordable for persons qualifying by reason of disability.

Stat. Auth.: ORS 731.244 & 743.680

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96

836-052-0107

Authority

OAR 836-052-0103 to 836-052-0194 are adopted pursuant to the general rulemaking authority of the Director under ORS 731.244 and the specific authority in ORS 742.009, 743.013, 743.680 to 743.689 and 746.240.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.010(2) & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0114

Applicability and Scope

(1) Except as otherwise specifically provided in OAR 836-052-0134, 836-052-0140, 836-052-0145, 836-052-0160 and 836-052-0185, OAR 836-052-0103 to 836-052-0194 apply to the following Medicare supplement policies and certificates issued under group Medicare supplement policies, as follows:

(a) All Medicare supplement policies delivered or issued for delivery in this state on or after July 1, 1992; and

(b) All certificates issued under group Medicare supplement policies and delivered or issued for delivery in this state on or after July 1, 1992.

(2) Except as otherwise specifically provided in OAR 836-052-0134, 836-052-0140, 836-052-0154, 836-052-0160 and 836-052-0185, on or after September 1, 1993, OAR 836-052-0103 to 836-052-0194 apply to Medicare supplement policies and certificates issued under group Medicare supplement policies that are made subject to OAR 836-052-0103 to 836-052-0194 because of amendments to the definition of "Medicare supplement policy" in ORS 743.680 and OAR 836-052-0119.

(3) A prepayment plan offered by a health maintenance organization under which the health maintenance organization provides Medicare services under the authority of Section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.) is not subject to OAR 836-052-0103 through 836-052-0194. The health maintenance organization must file with the Director, for information purposes, a copy of the Medicare contract forms and rates that the health maintenance organization uses in this state, and the marketing and sales materials used therewith.

(4) OAR 836-052-0103 to 836-052-0194 do not apply to an issued policy under a demonstration project specified in 42 U.S.C. sec. 1395ss (g)(1).

(5) OAR 836-052-0103 to 836-052-0194 do not apply to a policy or contract of one or more employers or labor organizations; or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.

Stat. Auth.: ORS 731.244 & 743.682

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert.

ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0119

Definitions

As used in OAR 836-052-0103 to 836-052-0194;

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits;

(b) In the case of a group Medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means any certificate delivered or issued for delivery under a group Medicare supplement policy.

(3) "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Insurance Policy" includes a subscriber contract or a prepayment contract of a health care service contractor and a policy or contract of a fraternal benefit society.

(5) "Issuer" includes insurers, fraternal benefit societies, health care service plans, health maintenance organizations as that term is defined in ORS 750.005, health care service contractors as that term is defined in ORS 750.005, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(6) "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(7) "Medicare Supplement Policy" means a group or individual insurance policy or a subscriber contract, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (**42 U.S.C. section 1395 et seq**.) or an issued policy under a demonstration project specified in **42 U.S.C. section 1395ss (g)(1)** that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(8) "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 743.682

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96

836-052-0124

Policy Definitions and Terms

A policy or certificate may not be advertised, solicited or issued for delivering in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the following requirements:

(1) "Accident," "accidental injury" or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The following provisions also apply to definition of the terms under this section:

(a) The definition shall not be more restrictive than the following: "'Injury or injuries for which benefits are provided' means accidental bodily injury sustained by the injured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force";

(b) The definition may provide that the policy shall not cover injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(2) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(3) "Convalescent nursing home", "extended care facility" or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(4) "Health care expenses" means expenses of health maintenance organizations that are associated with the delivery of health care services and that are analogous to incurred losses of insurers. Expenses shall not include any of the following:

(a) Home office and overhead costs;

(b) Advertising costs;

(c) Commissions and other acquisition costs;

(d) Taxes;

(e) Capital costs;

(f) Administrative costs; or

(g) Claims processing costs.

(5) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals but not more restrictively than as defined in the Medicare program.

(6) "Medicare" shall be defined in the policy and certificate. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

(7) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(8) "Physician" shall not be defined more restrictively than as defined in the Medicare program.

(9) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person that manifests itself after the effective date of insurance and while the insurance is in force". The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0129

Policy Provisions

(1) Except for permitted preexisting condition clauses as described in OAR 836-052-0133(2)(a) and 836-052-0134(2)(a), no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(3) No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1996, f. & cert. ef. 4-26-96

836-052-0133

Benefit Standards for Policies or Certificates Issued for Delivery on or After July 1, 1992

(1) The following standards in this rule are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with or exceeds the benefit standards set forth in this rule.

(2) The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of OAR 836-052-0103 to 836-052-0194.

(a) Regarding preexisting conditions, a Medicare supplement policy or certificate shall not:

(A) Exclude or limit benefits for a loss incurred more than six months after the effective date of coverage because the loss involved a preexisting condition. The benefits shall be available after the period of exclusion or limitation permitted under this subsection whether or not a claim concerning the condition was made during the period and whether or not a physician gave medical advice or recommended or gave treatment concerning the condition during the period;

(B) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(b) A Medicare supplement policy or certificate shall not cover losses resulting from sickness on a different basis than

losses resulting from accidents;

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes. An insurer must justify any premium modification actuarially and must obtain approval from the Director before implementing the modification;

(d) A Medicare supplement policy or certificate shall not provide for termination of coverage of a spouse because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium;

(e) Each Medicare supplement policy shall be guaranteed renewable for the life of the individual in the case of an individual policy and the life of the group in the case of a group policy. In addition:

(A) The insurer shall not cancel or nonrenew the policy on the ground of the health status of the individual;

(B) The insurer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or a material misrepresentation that is discovered within two years after the effective date of coverage;

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph (E) of this subsection, the issuer shall offer certificate holders an individual Medicare supplement policy at standard rates and without any waiver, limitation or exclusion, that at the option of the certificate holder:

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this section.

(D) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificate holder the conversion opportunity described in paragraph (C) of this subsection; or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy, whether the same or a different issuer, shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced;

(F) This subsection does not prohibit rate increases otherwise authorized by law.

(f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits;

(g)(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the policyholder or certificate holder becomes entitled to the assistance.

(B) If the suspension occurs and if the insured loses entitlement to the medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of such entitlement, if the insured provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective

as of the date of termination of the entitlement;

(C) Reinstitution of the coverage:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for coverage that is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the insured as the premium classification terms that would have applied to the insured had the coverage not been suspended.

(3) This section establishes standards for basic or core benefits common to all benefit plans. Each issuer shall make available to each prospective insured a policy or certificate including only the basic or core package of benefits established in this section. An issuer may make available to prospective insured any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. The basic core package includes the following:

(a) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(b) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day use;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(4) This section establishes standards for additional benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by OAR 836-052-0136:

(a) Medicare Part A Deductible benefit, providing coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;

(b) Skilled Nursing Facility Care benefit, providing coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B Deductible benefit, providing coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(d) 80 percent of the Medicare Part B Excess Charges benefit, providing coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(e) 100 percent of the Medicare Part B Excess charges benefit, providing coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(f) Basic Outpatient Prescription Drug benefit, providing coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefit received by the insured per calendar year, to the extent not covered by Medicare;

(g) Extended Outpatient Prescription Drug benefit, providing coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(h) Medically Necessary Emergency Care in a Foreign Country, providing coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, when the care would have been covered by Medicare if provided in the United States and when the care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden or unexpected onset;

(i) Preventive Medical Care benefit, providing coverage for the preventive health services set forth in this subsection. Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each services, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare. The preventive health services are:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from paragraph (B) of this subsection and patient education to address preventive health care measures;

(B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) Fecal occult blood test or digital rectal examination, or both;

(ii) Mammogram;

(iii) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

(iv) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(v) Serum cholesterol screening, every five years;

(vi) Thyroid function test;

(vii) Diabetes screening.

(C) Influenza vaccine administered at any appropriate time during the year, and Tetanus and Diphtheria booster, every ten years;

(D) Any other tests or preventive measures determined appropriate by the attending physician.

(j) At-home recovery benefit, providing coverage for services to furnish short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery. The following provisions apply to the at-home recovery benefit:

(A) For purposes of the benefit, the following definitions apply:

(i) "Activities of Daily Living" include but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(ii) "Care Provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(iii) "Home" means any place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(iv) "At-Home Recovery Visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) Coverage requirements and limitations are as follows:

(i) At-home recovery services provided must be primarily services that assist in activities of daily living;

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in subparagraph (A)(ii) of this subsection;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(C) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(k) New or innovative benefits, providing coverage as set forth in this subsection. With the prior approval of the Director, an issuer may offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective and offered in a manner consistent with the goal of simplification of Medicare supplement policies.

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0134

Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 1, 1992

(1) A policy or certificate may not be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the standards described in this rule. The standards described in this rule are minimum standards and do not preclude the inclusion of other provisions or benefits that are not inconsistent with the standards.

(2) The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of OAR 836-052-0103 to 836-052-0194:

(a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses insured more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

(b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes. An insurer must justify any premium modification actuarially and must obtain approval from the Director before implementing the modification;

(d) A "noncancelable", "guaranteed renewable" or "noncancelable and guaranteed renewable" Medicare supplement policy shall not;

(A) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(B) Be canceled or nonrenewed by the issuer on the grounds of deterioration of health.

(e)(A) Except as authorized by the Director, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or a material misrepresentation;

(B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (D) of this subsection, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy that provides only such benefits as are required to meet the minimum standards as defined in OAR 836-052-0133(3).

(C) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder the conversion opportunities described in paragraph (B) of this subsection; or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced;

(E) This subsection does not prohibit rate increases otherwise authorized by law.

(f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefit.

(3) The following minimum benefit standards apply:

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(c) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(d) Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days;

(e) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(f) Coverage for the co-insurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($100);

(g) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount; and

(h) Effective January 1, 1990, coverage for the coinsurance amount of Medicare eligible expenses for outpatient drugs used in immunosuppressive therapy, subject to the Medicare outpatient prescription drug deductible, if applicable.

Stat. Auth.: ORS 743.010 & 743.683

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0136

Standard Medicare Supplement Benefit Plans

(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in OAR 836-052-0133(3).

(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state except as may be permitted in OAR 836-052-0133(4)(k) and in OAR 836-052-0139.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this rule and conform to the definitions in OAR 836-052-0119. Each standard benefit plan must be designated by the letter assigned to it under this rule. Each benefit must be structured in accordance with the format provided in OAR 836-052-0133(3) and (4) and list the benefits in the order shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement, layout and overall content of a benefit.

(4) In addition to the benefit plan designations required in section (3) of this rule, an issuer may use other designations to the extent permitted by law.

(5) The content of benefit plans must be as follows:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the basic core benefits common to all benefit plans, as defined in OAR 836-052-0133(3);

(b) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible as defined in OAR 836-052-0133(4)(a);

(c) Standardized Medicare supplement benefit plan "C" shall include only the following: the core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country, each as defined in OAR 836-052-0133(4);

(d) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit, as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit, each as defined in OAR 836-052-0133(4);

(e) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care, each as defined in OAR 836-052-0133(4);

(f) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 percent of the Medicare Part B excess Charges and Medically Necessary Emergency Care in a Foreign Country, each as defined in OAR 836-052-0133(4);

(g) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit, each as defined in OAR 836-052-0133(4).

(h) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country, each as defined in OAR 836-052-0133(4);

(i) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit, each as defined in OAR 836-052-0133(4);

(j) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit, each as

defined in OAR 836-052-0133(4).

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010(1)(a), (2) & 743.683(2)

Hist.: ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 2-1995, f. & cert. ef. 4-26-95; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0138

Open Enrollment

(1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, or discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a Medicare supplement policy or certificate that is submitted to the issuer prior to or during the six month period beginning with the first day of the first month in which an individual is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available on a guaranteed issue basis to all applicants who qualify under this section without regard to age.

(2) Except as provided in OAR 836-052-0190, section (1) of this rule shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(3) This section applies to a person who qualifies for Medicare by reason of disability and who obtains a Medicare supplement policy during the six month period described in section (1) of this rule. For the period that a person to whom this section applies is 65 years of age or less, the premium charged the person by the issuer shall not be greater than the premium charged by the issuer for persons who are 65 years of age. Following that period, for issuers who change rates on policies on the basis of attained age, the rating plan shall not differentiate on the basis of the reason for eligibility for Medicare Part B.

(4) An issuer must comply with section (1) of this rule with respect to a person:

(a) Who qualifies for Medicare by reason of disability, who first enrolls for benefits under Medicare Part B on or after September 1, 1993, and who applies for a Medicare supplement policy or certificate during the period of eligibility described in section (1) of this rule; or

(b) Who enrolled in Medicare Part B before attaining 65 years of age, who applies for a Medicare supplement policy or certificate upon attaining 65 years of age, during the period of eligibility described in section (1) of this rule that would apply if the person first enrolled in Medicare Part B upon attaining 65 years of age.

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96

836-052-0139

Medicare Select Policies and Certificates

(1) This section applies to Medicare Select policies and certificates, as defined in this rule.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

(3) For the purposes of this rule:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers;

(b) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers;

(c) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate;

(d) "Medicare Select policy" or "Medicare Select certificate" means respectively a Medicare supplement policy or certificate that contains restricted network provisions;

(e) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy;

(f) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers; and

(g) "Service area" means the geographic area approved by the Director of the Department of Consumer and Business Services within which an issuer is authorized to offer a Medicare Select policy.

(4) The Director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Director finds that the issuer has satisfied all of the requirements of OAR 836-052-0103 to 836-052-0194.

(5) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Director.

(6) A Medicare Select issuer shall file a proposed plan of operation with the Director in a format prescribed by the Director. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(A) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual travel times within the community. Geographic availability shall reflect the usual travel times within the community;

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities;

(D) Emergency care is available 24 hours per day and seven days per week; and

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsubparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(b) A statement or map providing a clear description of the service area;

(c) A description of the grievance procedure to be utilized;

(d) A description of the quality assurance program, including:

(A) The formal organizational structure;

(B) The written criteria for selection, retention and removal of network providers; and

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(e) A list and description, by specialty, of the network providers;

(f) Copies of the written information proposed to be used by the issuer to comply with section (10) of this rule; and

(g) Any other information requested by the Director.

(7) A Medicare Select issuer:

(a) Shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director prior to implementing the changes. Changes shall be considered approved by the Director after 30 days unless specifically disapproved; and

(b) An updated list of network providers shall be filed with the Director at least quarterly.

(8) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(b) It is not reasonable to obtain services through a network provider.

(9) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(10) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(A) Other Medicare supplement policies or certificates offered by the issuer; and

(B) Other Medicare Select policies or certificates.

(b) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized;

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(e) A description of limitations on referrals to restricted network providers and to other providers;

(f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(g) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(11) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to section (10) of this rule and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(12) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The following apply to grievance procedures:

(a) The grievance procedure shall be described in the policy and certificates and in the outline of coverage;

(b) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(c) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(d) If a grievance is found to be valid, corrective action shall be taken promptly.

(e) All concerned parties shall be notified about the results of a grievance.

(f) The issuer shall report no later than each March 31st to the Director regarding its grievance procedure. The report shall be in a format prescribed by the Director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(14) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(15)(a) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(b) For the purposes of this section, a Medicare supplement policy or certificate is considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(16) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this rule should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial

amendment.

(a) Each Medicare Select issuer shall make available to each individual insurer under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(b) For the purposes of this subsection, a Medicare supplement policy or certificate is considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(17) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010 & 743.683

Hist.: ID 9-1997, f. & cert. ef. 7-10-97

836-052-0140

Standards for Claims Payment

(1) An issuer must comply with Section 1882(c)(3) of the Social Security Act, as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Public Law No. 100-203, by:

(a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing each enrollee, at the time of enrollment, with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Each insurer providing Medicare supplement coverage in this state shall, concurrent with the filing of the Accident and Health Policy Experience Exhibit, file a Medicare Supplement Insurance Experience Exhibit. The exhibit shall be in a format prescribed by the Director. The Director may prescribe the format adopted by the National Association of Insurance Commissioners. The following provisions also apply:

(a) Every insurer providing Medicare supplement coverage in this state shall file with the Medicare Supplement Insurance Experience Exhibit a list of its Medicare supplement policies or certificates offered or issued and outstanding in this state as of the end of the previous calendar year;

(b) The list under subsection (a) of this section shall identify the filing insurer by name and address, shall identify each policy or certificate by name and form number, and shall differentiate between policies and certificates filed with and approved by the Director in years prior to the previous calendar year and those filed and approved in the previous calendar year;

(c) Policies and certificates that are issued and outstanding in this state but are no longer offered for sale shall be specifically identified, as shall any policies or certificates that for any reason were not filed with and approved by the Director;

(d) The list shall include identification of any policy or certificate for which the Director's approval was withdrawn within the previous calendar year;

(e) On or before the first day of September of each year, commencing September 1, 1989, the Director shall provide the Secretary of Health and Human Services with a list containing the information required to be submitted by this section and identifying each insurer by name and address.

(3) Compliance with the requirements set forth in this rule must be certified by the insurer on the Medicare supplement insurance experience reporting form.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.683(2) & (6)

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92

836-052-0145

Loss Ratio Standards and Refund or Credit of Premium

(1) The following provisions of this section establish loss ratio standards:

(a) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return the applicable percentage specified in this section to the policyholder and certificate holder in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form. The amount of the percentage shall be calculated on the basis of incurred claims experience or incurred health care expenses when coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. The percentage to be returned shall be:

(A) At least 75 percent of the aggregate amount of premiums earned, in the case of group policies; or

(B) At least 65 percent of the aggregate amount of premiums earned, in the case of individual policies.

(b) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards;

(c) For purposes of applying section (1)(a) of this rule and section (3)(c) of OAR 836-052-0151 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and

broadcast advertising) shall be deemed to be individual policies;

(d) For policies issued prior to September 1, 1993, expected claims in relation to premiums shall meet:

(A) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(B) The appropriate loss ratio requirement from section (1)(a)(A) and (B) of this rule when combined with actual experience beginning with April 28, 1996, to date; and

(C) The appropriate loss ratio requirement from section (1)(a)(A) and (B) of this rule over the entire future period for which the rates are computed to provide coverage.

(2) The following provisions of this section apply to refund and credit calculations:

(a) An issuer shall collect and file with the Director by May 31 of each year the data contained in the applicable reporting form contained in Exhibit 1 to this rule for each type in a standard Medicare supplement benefit plan;

(b) If on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded;

(c) For the purpose of this rule, policies or certificates issued prior to September 1, 1993, the issuer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.

(d) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a negligible level. The refund must include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(3) An issuer of Medicare supplement policies and certificates issued before, on or after July 1, 1992, in this state shall file annually its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration for approval by the Director in accordance with the filing requirements and procedures prescribed by the Director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director for approval, in accordance with the applicable filing procedures of this state:

(a)(A) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents necessary to justify the adjustment shall accompany the filing;

(B) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and to be expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date;

(C) If an issuer fails to make premium adjustments acceptable to the Director, the Director may order premium

adjustments, refunds or premium credits that the Director considers necessary to achieve the loss ratio required by this rule.

(b) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(4) For purposes of this rule, experience of insureds who qualify for Medicare by reason of disability shall be combined with experience of insureds who qualify for Medicare by reason of age.

(5) The Director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before, on or after July 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance may be made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished as the Director determines to be appropriate.

Stat. Auth.: ORS 743.684

Stats. Implemented: ORS 743.010 & 743.684

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0151

Filing and Approval of Policies and Certificates and Premium Rates

(1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Director in accordance with filing requirements and procedures prescribed by the Director.

(2) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with an approved by the Director in accordance with filing requirements and procedures prescribed by the Director.

(3) Except as provided in this section, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan. For the purposes of this section, a "type" means an individual policy or a group policy. An issuer may offer, with the approval of the Director, not more than four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage.

(4) The following applies to continuance and discontinuance of Medicare supplement policies and certificates:

(a) Except as provided in this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after July 1, 1992, that has been approved by the Director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months. The following applies to discontinuance of a policy form or certificate form to which this subsection applies:

(A) An issuer may discontinue the availability of a policy form or certificate form for new issues if the issuer provides to the Director in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Director, the issuer shall no longer offer for sale the policy form or certificate form in this state. The issuer must continue to renew outstanding policies and certificates;

(B) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (A) of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Director of the discontinuance. The period of discontinuance may be reduced if the Director determines that a shorter period is appropriate.

(b) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection;

(c) A change in the rating structure or methodology shall be considered a discontinuance under subsection (a) of this section unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum satisfactory to the Director, in a form and manner prescribed by the Director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates;

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Director may approve a change to the differential that is in the public interest.

(5) Except as provided in this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in OAR 836-052-0145. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Stat. Auth.: ORS 743.683

Stats. Implemented: ORS 743.010, 743.684(1)-(2) & 743.683(2)

Hist.: ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 2-1995, f. & cert. ef. 4-26-95

836-052-0156

Permitted Compensation Arrangements

(1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation, including overrides and other sales-connected remuneration to field supervisory personnel, does not exceed 200 percent of the commission or the compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) The commission or other compensation provided in subsequent renewal years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years. The total number of renewal years shall not be fewer than five renewal years.

(3) An issuer or entity shall not provide compensation to its agents or other producers and an agent or producer shall not receive compensation greater than the renewal compensation payable by the replacing issuer if an existing policy or certificate is replaced.

(4) For purposes of this rule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards and finder's fees.

(5) Violation of this rule is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.684(3)

Hist.: ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92

836-052-0160

Required Disclosure Provisions

(1) The following provisions apply to all Medicare supplement policies and certificates:

(a) Each Medicare supplement policy and certificate shall include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. The provision shall be appropriately captioned, shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(b) Each rider or endorsement added to a Medicare supplement policy after the date that the policy is issued or at reinstatement or renewal, that reduces or eliminates benefits or coverage in the policy, shall require a signed acceptance by the insured, except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits. After the date of issuance of the policy or certificate, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy;

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import;

(d) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations";

(e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder may return the policy or certificate within 30 days of its delivery and may have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason;

(f)(A) An issuer of health policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in OAR 836-052-0119. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(B) For the purposes of this rule, "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

(2) The following notice requirements apply to all insurers providing Medicare supplement insurance:

(a) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit change, an issuer shall notify its policyholders and certificate holders of modification it has made to Medicare supplement insurance policies or certificates. The notice must be made in a format acceptable to the Director. The notice shall:

(A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(B) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(b) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension;

(c) Notices under this rule shall not contain or be accompanied by any solicitation.

(3) Each issuer shall provide an outline of coverage for Medicare supplement policies as follows:

(a) An issuer shall provide an outline of coverage to each applicant at the time the sales presentation is made to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant;

(b) If an outline of coverage provided at the time of the sales presentation and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline of coverage, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered. The revised outline of coverage shall contain the following statement, or similar language approved by the Director, in not less than twelve point type, immediately above the insurer's name: "Notice: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued";

(c) The outline of coverage provided to applicants pursuant to this section consists of four parts; a cover page, premium information, disclosure pages and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Exhibit 1;

(d) The outline of coverage may be designated by the insurer either as an outline of coverage or as a fact sheet.

(4) An issuer shall give notice regarding policies or certificates that are not Medicare supplement policies, as follows:

(a) Any health insurance policy, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.); any disability income policy or other policy identified in OAR 836-052-0114(4), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate;

(b) The notice under subsection (a) of this section shall be printed on or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language: "THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company";

(c) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in section (4)(a) of this rule shall disclose, using the applicable standard statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with, the application for the policy or certificate.

Stat. Auth.: ORS 731.244, 743.683 & 743.685

Stats. implemented: ORS 743.683, 743.685 & 743.686

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0165

Requirements for Application Forms, Replacement Coverage

(1) Application forms shall include the statements and questions set forth in this section designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other health insurance policy or certificate currently in force. A supplementary application or other form to be signed by the applicant and agent containing such statements and questions may be used. The statements and questions are as follows:

(a) Statements:

(A) You do not need more than one Medicare supplement policy;

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages;

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy;

(D) The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility; and

(E) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

(b) Questions -- To the Best of Your Knowledge:

(A) Do you have another Medicare supplement policy or certificate in force?

(i) If so, with which company?

(ii) If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?

(B) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(i) If so, with which company?

(ii) What kind of policy?

(C) Are you covered for medical assistance through the state Medicaid program:

(i) As a Specified Low Income Medicare beneficiary (SLMB)?

(ii) As a Qualified Medicare Beneficiary (QMB)?

(iii) For other Medicaid medical benefits?

(2) An agent shall list any other health insurance policies that the agent has sold to the applicant, and:

(a) List such policies sold that are still in force;

(b) List such policies sold in the past five years that are no longer in force.

(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

(4) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except when the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(5) The notice required by section (4) of this rule for an issuer, shall be provided in substantially the form shown in Exhibit 1 to this rule in no less than 12 point type.

Stat. Auth.: ORS 743.010 & 743.685

Stats. Implemented: ORS 743.010, 743.683 & 743.685

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 1-1990, f. 1-10-90, cert. ef. 4-1-90; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1996, f. & cert. ef. 4-26-96; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0170

Filing Requirements for Advertising

An issuer shall provide to the Director a copy of any Medicare supplement advertisement intended for use in this state, whether through the written, radio or television medium, for review or approval by the Director to the extent it may be required under ORS 742.009 and other state law. Each advertisement shall comply with all applicable laws and rules of this state.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.687

Hist.: ID 1-1989(Temp), f. & cert. ef. 1-3-89; ID 5-1989, f. 6-30-89, cert. ef. 7-3-89; ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92

836-052-0175

Standards for Marketing

(1) An issuer, directly or through its producers, shall:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(b) Establish marketing procedures to assure excessive insurance is not sold or issued;

(c) Display prominently by type, stamp or other appropriate means, on the first page of the policy, the following: **"Notice to Buyer: This policy may not cover all of your medical expenses"**;

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has health insurance and the types and amounts of any such insurance;

(e) Establish auditable procedures for verifying compliance with this section.

(2) In addition to the practices prohibited under ORS Chapter 746, the following acts and practices are prohibited:

(a) Twisting, which includes knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing or tending to induce any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer;

(b) High pressure tactics, which include the employing of any method of marketing having the effect of inducing or tending to induce the purchase of insurance through force, fright or threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(c) Cold lead advertising, which is making use, directly or indirectly, of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(3) Violation of any provision of section (2) of this rule is an unfair trade practice under ORS 746.240.

(4) The terms "Medicare Supplement", "Medigap", "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with OAR 836-052-0103 to 836-052-0194.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.010(1)(c), (2), 743.685(8) & 746.240

Hist.: ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 9-1997, f. & cert. ef. 7-10-97

836-052-0180

Appropriateness of Recommended Purchase and Excessive Insurance

(1) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.010(1)(c), (2), 743.683(2) & 743.685(8)

Hist.: ID 1-1990, f. 1-10-90, cert. ef. 4-1-90, ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92

836-052-0185

Reporting of Multiple Policies

(1) On or before March 1 of each year, each issuer shall report to the Director the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement insurance policy or certificate:

(a) Policy and certificate number; and

(b) Date of issuance.

(2) The information required under section (1) of this rule must be grouped by individual policyholder.

(3) Each issuer shall report the information required under this rule on the reporting form prescribed in **Exhibit 1** to this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.010(1)(c), (2)

Hist.: ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92

836-052-0190

Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and ProbationaryPeriodsinReplacement Policies and Certificates

(1)If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy to the extent such a time period was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate that has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 743.010(1)(c), (2), 743.683(2) & 743.685(8)

Hist.: ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 5-1993(Temp), f. 8-11-93, cert. ef. 9-1-93; ID 9-1993, f. 9-28-93, cert. ef. 10-1-93

836-052-0194

Separability

If any provision of OAR 836-052-0103 to 836-052-0194 or the application thereof to any person or circumstance is held to be invalid for any reason, the remainder of OAR 836-052-0103 to 836-052-0194 shall not be affected thereby.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240

Stats. Implemented: ORS 174.040 & 731.244

Hist.: ID 7-1992, f. & cert. ef. 5-8-92

Hospital Room and Board Expense Benefits

836-052-0200

Statutory Authority; Purpose; Applicability; Effective Date

(1) OAR 836-052-0200 and 836-052-0205 are adopted pursuant to the general rulemaking authority of the Director in ORS 731.244 and the specific authority in ORS 743.613(2).

(2) The purpose of OAR 836-052-0200 and 836-052-0205 is to determine the maximum daily hospital room and board expense benefits of individual health insurance policies converted from group health insurance policies and issued under ORS 743.611.

(3) OAR 836-052-0200 and 836-052-0205 apply to all individual health insurance policies converted from group health insurance policies and issued under ORS 743.611 that are delivered or issued for delivery on or after the effective date specified in section (4) of this rule.

(4) OAR 836-052-0200 and 836-052-0205, as last amended, become effective June 1, 1995.

Stat. Auth.: ORS 731.244 & 743.613(2)

Stats. Implemented: ORS 743.611 & 743.613

Hist.: IC 5-1981, f. 12-31-81, ef. 1-1-82; IC 6-1986, f. 5-2-86, ef. 11-1-86; ID 23-1990, f. 12-27-90, cert. ef. 4-1-91; ID 3-1995, f. 4-26-95, cert. ef. 6-1-95

836-052-0205

Maximum Daily Hospital Room and Board Expense Benefits

The maximum daily hospital room and board expense benefits of individual health insurance policies issued under ORS 743.613 under one of the following plans are as follows:

(1) Plan A: $500.

(2) Plan B: $375.

(3) Plan C: $250.

Stat. Auth.: ORS 731.244 & 743.613(2)

Stats. Implemented: ORS 743.611 & 743.613

Hist.: IC 5-1981, f. 12-31-81, ef. 1-1-82; IC 6-1986, f. 5-2-86, ef. 11-1-86; ID 23-1990, f. 12-27-90, cert. ef. 4-1-91; ID 3-1995, f. 4-26-95, cert. ef. 6-1-95

836-052-0220

Statutory Authority; Purpose; Effective Date

(1) OAR 836-052-0220 to 836-052-0245 are adopted pursuant to the general rulemaking authority of the Director of the Department of Insurance and Finance in ORS 731.244 and the specific authority of the Director in ORS 743.556 to adopt rules that carry out requirements in ORS 743.556 relating to coverage under group health insurance policies and contracts for treatment for chemical dependency including alcoholism and for mental or nervous conditions.

(2) OAR 836-052-0220 to 836-052-0245 become effective on July 1, 1988, and apply to group health insurance policies and contracts entered into, renewed or extended on or after July 1, 1988.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.556

Hist.: ID 9-1988, f. 6-9-88, cert. ef. 7-1-88

836-052-0225

Durational Limits for Health Maintenance Organizations

(1) As provided in this rule, a health maintenance organization may establish and implement durational limits for the categories of treatment specified in ORS 743.556. The durational limit for each category of treatment must be actuarially equivalent to the benefits required by ORS 743.556.

(2) Before issuing or renewing a policy containing durational limits under this rule, a health maintenance organization shall submit to the Director for review and approval the policy form supported by a description of each durational limit that includes the following:

(a) The specific category of treatment;

(b) The durational limit for the category of treatment;

(c) A description of the services to be provided in the treatment;

(d) Any limitations in the length or frequency of the services to be provided;

(e) A demonstration that the services to be provided within the durational limit established by the health maintenance organization for a category of treatment are actuarially equivalent to the services provided with the minimum benefit established in ORS 743.556 for that category of treatment, as shown by the health maintenance organization under section (3) of this rule.

(3) In order to demonstrated the durational limit under section (2) of this rule for a category of treatment specified in ORS 743.556, a health maintenance organization shall describe the quantity of the services that may be purchased in the private health care market for the amount of money stated in ORS 743.556 as the minimum benefit for the category of treatment. The description may use a statistically credible sampling and projection method, or any other method, that is satisfactory to the Director. The method may include averaging to accommodate variations in cost related to the seriousness of a patient's condition and the intensity of care. The description shall be made separately for each category

of treatment, such as inpatient care of mental or nervous conditions for adults, in patient care of mental or nervous conditions for children and adolescents, inpatient care of chemical dependency for adults or inpatient care of chemical dependency for children and adolescents, for which the health maintenance organization establishes a durational limit. For each category of treatment, the health maintenance organization also shall include an estimate of the costs to the health maintenance organization for providing the services within the category of treatment.

(4) The Director may disapprove a durational limit submitted under this rule as not being actuarially equivalent to benefits required by ORS 743.556 if the Director determines either of the following:

(a) That the services to be provided within the durational limit for a category of treatment are not equivalent in quality or treatment setting to the services provided within the corresponding minimum benefit established in ORS 743.556. In order to determine whether services in a category of treatment are equivalent in quality or treatment setting, the Director may consult with appropriate state health agencies, such as the Health Division;

(b) That the durational limit is unsubstantiated.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.556

Hist.: ID 9-1988, f. 6-9-88, cert. ef. 7-1-88

836-052-0230

Provider Services Limits for Insurers and Health Care Contractors

(1) Before an insurer or a health care service contractor other than a health maintenance organization issues or renews a policy with respect to which the insurer or health care service contractor contracts with one or more providers to furnish services for chemical dependency or mental or nervous conditions under the policy, the insurer or health care service contractor shall submit the policy form or contract, supported by the following, to the Director for review and approval:

(a) A description of the contracted services, including the treatment settings for the services, and a demonstration of their equivalency to the services required under ORS 743.556;

(b) A statement of the policy limits established for the contracted services;

(c) A statement of the discount for each service furnished by the provider.

(2) When an insurer or a health care service contractor other than a health maintenance organization contracts with one or more providers of health care services to furnish services under a group policy form or contract, the insurer or health care contractor must demonstrate to the Director, for the Director's review and approval, that the policy form or contract offers services that equal or exceed the range of services and treatment settings provided within the benefit levels specified in ORS 743.556. The insurer or health care services contractor must demonstrate that the discount provided in the contract for services furnished by the provider and the limited established for contracted services allow for services that equal or exceed the range of services and treatment settings provided within the benefit levels specified in ORS 743.556.

(3) If the Director has previously reviewed and approved a policy form or contract under this rule, the Director need not review a renewal of the policy unless the contract with the provider is altered with regard to services or policy limits

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.556

Hist.: ID 9-1988, f. 6-9-88, cert. ef. 7-1-88

836-052-0235

Copayment, Health Maintenance Organizations

For the purpose of ORS 743.556(23) (a), a health maintenance organization may not establish a provision for enrollee cost-sharing that provides that the amount to be paid by the enrollee reduces the amount of the minimum benefits required to be provided by the health maintenance organization under ORS 743.556.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.556

Hist.: ID 9-1988, f. 6-9-88, cert. ef. 7-1-88

836-052-0240

Renewal of Benefits

A group health insurance policy or contract that is subject to ORS 743.556 shall state whether the benefits described in ORS 743.556 renew in full on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.556

Hist.: ID 9-1988, f. 6-9-88, cert. ef. 7-1-88

836-052-0245

Prior Approval

(1) Except as provided for health maintenance organizations in section (2) of this rule, when an insurer or a health care service contractor requires prior approval of treatment as part of the utilization review process under ORS 743.556, the insurer or health care services contractor may limit payments on claims under an urgent or emergency admission only as provided in this section. An insurer or health care service contractor that limits such claims must provide in the policy that each claim under the urgent or emergency admission is limited to not fewer than 48 hours after the admission or any additional period during which the insured is unable to notify the insurer or health care service contractor of the claim either because of incapacity of the insured or because the insurer cannot be reached.

(2) A health maintenance organization is not required under section (1) of this rule to provide coverage for the 48-hour period or any additional period prior to notice by the patient if provision of such coverage is contrary to any limitation imposed by the health maintenance organization under ORS 743.556(23)(c) on the receipt of covered services.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 743.556

Hist.: ID 9-1988, f. 6-9-88, cert. ef. 7-1-88

Long-Term Care Insurance

836-052-0500

Statutory Authority; Applicability

(1) OAR 836-052-0500 to 836-052-0645 are adopted pursuant to the requirements and authority of ORS 731.244, 742.003, 742.005, 742.023, 743.013, 743.655, 743.685 and 746.240.

(2) OAR 836-052-0510 to 836-052-0550 and 836-052-0570 to 836-052-0580 apply to all new forms and related rates submitted for approval on and after January 1, 1991.

(3) OAR 836-052-0600 to 836-052-0620 apply to the solicitation of policies occurring on and after March 1, 1991.

(4) OAR 836-052-0640 and 836-052-0645 apply to the solicitation of policies occurring on and after January 1, 1991.

(5) OAR 836-052-0565 applies to all new forms and related rates submitted for approval on and after July 1, 1991.

(6) OAR 836-052-0500 to 836-052-0645 do not apply to a provision in a life insurance policy, rider or endorsement that provides accelerated death benefits in a single lump-sum upon the occurrence of a single qualifying event as defined in ORS 743.154.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656.

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; ID 1-1996, f. & cert. ef. 1-12-96

Rate Filings and Loss Ratios

836-052-0510

Rate Filings for New Forms

(1) Each insurer submitting an individual long-term care insurance policy form for approval must include a rate filing with the form. Each such rate filing is subject to approval by the Director as part of the filing of the form.

(2) Each rate filing shall include an actuarial memorandum. The actuarial memorandum shall include:

(a) A description of the basis on which rates were determined;

(b) A description of the calculation of the anticipated loss ratio required under OAR 836-052-0530;

(c) A description of the basis for the reserves;

(d) A summary of the type of policy, benefits, renewability, general marketing method and limits on ages of issuance;

(e) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium, dollars per policy and dollars per unit of benefits;

(f) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(g) The estimated average annual premium per policy and the average issue age;

(h) The aggregate loss ratio, including a brief description of the method by which it was calculated;

(i) If the aggregate loss ratio under subsection (h) of this section is less than the minimum requirements of OAR 836-052-0530, supporting documentation for the use of the proposed premium rates;

(j) Certification by an actuary who is a member of the American Academy of Actuaries that to the best of the actuary's knowledge and judgment, the entire rate filing complies with the applicable statutes and rules of this state, the reserves are anticipated to be adequate and the benefits are reasonable in relation to the premiums; and

(k) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

(3) When long term care benefits are provided through early payment of a portion of a life insurance policy death benefit, the actuarial memorandum included with the rate filing must comply with the requirements of section (2) of this rule except as follows:

(a) The memorandum must include a description of the effect of the long term care policy provision on the required premiums, nonforfeiture values and reserves of the underlying life insurance policy, both for active lives and those in long term care claim status; and

(b) Instead of the information required in subsection (h) or (i) of section (2) of this rule, the memorandum must include a complete supporting demonstration that the reduction in life insurance policy benefits, combined with any increase in the underlying life insurance policy premiums or other charges made for the long term care benefits, is reasonable in relation to the long term care benefits to be provided.

(4) For purposes of sections (2) and (3) of this rule, assumptions applying to the future period for which rates are computed must be reasonable in relation to the circumstances. If future rates of inflation are a major factor or if projections are based on statistics of little credibility, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly when the basic rate structure is one of "level" premiums based on original issue age.

(5) An insurer may use interest in calculating each loss ratio under this rule.

(6) Each rate filing must include a statement as to its status in the insurer's home state.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656.

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; ID 1-1996, f. & cert. ef. 1-12-96

836-052-0515

Rate Filings for Previously Approved Forms

(1) Any addition to or change in rates applicable to a previously approved individual long-term care insurance policy

form is subject to approval by the Director as any other addition to or change in the form. Each filing of a rate revision for a previously approved policy form shall include the following:

(a) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the aggregate loss ratio for the form;

(b) The scope and reason for the proposed rate revision, including a statement as to whether the revision applies only to new business, only to in-force business or to both, and an outline of all past rate increases on this form and all other forms grouped with this form for purposes of statistical reliability;

(c) An actuarial memorandum meeting the requirements of section (2) of this rule.

(2) The memorandum required under section (1) of this rule must include the following:

(a) A brief description of the type of policy, benefits, renewability, general marketing method and limits on ages of issuance;

(b) The estimated average annual premium per policy and average issue age, before and after the rate increase. The memorandum must include a descriptive relationship of proposed rate scale to current scale;

(c) A tabular history, by policy year, of the incurred claims and earned premium experience under existing rates, including at least the data required in OAR 836-052-0530. The history may also include the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates;

(d) A brief description of the method by which revised rates were determined, including the source and a table of each assumption used. For expenses, an insurer must include the percent of premium, dollars per policy and dollars per unit of benefit;

(e) A description and a tabular history of the policy and additional reserves held for active lives and a projection of such reserves to be held in future years;

(f) The aggregate loss ratio and description of the method by which it was calculated;

(g) If the aggregate loss ratio under subsection (f) of this section is less than the required minimum standards, supporting documentation for the use of the proposed premium rates;

(h) Certification by an actuary who is a member of the American Academy of Actuaries that to the best of the actuary's knowledge and judgment, the rate submission complies with the applicable statutes and rules of this state, the reserves are anticipated to be adequate and the benefits are reasonable in relation to the premiums;

(i) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

(3) An insurer may include and the Director may require any of the following additional data in a rate filing:

(a) Substitution of actual claim run-offs for claim reserves and liabilities;

(b) Accumulation of experience fund balances;

(c) Substitution of net level policy reserves for preliminary term policy reserves;

(d) Reserve adjustments arising because of select period loss experience;

(e) Adjustment of premiums to an annual mode basis;

(f) Other adjustments or schedules suited to the form and to the records of the insurer;

(g) The date and magnitude of each previous rate change, if any.

(4) All additional data under section (3) of this section must be reconciled, as appropriate, to actuarial, financial and accounting records.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.005 & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0520

Experience Records

(1) An insurer offering long-term care insurance shall maintain records of earned premiums and incurred benefits for each calendar year for each long-term care insurance policy form since first issued, including data for rider and endorsement forms used with the policy form, on the same basis, including all reserves. Separate data may be maintained for each rider or endorsement form to the extent appropriate.

(2) Experience under policy forms must be combined for purposes of evaluating experience data in relation to premium rates and rate revisions when statistical credibility would be materially improved by the combination and when the forms:

(a) Provide substantially similar coverage and provisions;

(b) Are issued to substantially similar risk classes; and

(c) Are issued under similar underwriting standards.

(3) After an insurer has combined policy forms under section (2) of this rule, the insurer may separate the experience only with approval of the Director.

(4) An insurer maintaining records as required under this section may use the reporting forms developed by the National Association of Insurance Commissioners. The Director may require submission of information in addition to that required in the reporting forms when the Director determines that the information is needed to ascertain compliance with the requirements of this rule.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.005 & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0525

Evaluating Experience Data

In determining the credibility and appropriateness of experience data, an insurer must consider all relevant factors, including:

(1) Statistical credibility of premiums and benefits.

(2) Low exposure or low loss frequency.

(3) Experienced and projected trends relative to the kind of coverage, such as inflation in medical expense and economic cycles affecting disability experience.

(4) The concentration of experience at early policy duration when select morbidity and preliminary term reserves are applicable and when loss ratios are expected to be substantially lower than at later policy durations. When this consideration is pertinent, the insurer may also consider ratios of actual to expected claims, on a select basis, as appropriate for an adequate evaluation.

(5) The mix of business by risk classification.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.005 & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0530

Reasonableness of Benefits in Relation to Premiums

(1) Loss ratios for long-term care insurance shall be calculated as provided in this rule. The loss ratios for each policy year shall be calculated as the sum of the incurred claims and the increase in the policy and other reserves, all divided by the earned premiums.

(2) Benefits under individual long-term care insurance policies and riders shall be deemed reasonable in relation to premiums only if the aggregate loss ratio is at least 60 percent and is calculated in a manner providing for adequate reserving of the long-term care insurance risk.

(3) The aggregate loss ratio shall be based on:

(a) The actual incurred claims and earned premiums, derived from past experience, if any; and

(b) The expected incurred claims and earned premiums, estimated from future experience over a period limited by the consideration of inflation in the cost of providing health care and consideration of other factors that may make an extended projection of the claims and premiums difficult and unreliable.

(4) In evaluating the aggregate loss ratio, an insurer shall consider all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) Concentration of experience within early policy duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) The experimental nature of coverage;

(k) Policy reserves;

(l) The mix of business by risk classification;

(m) Product features, such as long elimination periods, high deductibles and high maximum limits.

(5) The loss ratio requirements under this rule apply with respect to Oregon policyholders. Subject to the approval of the Director, an insurer may use national or regional loss ratio experience to modify the Oregon experience when the experience for Oregon policyholders is small and statistically unreliable. Oregon experience and national or regional experience must be submitted in separate tables and the modification approved by the Director.

(6) The experience under all policy and rider forms insuring a class of insureds with similar benefits and underwriting requirements shall be combined when demonstrating compliance with the requirements of this section.

(7) The effect on loss ratios of all requirements necessary to qualify for benefits shall be included in the calculations required under this rule.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.005 & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0535

Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

(1) A long-term care insurance policy, certificate or rider that provides benefits for home health care services may not limit or exclude those benefits:

(a) By requiring that the insured would need care in a nursing facility if home health care services were not provided;

(b) By requiring that the insured first receive nursing and therapeutic services, or either service or simultaneously receive both services, in a home or community setting before home health care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered by the policy when the services can be provided by a home health aide or other licensed or certified home care worker acting within the scope of the licensure or certification;

(e) By requiring that the insured have an acute condition before home health care services are covered; or

(f) By limiting benefits to services provided by Medicare-certified agencies or providers.

(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy, certificate or rider when determining maximum coverage under the terms of the policy, certificate or rider.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(1)(a) & 743.656

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0540

Rate Revision

(1) When an insurer files rate revisions for a previously approved individual long-term care insurance policy form, or a group of previously approved forms combined for statistical reliability, the Director may consider benefits reasonable in relation to premiums if the revised rate meets the standard applicable to the prior rate filing for the form or forms.

(2) A rate revision is subject to the standards under which the previous rates were filed, with consideration of all relevant rating factors, such as morbidity, expenses, persistency and interest, and consideration of regulatory standards, if any, that were in effect when the previous rates were filed. If no written guideline applicable to the prior filing exists, the regulatory benchmark then generally recognized, such as the 1953 NAIC benchmark, governs rate revisions of such prior rate filings.

(3) An insurer must provide justification to the Director for any aggregate loss ratio that is lower than a loss ratio indicated in OAR 836-052-0530. Justification must be based on applicable special circumstances, such as:

(a) Marketing methods, including consideration of acquisition and administration costs and premium mode;

(b) High risk of claim fluctuation because of low loss frequency or the catastrophic or experimental nature of the coverage;

(c) Product features such as long elimination periods, high deductibles and high maximum limits;

(d) The industrial or debit method of distribution.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.005 & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0545

Reserve Standards

(1) Each insurer shall use the following standards for determining policy reserves for long-term care insurance:

(a) The active life policy and rider reserves for long-term care insurance policies shall be determined in accordance with the Standard Valuation Law as defined in ORS 733.080 and rules adopted thereunder, using a valuation table or tables certified as appropriate for use as a statutory valuation table or tables by a member of the American Academy of Actuaries, and found acceptable to the Director, and shall be at least as large as those calculated on a one year full preliminary term basis;

(b) Reserves for policies and riders shall be based on the multiple decrement model using all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative or if the reserve is immaterial;

(c) In the development and calculation of reserves for long-term care insurance policies and riders, an insurer shall consider the applicable policy and rider provisions, marketing methods, administrative procedures and all other considerations that affect projected claim costs, including at least the following:

(A) Definition of insured events;

(B) Covered long-term care facilities;

(C) Existence of home care and home health care coverage. For purposes of this paragraph, "home" has the meaning provided in OAR 836-052-0580;

(D) Definition of facilities;

(E) Existence or absence of barriers to eligibility;

(F) Premium waiver provisions;

(G) Renewability;

(H) Ability to raise premiums;

(I) Marketing methods;

(J) Underwriting procedures;

(K) Claims adjustment procedures;

(L) Waiting periods;

(M) Maximum benefits;

(N) Availability of eligible facilities;

(O) Margins in claim costs;

(P) Optional nature of benefit;

(Q) Delay in eligibility for benefit;

(R) Inflation protection provisions;

(S) Guaranteed insurability option.

(2) Each insurer shall establish additional reserves as follows:

(a) In the absence of a demonstration of adequate reserves held under section (1) of this rule, for all benefits and optional coverages available to the insured under all provisions of the policy;

(b) There is a rapid growth of long-term care insurance policies in force relative to other types of policies and riders;

(c) There is a rapid growth of all types of insurance policies, including long-term care policies and riders;

(d) There are extensive benefit guarantees with permutations of benefits that the valuation tables may not have considered;

(e) There is concern for selection against the insurer by the insureds.

(3) When long term care benefits are provided through early payment of a portion of a life insurance policy death benefit, contract reserves for the policy must comply with the requirements of section (1) of this rule. The calculations may take into account the reduction in life insurance benefits owing to the payment of long term care benefits. In no event, however, shall the reserves for long term care benefits and life insurance benefits be less than the reserves for the life insurance benefits alone, assuming no long term care benefits.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656.

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; ID 1-1996, f. & cert. ef. 1-12-96

836-052-0550

Filing Requirements for Out-of-State Group Policies

Each insurer providing group long-term care insurance benefits to a resident of this state shall file, for informational purposes, a copy of the policy form filed for approval with the state of domicile of the insurer and any rider or certificate used in this state in accordance with the filing requirements and procedures applicable to group long-term care insurance policies issued in this state.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 731.244 & 743.653

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

Long-Term Care Insurance Policy Terms

836-052-0565

Activities of Daily Living

(1) Pursuant to ORS 743.656, an insurer shall provide for determination of eligibility of an insured for benefits under a long-term care insurance policy, rider or certificate on the basis of performance by the insured of activities of daily living. The insurer shall not define activities of daily living more restrictively than the following minimum standards, or similar standards found by the Director to be substantially as favorable to the consumer:

(a) Eating and prescription drugs. Whether the insured needs assistance from another person, whether for a physical or cognitive reason, to take medicine or to maintain an adequate food and fluid intake according to the dietary needs of the insured;

(b) Dressing. Whether the insured needs assistance from another person to dress, whether for a physical or cognitive reason, such as in selecting appropriate clothing, tying shoes, fastening buttons or attaching a prosthetic device;

(c) Personal hygiene. Whether the insured needs assistance from another person, whether for a physical or cognitive reason, with activities associated with personal hygiene such as bathing and washing, and including rebandaging of sores and wounds;

(d) Mobility. Whether the insured needs assistance from another person in order to change position or get into or out of

a chair, wheelchair, bed or other stationary position, or needs assistance from another person to walk or transfer;

(e) Bowel and bladder control. Whether the insured needs assistance from another person, whether for a physical or cognitive reason, relative to the occasional loss of control of either the bowel or bladder, or both, or cannot clean up or perform external care of a catheter or appliance without assistance from another person.

(2) For purposes of this rule, a cognitive reason must be a result of a clinically diagnosed organic dementia.

Stat. Auth.: ORS 731.244, Ch. 742 & 743.656

Stats. Implemented: ORS 743.656

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; ID 9-1991, f. 12-24-91, cert. ef. 1-1-92

836-052-0570

Alzheimer's and Related Dementias

(1) No long-term care insurance policy, rider or certificate shall exclude coverage for Alzheimer's disease and related progressive degenerative dementias of an organic origin such as the following, by way of example only:

(a) Parkinson's Disease;

(b) Huntington's Disease;

(c) Creutzfeldt-Jakob Disease;

(d) Picks Disease;

(e) Multi-infarct dementia;

(f) Normal pressure hydrocephalus;

(g) Multiple sclerosis;

(h) Inoperable tumors of the brain.

(2) An insured under a long-term care insurance policy shall be eligible for benefits if the insured is a danger to the insured or to others, as caused by an organic disorder as determined and documented by a physician, by frequently being disruptive or aggressive, or extremely agitated or anxious and, according to a physician's order, professional medical and nursing judgment is required to determine when to administer prescribed medication or to apply physical restraints.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(2)(d)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0575

Prohibition Against Preexisting Conditions, Waiting Periods and Probational Periods in Replacement Policies and Certificates

(1) If an individual long-term care insurance policy replaces another long-term care insurance policy, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods and probationary periods in the new long-term care insurance policy for similar benefits to the extent such a time period was spent under the original policy.

(2) If a group long-term care policy is replaced by another group long-term care policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0580

Use and Definition of "Home" or Similar Wording

A long-term care insurance policy that defines "home" or uses similar wording to refer to the residence of the insured shall define or use wording that means or refers to the principal place of residence for the insured, whether a private home, a foster home, congregate care or assisted living facility or other place in a community setting, other than a licensed nursing facility.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(1)(a) & 743.656

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0583

Standards for Covered Services

(1) This rule establishes standards for covered services for the purpose of payment of benefits pursuant to ORS 743.656. An insurer shall not define the covered services more restrictively than the following minimum standards, or similar standards found by the Director to be substantially as favorable to the consumer:

(a) Nursing home services, when provided to the insured in this state, include services provided in or by a nursing home licensed under ORS 678.710 to 678.840. When provided to the insured outside this state, nursing home services include services provided in or by a nursing home in the other state. The nursing home must be licensed by the other state if so required by a similar licensing or other regulatory program;

(b) Assisted living services, when provided to the insured in this state, include those services provided in a facility or by a person licensed or otherwise regulated by this state to provide assisted living services as that term is defined in OAR 411-056-0005. When the services are provided to the insured outside this state, the provider or providing facility must be licensed by the other state if so required by a similar licensing or other regulatory program;

(c) Home care services, regardless of the state in which they are provided, include service provided in the insured's own home rather than a facility such as an assisted living facility or adult foster care facility. An insured qualifies for benefits for home care on either of the following bases:

(A) On the basis of the insured's inability to perform three or more instrumental activities of daily living described in section (2) of this rule, or the insured's need for assistance in three or more activities of daily living as defined in OAR 836-052-0565, or any combination of three thereof. The inability to perform an instrumental activity must be determined by a physician, registered nurse or case manager;

(B) On a basis approved by the Director that is not more restrictive than the basis set forth in paragraph (A) of this subsection.

(d) Adult foster care services, when provided to the insured in this state, include those services that are provided in an adult foster home pursuant to a license issued under ORS 443.705 to 443.825. When the services are provided to the insured outside this state, the provider or providing facility must be licensed by the other state if so required by a similar licensing or other regulatory program.

(2) For purposes of qualifying for home care services under subsection (1)(c) of this rule, an instrumental activity of daily living is any of the following:

(a) Handling money. The insured is unable to perform this activity when the insured is unable for a cognitive reason to deposit or to withdraw funds at a financial institution, or to write a check, or pay for a purchase with the exact change or verify that the right change is returned;

(b) Using the telephone. The insured is unable to perform this activity when the insured is unable for a cognitive reason to use a telephone directory or dial a telephone;

(c) Shopping. The insured is unable to perform this activity when the insured is unable for a cognitive reason to select the proper store for necessary purchases, to select the merchandise or determine that the selections meet the insured's present needs, or to carry the purchase home;

(d) Preparing meals. The insured is unable to perform this activity when the insured is unable for a cognitive reason to prepare a meal;

(e) Transportation. The insured is unable to perform this activity when the insured is unable for a cognitive reason to use private or public transportation for purposes of appointments or shopping.

(3) For purposes of this rule, a cognitive reason must be a result of a clinically diagnosed organic dementia.

Stat. Auth.: ORS 731.244 & 743.656

Stats. Implemented: ORS 743.656

Hist.: ID 9-1991, f. 12-24-91, cert. ef. 1-1-92

836-052-0588

Benefits Provided Through Advancement of Life Insurance Proceeds

(1) When long term care benefits are provided through early payment of a portion of a life insurance policy death benefit, the insurer may make no more than a pro rata reduction in the life insurance policy cash value, based on the percentage of death benefits advanced. When the cash value is reduced in this manner, the insurer may apply no more of the payment to the reduction of any outstanding policy loans than this same pro rata percentage.

(2) For each month in which a long term care benefit has been provided through early payment of a portion of a life insurance death benefit, the insurer shall provide a report to the policyholder showing the benefits paid during the month, the change in the life insurance policy cash value, loan balance and death benefit, and the amount of benefits remaining.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656

Hist.: ID 1-1996, f. & cert. ef. 1-12-96

Long-Term Care Insurance Sales

836-052-0600

Outline of Coverage

(1) When long-term care insurance coverage is offered in this state, the offeror shall provide an outline of coverage as required in this rule to each prospective applicant as follows:

(a) In the case of a solicitation by an agent, prior to the presentation of an application or enrollment form;

(b) In the case of a direct response solicitation, in conjunction with any application or enrollment form.

(2) The following requirements apply to the outline:

(a) The outline and its text must be presented in the sequence and format prescribed in **Exhibit 1** or **Exhibit 2** to this rule, except as otherwise specifically indicated;

(b) The outline must be printed in not less than ten-point type;

(c) The outline may not contain material of an advertising nature;

(d) Text that is capitalized or underscored in the outline in **Exhibit 1** or **Exhibit 2** to this rule may be emphasized by other means that provide equivalent prominence.

(3) When long term care benefits are provided through early payment of a portion of a life insurance policy death benefit, the following statements must be included in the first page of the outline of coverage:

(a) "NOTICE: The long term care benefits described here are provided as part of a life insurance policy. Your premiums pay for life insurance. Whenever long term care benefits are paid from this policy, the payments will reduce the available cash value and death benefit under the life insurance policy";

(b) A statement of disclosure regarding tax consequences, as described in OAR 836-052-0607.

(4) If an outline is given to the applicant as provided in section (1) of this rule and the long-term care insurance policy, rider or certificate subsequently is issued on a basis that would require revision of the outline, a substitute outline properly describing the policy, rider or certificate must accompany the policy, rider or certificate when it is delivered. The revised outline shall contain the following statement, or similar language approved by the Director, in not less than ten point type, immediately above the insurer's name: "**NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided to you earlier. The coverage originally applied for has not been issued.**"

(5) An insurer may use the term "guaranteed issue" or similar wording in the outline, sales materials and policy or certificate only if the insurer does not require the applicant to answer any medical questions. However, an insurer using the term may require an applicant to answer whether, within the year preceding the date of the application, the applicant has been treated by a physician or has been confined in a hospital or nursing home.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656.

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; ID 1-1996, f. & cert. ef. 1-12-96

836-052-0605

Disclosure Statement

(1) An insurer offering long-term care insurance coverage in this state shall deliver a disclosure statement as provided in this rule to the insured under a long-term care insurance policy, rider or certificate or separately but at the same time as delivery of the policy, rider or certificate.

(2) The disclosure statement must include the following matters:

(a) A statement of the premium. The statement must give the total annual premium for the policy, rider or certificate and, if the premium varies with an applicant's choice among benefits options, must indicate the portion of annual premium corresponding to each benefit option;

(b) The terms of renewability. The terms used to describe renewability must be stated on the first page of the policy and must be one of the following, defined as follows:

(A) A policy is "optionally renewable" when renewal is at the option of the insurer;

(B) A policy is "conditionally renewable" when renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health;

(C) A policy is "guaranteed renewable" when renewal cannot be declined by the insurer for any reason, but the insurer can revise rates on a class basis;

(D) A policy is "noncancellable" if the insurer cannot decline renewal and cannot revise rates.

(c) Initial and subsequent conditions of eligibility;

(d) A statement of nonduplication of coverage provisions;

(e) Coverage of dependents;

(f) Preexisting conditions;

(g) Termination of insurance;

(h) Continuation or conversion of coverage;

(i) Any probationary periods;

(j) Limitations, exceptions and reductions;

(k) Elimination periods;

(l) Requirements for replacement;

(m) Recurrent conditions;

(n) Definitions of terms.

(3) The disclosure statement:

(a) Must be printed in not less than twelve point type;

(b) May not contain material of an advertising nature.

(4) The disclosure statement must include the following statement: **CAUTION: Issuance of this long-term care insurance (policy) (rider) (certificate) is based upon your answers to the questions on your application. (A copy of your (application) (enrollment form) is enclosed.) -OR- (You retained a copy of your (application) (enrollment form) when you applied.) If your answers are incorrect or untrue, the company may deny benefits or rescind your policy.**

(5) When long term care benefits are provided through early payment of a portion of a life insurance policy death benefit, the disclosure statement must include the following statements:

(a) "NOTICE: The long term care benefits described here are provided as part of a life insurance policy. Your premiums pay for life insurance. Whenever long term care benefits are paid from this policy, the payments will reduce the available cash value and death benefit under the life insurance policy";

(b) A statement of disclosure regarding tax consequences, as described in OAR 836-052-0607.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656.

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; ID 1-1996, f. & cert. ef. 1-12-96

836-052-0607

Disclosure of Tax Consequences; Advance Payment of Benefits

When long term care benefits are provided through early payment of a portion of a life insurance policy death benefit, a prominent statement must be included in the first page of the outline of coverage, in the first page of the disclosure statement and at the time a long term care benefit payment request is submitted, that the receipt of the long term care benefits may be taxable and that assistance should be sought from a personal tax advisor.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240

Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656.

Hist.: ID 1-1996, f. & cert. ef. 1-12-96

836-052-0610

Shopper's Guide

(1) An insurer issuing long-term care insurance policies shall provide to all applicants a long-term care insurance **Shopper's Guide** in a form approved by the Director. A **Shopper's Guide** provided with respect to a policy providing care in a continuing care retirement community or with respect to an employer or association group policy may give

specific descriptions and explanation of coverage under such a policy. For the purpose of approving the form of a guide under this section, the Director may consider the **Shopper's Guide** developed by the National Association of Insurance Commissioners, or any other guide, as a comparative standard.

(2) Delivery of the **Shopper's Guide** required under section (1) of this rule shall be made for all policies, riders or certificates that offer long-term care type benefits whether or not the policies, riders or certificates are advertised, solicited or issued as long-term care insurance policies.

(3) Except in the case of direct response insurers, delivery of the **Shopper's Guide** shall be made to the applicant at the time of application, and acknowledgement of receipt of the **Shopper's Guide** shall be obtained by the insurer. Direct response insurers shall deliver the **Shopper's Guide** to the applicant upon request but not later than delivery of the policy.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0615

Requirements for Application Forms, Replacement Coverage

(1) An application form for long-term care insurance shall include the questions set forth in this section designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy, rider or certificate in force or whether a long-term care insurance policy, rider or certificate is intended to replace any other health insurance policy, rider or certificate currently in force. A supplementary application or other form to be signed by the applicant and agent, except when the coverage is sold without an agent, containing such questions may be used. The questions are as follows:

(a) Do you have another long-term care insurance policy, rider or certificate in force?

(b) Did you have another long-term care insurance policy, rider or certificate in force during the last 12 months?

(A) If so, with which insurer?

(B) If that policy lapsed, when did it lapse?

(C) Are you covered by a state assistance program (Medicaid)?

(d) Do you intend to replace any of your medical or health insurance coverage with this policy, rider or certificate?

(2) An agent shall list any other health insurance policies that the agent has sold to the applicant, and:

(a) List such policies sold that are still in force;

(b) List such policies sold in the past five years that are no longer in force.

(3) Upon determining that a sale will involve replacement of long-term care insurance coverage, the insurer, or its agent when applicable, shall do the following:

(a) The insurer or its agent shall give notice of the replacement to the insurer whose long-term care insurance policy will be replaced;

(b) The insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the long-term care insurance policy or certificate, a notice regarding replacement of long-term care insurance coverage. One copy of the notice signed by the applicant and the agent, except when the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of long-term care insurance coverage. The notice under this subsection:

(A) When provided by an insurer other than a direct response insurer shall be provided in substantially the form shown in **Exhibit 1** to this rule;

(B) When provided by a direct response insurer, shall be provided in substantially the form shown in **Exhibit 2** to this rule.

(4) The requirements of this rule do not apply with respect to a negotiated group long-term care insurance policy.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.010(1)(c) 743.013(3) & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0620

Filing Requirements for Advertising

Upon request of the Director, every insurer providing long-term care insurance or benefits in this state shall provide to the Director a copy of any long-term care insurance advertisement intended for use in this state, whether through the written, radio or television medium, for review or approval by the Director to the extent it may be required under ORS 742.009 and other state law. Each advertisement shall comply with all applicable laws and rules of this state.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 742.009 & 743.655(1)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

Long-Term Care Insurance Trade Practices

836-052-0640

Standards for Marketing

(1) Every insurer marketing long-term care insurance coverage in this state, directly or through its agents or other producers, shall:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(b) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health insurance and the types and amounts of any such insurance;

(c) Establish auditable procedures for verifying compliance with this section.

(2) In addition to the practices prohibited under ORS Chapter 746, the following acts and practices are prohibited:

(a) Twisting, which includes knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer;

(b) High pressure tactics, which include the employing of any method of marketing having the effective of inducing or tending to induce the purchase of insurance through force, fright or threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(c) Blocking, which occurs when an insurer or agent isolates or attempts to isolate unhealthy policyholders under one policy form, with the consequence or likely consequence of excessive claims costs that in turn justify rate increases, which cause the insurer to quickly become unaffordable to the policyholders;

(d) Rolling, which occurs when an insurer or agent moves or attempts to move insureds from one policy to another with the same insurer or a different insurer for the benefit of the insurer or agent rather than for the best interest of the insured;

(e) Making use, directly or indirectly, of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurer.

(3) Violation of any provisions of section (2) of this rule is an unfair trade practice under ORS 746.240.

(4) The provisions of this rule do not apply with respect to a negotiated group long-term care insurance policy.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(1)(a) & 746.240

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

836-052-0645

Prohibition Against Post-Claims Underwriting

(1) Each application for a long-term care insurance policy, rider or certificate shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2) If an application for long-term care insurance contains a question asking whether the applicant has had medication prescribed by a physician:

(a) The application must also ask the applicant to state the medication or medications prescribed;

(b) If the medication or medications stated in the application were known by the insurer, or should have been known by the insurer at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, the policy, rider or certificate shall not be rescinded for that condition.

(3) When an application for a long-term care insurance policy, rider or certificate asks any health question:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy, rider or certificate: **Caution: If your answers on this application are incorrect or untrue, (insurer) has the right to deny benefits or rescind your policy**;

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy, rider or certificate at the time of delivery: **Caution: The issuance of this long-term care insurance (policy) (rider) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when your applied). If your answers are incorrect or untrue, the insurer has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address)**;

(c) Prior to issuance of a long-term care policy, rider or certificate to an applicant age 80 or older, the insurer shall obtain one or more of the following:

(A) A report of physical examination;

(B) An assessment of functional capacity;

(C) An attending physician's statement;

(D) Copies of medical records.

(4) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured not later than the time of delivery of the policy, rider or certificate unless it was retained by the applicant at the time of application.

(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all rescissions of policies, riders and certificates, both state- and country-wide, except those that the insured voluntarily effectuated, and shall annually furnish this information to the Director in the format prescribed by the National Association of Insurance Commissioners and approved by the Director.

Stat. Auth.: ORS Ch. 731, 742 & 743

Stats. Implemented: ORS 743.655(10)(a)

Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91

Notice of Termination of Group Health Insurance

836-052-0800

Purpose; Applicability

(1) OAR 836-052-0800 to 836-052-0860 are adopted for the purpose of carrying out ORS 743.526, 743.560 and 743.562.

(2) OAR 836-052-0800 to 836-052-0860 apply to the termination of any group health insurance policy occurring on or after July 1, 1992.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.526, 743.560 & 743.562

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

836-052-0810

Notice to Employer; Period for Exercising Right; Replacement

(1) An insurer complies with the requirement of ORS 743.560(1) that the insurer must give notice to the group policyholder, the bureau of Labor and Industries and the Depart-ment of Insurance and Finance, when the insurer mails or otherwise delivers the notice to the last of the three entities.

(2) The time period during which a certificate holder may exercise the right to continue or convert group health coverage following notice of termination commences on the date that the insurer complies with the notice requirement of ORS 743.560 to the group policyholder, the Bureau of Labor and Industries and the Department of Insurance and Finance. This section does not apply to a person's right to continue coverage under federal law.

(3) For purposes of the notice requirement under ORS 743.560, replacement of the terminated group health insurance coverage occurs when all classes of persons covered by the terminated policy are eligible for coverage:

(a) Under a group health insurance policy of the group policyholder that takes effect on the day after the end of the period through which coverage is paid up; or

(b) Under one or more group health insurance policies of the group policyholder in existence at the termination of the terminated policy.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.560

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

836-052-0820

Termination; Conversion Coverage

For purposes of ORS 743.560 and 743.562, coverage of an employee under an individual health insurance policy obtained under ORS 743.611 becomes effective on the first day that the employee was effectively without coverage under the group health insurance policy. For a group policy that provides a grace period, the first day without coverage is the first day of the grace period when the premium is not paid within the grace period.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.560

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

836-052-0830

Notice by Replacing Insurer

Not later than the tenth day after an insurer first receives an application for a group health insurance policy that indicates proposed replacement of an existing group health insurance policy subject to ORS 743.560, the replacing insurer shall give notice to the insurer to be replaced that the replacing insurer has received the application for replacement coverage. The notice shall disclose the name of the policyholder, the date on which the replacing insurer's policy is proposed to become effective and the policy number of the policy proposed to be replaced.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.560

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

836-052-0840

Termination of Group Policy

(1) For the sole purpose of the requirement under ORS 743.560 that an insurer give notice of termination:

(a) Except as provided in subsection (b) of this section, a group health insurance policy terminates on the last day of the period through which coverage is paid up;

(b) A group health insurance policy that provides for a grace period for paying premium on the policy terminates on the final day of the grace period.

(2) For purposes of ORS 743.560 and 743.562, termination of coverage under a group health insurance policy includes the amendment or reissuance of a policy to delete one or more classes of certificateholders from coverage.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.560

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

836-052-0850

Multiple Employer Trusts

(1) For purposes of ORS 743.560 and 743.562, a multiple employer trust is a trust to which a group health insurance policy has been issued, that is established and controlled by the insurer issuing the group health insurance policy.

(2) Termination of a group health insurance policy includes termination of an employer's participation in a group health insurance policy issued to a multiple employer trust described in this rule, whether or not the group policy itself terminates.

(3) OAR 836-052-0840(1) does not apply to a multiple employer trust described in this rule. Instead, termination by an employer of the employer's participation in a group health insurance policy issued to a multiple employer trust commences on the effective date of the employer's termination of participation, unless participation is terminated because the policy is terminated.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.526, 743.560 & 743.562

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

836-052-0860

Form of Notice to Group Policyholder, the Bureau and the Department

(1) The form of the notice required by ORS 743.560 shall be as established in this rule. The form shall be printed in 12 point type, one point leaded, and shall provide at least the following:

(a) The date of the notice and, if different, the date on which the period for exercising any rights

of conversion or continuation begins. The applicable date shall be described as the beginning of the period for exercising such rights;

(b) A statement to the effect that the group coverage provided through the group policyholder by the insurer has terminated, and the effective date of termination. The effective date of termination shall be the date preceding the first day that a group policyholder is effectively without coverage under the group health insurance policy;

(c) The number of the group health insurance policy;

(d) The name of the employer;

(e) An explanation of the rights of the certificateholders under federal law and state law regarding the continuation or conversion of coverage.

(2) In the notice to a group policyholder under this rule:

(a) The insurer need include only the information that applies to the group policyholder and certificateholders;

(b) If continuation rights do not exist under the terminated policy with respect to the group policyholder or the certificateholders, the insurer need not include information about continuation of coverage but must include a statement to the effect that the certificateholders do not have a right to continue coverage under the group policy;

(c) Regarding state law pertaining to conversion of coverage, the insurer may use the following statement, if appropriate, or other appropriate wording:

Conversion Right

You may have the right to convert your group policy coverage to coverage under an individual health insurance policy. In order to do so, you must apply to your group insurer within 31 days following the date described in this notice as the beginning of the period for exercising the right of conversion.

(d) The insurer may include a statement to the effect that the group policyholder has or may have replaced the terminated coverage and that replacement of coverage eliminates or may eliminate the right of the certificateholders to convert to individual coverage.

Stat. Auth.: ORS 731.244, 743.526, 743.560 & 743.562

Stats. Implemented: ORS 743.560

Hist.: ID 9-1992, f. 5-26-92, cert. ef. 7-1-92

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 53

REGULATION OF SMALL EMPLOYER CARRIERS

836-053-0010

Purpose; Statutory Authority

OAR 836-053-0010 to 836-053-0070 are adopted for the purpose of implementing ORS 743.730 to 743.745, pursuant to the authority of ORS 731.244 and 743.730 to 743.745.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240

Stats. Implemented: ORS 743.730 et seq.

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0020

Rating

(1) There shall be one rating class for each small employer carrier. All small employer health benefit plans of the carrier shall be rated in that class.

(2) The variation in geographic average rates among different small employer health benefit plans offered by a carrier must be based solely on objective differences in plan design or coverage. The variation must not include differences based on the risk characteristics or claims experience of the actual or expected enrollees in a particular plan.

(3) A small employer carrier shall file its geographic average rates for small employer health benefit plans in accordance with the filing requirements of OAR 836-053-0185.

(4) A small employer carrier may not assess administrative expenses to the basic health plan in an amount greater than the level it assesses to other plans in the small employer market. Administrative expenses shall be expressed as a percentage and may not vary with the size of the small employer.

(5) Plans shall be rated within the following geographic areas comprised of counties:

(a) Area 1 shall include: Clackamas, Multnomah, Washington, and Yamhill;

(b) Area 2 shall include: Benton, Lane, and Linn;

(c) Area 3 shall include: Marion and Polk;

(d) Area 4 shall include: Deschutes, Douglas, Jackson, Josephine, Klamath, and Lake;

(e) Area 5 shall include: Clatsop, Columbia, Coos, Curry, Lincoln, and Tillamook;

(f) Area 6 shall include: Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler.

(6) A small employer carrier may use five digit zip codes to describe the geographic areas. This description can vary from the described areas by no more than ten percent of the population of a county. The small employer carrier must use either the zip code system or the county system.

(7) A small employer carrier may use the same geographic average rate for multiple rating areas.

(8) A small employer carrier shall not modify the geographic areas in section (5) of this rule, other than as described in section (6) of this rule.

(9) A small employer carrier may deviate from the requirements of the rate bands for coverage that extends to a geographic area outside the state of Oregon. The carrier must do so in a reasonable fashion and maintain records regarding the basis for the rate charged in the small employer's file.

(10) A small employer carrier may request approval from the Director to phase in the premium rating requirements of ORS 743.737 that are effective on October 1, 1996. Such a phase-in must begin on October 1, 1996, and may not extend beyond October 1, 1999. The premium rates authorized under an approved phase-in plan shall be applied only to small employers that were enrolled in a small employer plan with the same carrier prior to October 1, 1996.

Stat. Auth.: ORS 731.244 & 743.731

Stats. Implemented: ORS 743.731, 743.734 & 743.737

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 1-1994, f. & cert. ef. 1-26-94; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0030

Marketing

(1) A small employer carrier may not use its sales compensation arrangements for the purpose of avoiding or limiting acceptance of risk.

(2) A small employer carrier must use the same compensation methodology for the basic health care plan for agents or other persons involved in marketing as the carrier uses on other health benefit plans issued to small employers.

(3) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the following: the health status, claims experience, occupation, geographic location of small employer groups, or the type of small employer plans placed by the agent with the carrier.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240

Stats. Implemented: ORS 743.736(4), (7), 743.737(9) & 746.650(1)

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0040

Underwriting

(1) A small employer carrier shall not use health statements when offering small employer health benefit plans, except as provided in ORS 743.734.

(2) A small employer carrier shall not modify health insurance with respect to an employee or any eligible employee dependent by means of riders, endorsements or otherwise, for the purpose of restricting or excluding coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. However, in the case of a late enrollee, an exclusion limited to specified health conditions may be used in lieu of a total exclusion from coverage. Such a limited exclusion is subject to the time limits contained in ORS 742.737.

(3) Participation and contribution requirements established by a small employer carrier shall be governed by the following:

(a) Participation requirements must apply on an aggregate basis in which all categories of eligible employees of a small employer are combined;

(b) Except as provided in this subsection, a small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer except at plan anniversary. At plan anniversary, the carrier may increase the requirements only to the extent those requirements are applicable to all other small employer groups of the same size. At the anniversary of a plan or at any time other than the anniversary, an insurer may consider the existing group as a new group for purposes of coverage if the eligibility requirements applicable to the group are changed by the employer;

(c) If a carrier requires 100 percent participation of eligible employees, as allowed by ORS 743.737, the carrier shall not impose a contribution requirement upon the employer that exceeds 50 percent of the premium of an employee-only benefit plan;

(d) A small employer may establish the hours per work week required for eligibility for a health benefit plan, but the establishment of hours is subject to rules of the small employer carrier. The rules adopted by a small employer carrier:

(A) Must allow for a minimum eligibility requirement of 17.5 hours per week and must not establish an eligibility requirement greater than 40 hours per week;

(B) Must be uniformly applied to all categories of employees of a small employer; and

(C) Must be applied uniformly to all products issued by the carrier in the small employer market.

(e) A small employer may establish the required employment period that must be met before coverage begins, but the establishment of such period is subject to the rules of the small employer carrier. The rules adopted by a small employer carrier:

(A) Must not establish a required employment period of greater than 90 days;

(B) Must be uniformly applied to all categories of employees of a small employer;

(C) Must be uniformly applied to all products issued by the carrier in the small employer market; and

(D) Must permit coverage to begin no later than the first of the month subsequent to the completion of 90 days of employment;

(f) Every small employer health benefit plan issued by a small employer carrier must specify all of the participation, contribution, and eligibility requirements that have been agreed upon by the carrier and the small employer and the carrier must apply those requirements uniformly to all categories of eligible employees and their dependents. No small employer health benefit plan may contain enrollment eligibility requirements that relate to the actual or expected health status of an eligible employee or dependent; and

(g) For the purpose of determining whether an employer is a small employer as the term is defined in ORS 743.730, all eligible employees as defined in ORS 743.730 shall be counted regardless of the number of employees actually participating in the employer's health plan.

(3) When a plan is replaced at any time other than the anniversary of a plan because the eligibility requirements applicable to the group are changed:

(a) Not later than the fifth day after receipt of a completed application for the replacement plan, the replacing carrier must notify the carrier of the plan being replaced that the plan will be replaced and must request the carrier to provide a complete census or listing of employees covered under the plan to be replaced;

(b) The carrier of the plan being replaced must provide the replacing carrier the census or listing requested under subsection (a) of this section, including the addresses of the covered employees, within ten working days of a request by the replacing carrier; and

(c) The replacing carrier must give written notice of loss of coverage to each employee not covered under the replacing policy. The requirement of this subsection applies whether the replacing carrier is different from the carrier whose plan is being replaced or is the same carrier. The notice must be given not later than the latest of the following dates:

(A) The date on which the replacement plan becomes effective; or

(B) Ten working days after receipt of the census or listing of employees under subsection (a) of this section.

(4) A modification to an existing small employer health benefit plan that is required by ORS 743.730 to 743.745 or OAR 836-053-0010 to 836-053-0070 shall be implemented on the first anniversary of the most recent renewal date of the plan that occurs on or after the operative date of the governing statutory provision or, if the plan has not yet been renewed, on the first anniversary of the plan effective date. In addition:

(a) Any existing riders or endorsements in effect for an enrolled employee or dependent that exclude coverage for diseases or medical conditions that are otherwise covered by the enrollee's plan shall be eliminated and deemed ineffective as of the anniversary date;

(b) Individual employees or dependents of a small employer previously denied coverage because of health status or claims experience shall be offered coverage in the health benefit plan as of the anniversary date, if they are still eligible on that date; and

(c) If an enrolled employee or dependent has limited coverage because of late enrollment in the plan, credit shall be granted for the time so enrolled against the maximum exclusion or limitation specified in ORS 743.737 and such crediting of time shall be effective as of the anniversary date;

(5) A small employer carrier shall use health statements solely in accordance with the provisions of ORS 743.734.

(6) A late enrollee, as defined in ORS 743.730, must be accepted for coverage in a small employer health benefit plan, but may be subject to the coverage limitations specified in ORS 743.737, and credit for prior coverage does not apply to such limitations. Late enrollees do not include employees or dependents who declined to enroll in a small employer plan prior to October 1, 1996, in order to retain coverage in an individual health benefit plan, in accordance with the late enrollee provisions of ORS 743.730 that were in effect prior to October 1, 1996, if termination of the individual coverage is involuntary.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.736(4), (7), 743.737(9) & 746.650(1)

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 1-1994, f. & cert. ef. 1-26-94; ID 2-1995, f. & cert. ef. 4-26-95; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0050

Trade Practices

(1) When offering plans to small employers, carriers must briefly describe the variety of small employer plans that are available from the carrier and the rate adjustments that apply to the plans, in accordance with ORS 743.737.

(3) Small employer health benefit plans must be issued with an effective date no later than thirty-one (31) days after the carrier actually receives the application.

(4) An agent registered to transact small employer health insurance may not request or receive any remuneration for marketing small employer health insurance based on the anticipated or actual claims experience, health status, industry, occupation, or geographic location of the small employer.

(5) Neither a small employer carrier nor a registered small employer agent may encourage or direct a small employer to refrain from filing an application for coverage with the small employer carrier because of the small employer's health status, claims experience, industry occupation or geographic location, if within the carrier's service area.

(6) Neither a small employer carrier nor a registered small employer agent may encourage or direct a small employer to seek coverage from another carrier because of the small employer's health status, claims experience, industry occupation or geographic location, if within the carrier's service area.

(7) Sections (4) and (5) of this rule do not prohibit a small employer carrier or an agent of the carrier from providing information to a small employer regarding the established geographic service area or a restricted network provision of the small employer carrier.

(8) Neither a small employer carrier nor a registered small employer agent may induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from employment or from health coverage or benefits provided in connection with the employee's employment.

(9) An insurer must provide, within ten working days, verification of dates of prior coverage, when requested by a small employer carrier for the purpose of crediting time toward a preexisting conditions provisions in accordance with ORS 743.737.

(10) A small employer health benefit plan may specify that an enrolled small employer may replace its current coverage with another small employer plan offered by the carrier only on the anniversary date of the current coverage.

(11) Violation of any provision of this rule is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240

Stats. Implemented: ORS 743.736(5), (7), 743.737(2)-(4), (9) & 746.240

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0060

Benefit Design

(1) No limitations may be placed on any benefit in the basic health benefit plan to extend a waiting period, other than those contained in ORS 743.737 and specifically stated in the report of the Small Employer Carrier Advisory Committee dated April 13, 1992, or any subsequent report of the Health Insurance Reform Advisory Committee.

(2) A small employer carrier must offer an approved basic health benefit plan in accordance with ORS 743.736 and may offer additional plans. Additional plans may include greater or lesser benefit coverage than the basic plan.

(3) Coverage of maternity services is required in the basic plan, but is optional in other small employer plans. However, pregnancy does not constitute a preexisting condition in any small employer plan and maternity services, if covered, cannot be subject to a temporary exclusion period that is shorter than 12 months.

(4) For small employer plans other than the basic plan, a carrier may impose an exclusion period for specified covered services that applies to all employees and dependents upon enrollment in the plan. A carrier may determine the excluded services, but the exclusion period shall not exceed 24 months and credit for prior coverage must be applied if:

(a) The prior coverage was continuous to a date not earlier than the 60th day prior to the effective date of the new coverage; and

(b) The excluded service was covered under the prior coverage.

(5) Prior coverage credit toward an exclusion period must be applied on the basis of elapsed time in the prior coverage. For example, if the exclusion period is 24 months and the enrollee had qualifying prior coverage for 12 months, the applicable exclusion period would be 12 months.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240

Stats. Implemented: ORS 743.731(4), 743.737(1)-(3)

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0070

Multiple Employer Welfare Arrangements

In determining whether an arrangement is a fully insured multiple employer welfare arrangement that is exempt from the small employer carrier requirements in accordance with ORS 743.730, the Director shall consider the following factors:

(1) Whether all of the benefits that are provided under the arrangement are guaranteed by policies of insurance issued by an authorized insurer;

(2) Whether the arrangement consists of an employee welfare benefit plan for employees of two or more employers or their beneficiaries as defined in ERISA sections 3 (5) and (40);

(3) Whether the arrangement is essentially controlled by an insurer, benefit service organization or individual for the purpose of creating a market for furnishing benefits to diverse individuals or groups rather than a bona fide multiple employer welfare arrangement.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240

Stats. Implemented: ORS 743.730(17)

Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96

836-053-0180

Purpose, Statutory Authority

OAR 836-053-0180 to 836-053-0185 are adopted under the authority of ORS 731.244 for the purpose of carrying out ORS 743.730 to 743.773 and providing rate filing requirements and procedures for small employer plans, individual plans and portability plans.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.730 - 743.773

Hist.: ID 13-1996(Temp), f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97

836-053-0185

Rate Filings

(1) A carrier shall file with the Director:

(a) The appropriate checklists and certification statements, as established by the Director;

(b) An actuarial demonstration of the basis for the differences in the geographic average rates of the various plans offered in the marketplace. This demonstration shall be certified by a member of the American Academy of Actuaries both at the initial submission and subsequently when the rate relativities between plans are changed.

(2) A carrier shall not offer a subject health benefit plan until the Director has determined that the filed geographic average rate meets the applicable statutory requirements;

(3) An approved geographic average rate shall not be modified by a carrier until the Director has determined that the filed modification meets the applicable statutory requirements.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.730 - 743.773

Hist.: ID 13-1996(Temp), f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97

Group Health Benefit Plans

836-053-0210

Purpose; Statutory Authority; Applicability

(1) OAR 836-053-0210 to 836-053-0270 are adopted under the authority of ORS 731.244 for the purpose of carrying out ORS 743.751 to 743.754 and 743.522.

(2) For the purpose of OAR 836-053-0210 to 836-053-0270, as used in administering and enforcing the provisions of ORS 743.751 to 743.754, the term "policyholder" as used in ORS 743.751 to 743.754 is construed by the Director to

mean a certificate holder. This interpretation is given in order to reconcile the contradiction evident in the use of the term in those statutes: a group policy has only one policyholder, but may have two or more certificate holders.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.522 & 743.751 - 743.754

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0220

Definitions

As used in OAR 836-053-0210 to 836-053-0270:

(1) "Eligible member" means each member of a group who qualifies to be a certificate holder in accordance with the terms of a group health benefit plan.

(2) "Group health benefit plan" means a health benefit plan, other than a small employer health benefit plan, that is offered or issued to a group consisting of two or more prospective certificate holders, including all policies of group health insurance issued in accordance with ORS 743.522.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.522 & 743.751 - 743.754

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0230

Underwriting

(1) Every group health benefit plan issued by a carrier must specify all of the participation, contribution and eligibility requirements that have been agreed upon by the carrier and the covered group, and the carrier must apply those requirements uniformly within each category of eligible members.

(2) A carrier offering a group health benefit plan shall use health statements solely in accordance with the provisions of ORS 743.751.

(3) A carrier shall not use health statements or other information that reveals individual health status to determine the acceptance or rejection of a group that has applied for coverage. Impermissible other information includes claim records that identify individual claimants. Permissible criteria for the declination of a group include such factors as:

(a) The risk status or claims experience of the group as a whole; and

(b) The financial condition of the group as a whole.

(4) When a group health benefit plan is issued to a collection of eligible subgroups or individuals, as may occur with an association, trust or fully insured multiple employer welfare arrangement, a carrier may determine the acceptance or rejection of coverage for each eligible subgroup or individual. The determination of the carrier, however, must be made in accordance with section (3) of this rule.

(5) If a carrier accepts a group for coverage, the carrier shall not:

(a) Decline to offer coverage to any eligible member; or

(b) Impose any terms or conditions on the coverage of an eligible member that are based on the actual or expected health status of the member, except as provided in ORS 743.754.

(6) A late enrollee, as defined in ORS 743.730, must be accepted for coverage in a group health benefit plan, but may be subject to the coverage limitations specified in ORS 743.754. Credit for prior coverage does not apply to such limitations.

(7) A modification to an existing group health benefit plan that is required by ORS 743.751 to 743.754 or by OAR 836-053-0210 to 836-053-0270 shall be implemented for each policyholder on the first renewal date of the policy issued to the policyholder that occurs on or after October 1, 1996. In addition:

(a) Any existing rider or endorsement in effect for a certificate holder or dependent that was based on the actual or expected health status of the certificate holder or dependent and that excludes coverage for a disease or medical condition that is otherwise covered by the plan shall be eliminated and deemed ineffective as of the anniversary date;

(b) A person who was previously eligible to enroll in a plan, but who was denied enrollment on the basis of the actual or expected health status of the person, shall be offered enrollment in the plan as of the anniversary date, if the person is still eligible as of that date; and

(c) If a certificate holder or dependent has limited coverage because of late enrollment in a plan, credit shall be granted for the time so enrolled against the maximum exclusion or limitation specified in ORS 743.754 and such crediting of time shall be effective as of the anniversary date.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.522 & 743.751 - 743.754

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0240

Trade Practices

A carrier must provide, within ten working days, verification of dates of prior coverage, when requested by another carrier for purpose of crediting time toward a preexisting conditions provisions in accordance with ORS 743.754.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.522 & 743.751 - 743.754

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0250

Benefit Design

(1) Coverage of maternity services is optional in a group health benefit plan. However, pregnancy does not constitute a preexisting condition in any group health benefit plan. Maternity services, if covered, cannot be subject to a temporary exclusion period that is shorter than 12 months.

(2) A carrier may impose an exclusion period for specified covered services that applies to all certificate holders and dependents upon enrollment in a group health benefit plan. The carrier may determine the excluded services and the duration of the exclusion period and credit for prior coverage must be applied if:.

(a) The prior coverage was continuous to a date not earlier than the 60th day prior to the effective date of the new coverage; and

(b) The excluded service was covered under the prior coverage.

(3) Prior coverage credit toward an exclusion period must be applied on the basis of elapsed time in the prior coverage. For example, if the exclusion period is 24 months and the enrollee had qualifying prior coverage for 12 months, the applicable exclusion period would be 12 months.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.522 & 743.751 - 743.754

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

Individual Health Benefit Plans

836-053-0410

Purpose; Statutory Authority

OAR 836-053-0410 to 836-053-0470 are adopted under the authority of ORS 743.769 for the purpose of implementing ORS 743.766 to 743.769, relating to individual health benefit plans.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0420

Rating

(1) Individual health benefit plans shall be rated in accordance with the geographic areas specified in OAR 836-053-0020.

(2) The variation in geographic average rates among different individual health benefit plans offered by a carrier must be based solely on objective differences in plan design or coverage. The variation must not include differences based on the risk characteristics or claims experience of the actual or expected enrollees in a particular plan.

(3) A carrier shall implement premium rate increases for an individual health benefit plan in a consistent manner for all enrollees in the plan. A carrier may use either of the following methods to schedule premium rate increases for all enrollees in a plan:

(a) A rolling schedule that is based on the date coverage is issued to each enrollee; or

(b) A fixed schedule that applies concurrently to all enrollees in a plan. If a fixed schedule is used, a carrier may adjust an enrollee's premium during the rating period if the enrollee moves into a higher age bracket or has a change in family composition.

(4) A carrier shall file its geographic average rates for individual health benefit plans in accordance with the rate filing requirements of OAR 836-053-0185.

(5) A carrier may request approval from the Director to phase in the premium rating requirements of ORS 743.766 to 743.773. Such a phase-in must begin on October 1, 1996, and may not extend beyond October 1, 1999. The premium rates authorized under an approved phase-in plan shall be applied consistently to all of the enrollees in the individual health benefit plan for which the phase-in has been approved.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0430

Marketing

The application forms used by a carrier in marketing individual health benefit plans may require applicants to make a preliminary election of a specific plan, but all application forms must:

(1) Briefly describe the variety of individual health benefit plans offered by the carrier and inform the applicant that additional information is available;

(2) State that an applicant who is accepted for coverage may elect to enroll in any of the individual health benefit plans offered by the carrier; and

(3) State that an accepted applicant may revoke a coverage election and make a replacement election with ten days of original acceptance.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0440

Underwriting

(1) A carrier shall not modify the benefit provisions of an individual health benefit plan for any enrollee by means of a rider, endorsement or otherwise, for the purpose of restricting or excluding coverage for medical services or conditions that are otherwise covered by the plan.

(2) A carrier may impose a waiting period on the coverage of certain new enrollees in an individual health benefit plan, in accordance with ORS 743.766 and 743.767. Such a waiting period may apply only when the carrier has determined, by evaluation of the Oregon Individual Standard Health Statement, that the enrollee has a preexisting health condition warranting the application of a waiting period.

(3) If a carrier imposes a waiting period on the coverage of a new enrollee, the carrier shall apply prior coverage credit to the waiting period. The credit must be applied in the following manner:

(a) The credit must apply equally to the waiting period and the related surcharge; and

(b) The credit must be applied on a prorated basis. For example, if the enrollee had completed 50 percent of the exclusion period for preexisting conditions in the prior plan, then the waiting period and surcharge must be reduced by 50 percent.

(4) In determining an enrollee's eligibility for prior coverage credit in accordance with ORS 743.766, a carrier shall consider the effective date of the new individual health benefit plan coverage to be the date the carrier received the enrollee's application for coverage.

(5) An enrollee in an individual health benefit plan may request enrollment in another individual plan offered by the enrollee's carrier, but such a request may be handled by the carrier as a new application for coverage.

(6) A modification to an existing individual health benefit plan that is required by ORS 743.766 to 743.773 or by OAR 836-053-0410 to 836-053-0470 must be implemented on the renewal date of the plan that occurs on or after October 1, 1996. The renewal date of an individual health benefit plan is the date on which the next due premium payment is made. In addition:

(a) Any existing riders or endorsements in effect for an enrollee that were based on the actual or expected health status of the enrollee and that exclude coverage for diseases or medical conditions that are otherwise covered by the enrollee's plan must be eliminated and deemed ineffective as of the renewal date that occurs on or after October 1, 1996; and

(b) If a recent enrollee who is still subject to the preexisting conditions provision of a plan has a rider or endorsement eliminated in accordance with this rule, the enrollee's medical condition that was subject to the rider or endorsement may be subject to the preexisting conditions provision of the plan, including the prior coverage credit provisions.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0450

Trade Practices

(1) A carrier must provide, within ten working days, verification of dates of prior coverage, when requested by another carrier for purpose of crediting time toward a preexisting conditions provisions in accordance with ORS 743.766.

(2) A carrier must include in every outline of coverage that is provided to enrollees in an individual health benefit plan a summary of the following information: Individuals who decline coverage under a group health benefit plan in order to retain or obtain coverage under an individual health benefit plan will be considered late enrollees if they seek subsequent enrollment in the group plan. As late enrollees, they may be excluded from coverage in the group plan for up to twelve months, or subjected to a twelve month preexisting conditions provision.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0460

Benefit Design

(1) Coverage of maternity services is optional in individual health benefit plans. However, if maternity services are covered and are subject to a preexisting conditions provision, the provision must meet the requirements of ORS 743.766.

(2) A carrier may impose an exclusion period for specified covered services that applies to all individuals enrolling for the first time in an individual health benefit plan. The carrier may determine the excluded services and the duration of the exclusion period and credit for prior coverage is not required.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0470

Oregon Standard Health Statement

(1) The Oregon Standard Health Statement is included as Exhibit 1 to this rule.

(2) The Standard Health Statement is the only health statement that a carrier may use to evaluate the health status of applicants for coverage in an individual health benefit plan and for late enrollees in a group health benefit plan.

(3) In evaluating the Standard Health Statement submitted by an applicant, a carrier may request medical records or an attending physician's statement for the applicant, but such a request shall be made only for questions that have been marked "Yes" by the applicant in the numbered questionnaire portion of the statement. The cost of obtaining such information shall be borne by the carrier. Although a carrier's request for additional medical information is limited to the specific questions marked "Yes", a carrier may use all of the information received in response to such a request in evaluating the applicant's health statement.

(4) In accordance with ORS 746.135, a carrier may not use genetic information to reject, deny, limit or alter the terms of a health benefit plan.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

Portability Health Benefit Plans

836-053-0700

Statutory Authority, Implementation

(1) OAR 836-053-0700 to 836-053-0770 are adopted under the authority of ORS 731.244 for the purpose of

implementing portability health benefit plans in accordance with ORS 743.731, 743.760 and 743.761.

(2) OAR 836-053-0700 to 836-053-0770 apply to carriers issuing transition portability plans during the period October 1, 1996, through December 31, 1996.

(3) OAR 836-053-0700, 836-053-0710, and 836-053-0730 to 836-053-0770 apply to carriers issuing portability plans on and after January 1, 1997.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731, 743.760 & 743.761

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0710

Purpose

The purpose of these rules is to implement portability health benefit plans in accordance with ORS 743.760 and 743.761 and to establish a transition plan converting coverage of persons under conversion plans pursuant to ORS 743.611 to 743.622 to coverage under portability plans.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731, 743.760 & 743.761

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0715

Eligible Individuals

For the purpose of determining eligibility in accordance with ORS 743.760:

(1) An individual must be an Oregon resident in order to enroll in portability coverage.

(2) Oregon group health benefits plans include insured plans that have been issued to group policyholders that are located in Oregon, self-funded plans that are sponsored by entities that are located in Oregon and multiple employer welfare arrangements as defined in ORS 750.301.

(3) A period of continuation coverage in accordance with federal COBRA provisions or Oregon continuation provisions is included in determining the eligibility threshold of 180 days of group coverage.

(4) An individual or dependent who has voluntarily terminated from group coverage and who would otherwise remain eligible for such coverage is not eligible for portability coverage unless eligibility is limited to federal or state continuation coverage.

(5) An eligible individual who has lost insured group coverage may elect portability coverage before, during or at the end of federal or state continuation coverage. An eligible individual who has lost noninsured group coverage must first exhaust federal or state continuation coverage, if eligible, before electing portability coverage through the Oregon Medical Insurance Pool.

(6) An individual who is eligible for enrollment in the federal Medicare program is not eligible to enroll in portability

coverage and is not eligible to retain portability coverage beyond the individual's Medicare eligibility date.

(7) An individual who is otherwise eligible to enroll in portability coverage, but who is covered under another group or individual health benefit plan when such enrollment would occur, is not an eligible individual.

(8) An individual who has enrolled in portability coverage and who subsequently obtains coverage in another group or individual health benefit plan may remain enrolled in the portability coverage.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 2-1997, f. & cert. ef. 3-28-97

836-053-0720

Transition Portability Plans

(1) During the period October 1, 1996, through December 31, 1996, for the purpose of implementing ORS 743.760 and 743.761, a carrier that is subject to the requirements of ORS 743.760 and 743.761 shall offer transition portability coverage to all persons eligible for portability coverage in accordance with ORS 743.760(1)(a) and 743.760(12).

(2) The transition portability coverage offered by a carrier shall comply with the conversion plan requirements of ORS 743.613 and 743.614 (1995 Replacement Part), as in effect on September 30, 1996. For purposes of this section, a carrier may offer as a transition portability plan any conversion plan that has been approved by the Director and is available from the carrier as of September 30, 1996.

(3) When a carrier makes an offer of transition portability coverage, the carrier shall provide to the offeree a copy of the notification described in OAR 836-053-0750(2).

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0730

Portability Plans

(1) Not later than January 1, 1997, a carrier shall offer the portability plans approved by the Director under ORS 743.760 and 743.761 and described in OAR 836-053-0760 to the following eligible individuals:

(a) Individuals who were issued a policy of conversion coverage prior to October 1, 1996, in accordance with ORS 743.611, 743.613 and 743.614 (1995 Replacement Part); and

(b) Individuals who were issued a transition portability plan during the period October 1, 1996, through December 31, 1996, in accordance with OAR 836-053-0720.

(2) On and after January 1, 1997, a carrier shall offer the portability plans approved by the Director under ORS 743.760 and 743.761 and described in OAR 836-053-0760 to all persons eligible for portability coverage in accordance with ORS 743.760(1)(a) and 743.760(12).

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0740

Discontinuation of Conversion Plans and Transition Portability Plans

(1) On and after October 1, 1996, a carrier may elect to discontinue the conversion plans that the carrier has established in accordance with ORS 743.611, 743.613 and 743.614 (1995 Replacement Part), if the carrier, at the time of discontinuation, offers all affected policyholders at least two other health benefit plans in accordance with ORS 743.766(7).

(2) On and after January 1, 1997, a carrier may elect to discontinue the transition portability plans that the carrier has established in accordance with OAR 836-053-0720 if the carrier, at the time of discontinuation, offers all affected policyholders at least two other health benefit plans in accordance with ORS 743.766(7).

(3) If a carrier does not discontinue a conversion or transition portability plan as provided in sections (1) and (2) of this rule, the carrier must amend the continued plan by January 1, 1997, so that the plans will comply with the portability requirements of ORS 743.760 and 743.761, other than the benefit matrix described in OAR 836-053-0760. Amendments for this purpose must be filed with and approved by the Director in accordance with OAR 836-053-0760. The continuation of such an amended plan does not relieve the carrier of the responsibility to offer the portability plans approved by the Director under ORS 743.760 and 743.761 and described in OAR 836-053-0760. Rather, such an amended plan will be an optional portability plan to be offered in addition to the mandatory portability plans established under ORS 743.760 and 743.761.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731, 743.760 & 743.761

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0750

Notification

(1) On or before September 30, 1996, a carrier that is subject to the requirements of ORS 743.760 and 743.761 must provide written notification regarding portability coverage to all affected policyholders. Such notification must be provided to:

(a) All group policyholders;

(b) All individuals who have been issued a policy of conversion coverage in accordance with ORS 743.611, 743.613 and 743.614 (1995 Replacement Part); and

(c) All individuals who are continuing group coverage in accordance with ORS 743.600, 743.610 or federal COBRA provisions.

(2) The notification required under section (1) of this rule shall contain at least the following information:

(a) An explanation of the purpose of portability coverage and citation of ORS 743.760 and 743.761 as the governing

statutes;

(b) An explanation of the eligibility requirements for transition portability plans and portability plans;

(c) An explanation of the process and timelines by which an eligible individual may enroll in portability coverage;

(d) A description of the plan options available to eligible individuals and a summary of the benefit provisions of each plan option; and

(e) The telephone number and title of a carrier representative that is available to answer questions regarding portability coverage.

(3) On and after October 1, 1996, a carrier that is subject to the requirements of ORS 743.760 and 743.761 shall include an explanation of portability coverage in all policies that are issued to group policyholders in Oregon and in every summary plan description that is issued in connection with such policies. In addition, an explanation of portability coverage shall be provided to an eligible individual in conjunction with any notice provided by a carrier regarding the election or termination of continued group coverage in accordance with ORS 743.600, 743.610 or federal COBRA provisions.

(4) The notification required under section (3) of this rule shall contain at least the following information:

(a) An explanation of the purpose of portability coverage and citation of ORS 743.760 and 743.761 as the governing statutes;

(b) An explanation of the eligibility requirements for portability coverage;

(c) An explanation of the process and timelines by which an eligible individual may enroll in portability coverage;

(d) A description of the plan options available to eligible individuals and a summary of the benefit provisions of each plan option; and

(e) The telephone number and title of a carrier representative that is available to answer questions regarding portability coverage.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 743.731, 743.760 & 743.761

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0760

(1) For the purpose of the form filing requirement of ORS 743.760(4), a carrier shall file:

(a) A prevailing benefit portability plan that conforms to the matrix for that plan established in Exhibit 1 to this rule; and

(b) A low cost benefit portability plan that conforms to the matrix established for that plan in Exhibit 2 to this rule.

(2) The policy forms must be submitted for approval by the Director as provided for under OAR 836-010-0011, relating to filing and review of rates and forms.

(3) A carrier may offer a portability health benefit plan only after the Director has approved the plan form and has approved the applicable geographic average rates under OAR 836-053-0770.

[ED. NOTE: The Exhibits referenced in this rule are not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96; ID 13-1996(Temp), f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97

836-053-0770

Portability Plans Rating Requirements

(1) For the purpose of the rate filing requirement of ORS 743.760, a carrier shall file its geographic average rate for each of its portability health benefit plans for a rating period with the Director on or before March 15 of each year as provided in section (2) in this rule. A filing under this section must include an actuarial demonstration of the portability rate consistency as shown in **Exhibit 1** to this rule. This actuarial demonstration shall be certified, at the initial submission and subsequently when the geographic average rate changes, by a member of the American Academy of Actuaries.

(2) A plan using the geographic average rates established by a carrier may not be offered until the Director has issued a determination that the relationship among the geographic average rates is reasonable.

(3) The actuarial data required in this rule must be filed as provided by OAR 836-010-0011.

[ED. NOTE: The Exhibit referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 11-1996, f. 6-28-96, cert. ef. 7-1-96

836-053-0780

Rating Standards

(1) Portability health benefit plans shall be rated in accordance with the geographic areas specified in OAR 836-053-0020.

(2) Except for portability health benefit plans issued in accordance with ORS 743.761, the variation in geographic average rates between a carrier's portability health benefit plans and the carrier's group health benefit plans must be based solely on objective differences in plan design or coverage. The variation shall not include differences based on the risk characteristics or claims experience of the actual or expected enrollees in a portability plan.

(3) For portability health benefit plans issued in accordance with ORS 743.761, the premium rates that apply to portability enrollees in the individual health benefit plan shall be identical to the rates that apply to non-portability enrollees.

(4) A carrier shall implement premium rate increases for a portability health benefit plan in a consistent manner for all enrollees in the plan. A carrier may use either of the following methods to schedule premium rate increases for all enrollees in a plan:

(a) A rolling schedule that is based on the date coverage is issued to each enrollee; or

(b) A fixed schedule that applies concurrently to all enrollees in a plan. If a fixed schedule is used, a carrier may adjust an enrollee's premium during the rating period if the enrollee moves into a higher age bracket or has a change in family composition.

(5) A carrier shall file its geographic average rates for portability health benefit plans in accordance with the rate filing requirements of OAR 836-053-0185.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 12-1996, f. & cert. ef. 9-23-96

836-053-0790

Underwriting; Dependent Eligibility

(1) A carrier may include a nonduplication of coverage provision, as approved by the Director, in its portability health benefit plans.

(2) A carrier shall not modify the benefit provisions of a portability health benefit plan for any enrollee by means of riders, endorsements, or otherwise, for the purpose of restricting or excluding coverage for medical services or conditions that are otherwise covered by the plan.

(3) A carrier shall not impose an exclusion period for specified covered services when an individual enrolls in a portability health benefit plan, but a carrier may apply to the portability plan the remaining portion of an exclusion period that was in force in an enrollee's prior group coverage.

(4) An enrollee's coverage in a portability health benefit plan shall commence on the first day following the termination of the enrollee's prior group coverage.

(5) A carrier shall not decline to enroll an eligible dependent of an enrollee in a portability health benefit plan. For the purposes of this rule, an "eligible dependent" is a dependent of the enrollee that was covered by the enrollee's prior group health benefit plan, provided that such dependent meets the eligibility requirements of the portability health benefit plan.

(6) If an enrollee in a portability health benefit plan elects not to enroll an eligible dependent when the enrollee's coverage commences, that dependent is not eligible for enrollment as a dependent in the plan at any later date.

(7) After an enrollee's coverage commences in a portability health benefit plan, the carrier shall accept for enrollment any new dependent that is acquired by the enrollee, provided that such dependent meets the eligibility requirements of the plan.

(8) A dependent who is covered in a portability plan and who becomes ineligible for dependent coverage in that plan may make a separate election of portability coverage as an eligible individual.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97

836-053-0800

Trade Practices

(1) A carrier may apply to the Director to meet the portability requirements of ORS 743.760 by use of the carrier's individual health benefit plans. To gain approval, a carrier shall do all of the following:

(a) Have an active and substantial book of individual health benefit plans;

(b) Add the prevailing and low cost portability plan models to its book of individual health benefit plans;

(c) Issue any individual health benefit plan offered by the carrier to an applicant who is eligible for portability coverage in accordance with ORS 743.760;

(d) Apply no preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations to the individual coverage that is issued for portability purposes; and

(e) Make the prevailing and low cost benefit plan models available to non-portability applicants who are accepted for coverage in an individual health benefit plan. An individual plan issued to a non-portability applicant, including the prevailing and low cost models, may include a preexisting conditions provision, exclusion period, waiting period or other similar limitation, in accordance with ORS 743.766 to 743.773 and OAR 836-053-0410 to 836-053-0470.

(2) The following standards apply to policy forms for portability health benefit plans that are submitted in accordance with ORS 743.760:

(a) If all of a carrier's group policyholders are covered by one type of plan, the carrier must submit policy forms for at least that type of portability plan, and the carrier instead may elect to submit policy forms for both types of portability plans;

(b) If a carrier has group policyholders covered by each type of plan, the carrier must submit policy forms for both types of portability plans;

(c) A carrier's certificate of authority does not determine the type or types of portability plans that must be submitted by the carrier. A carrier authorized as a commercial insurer or as a health care service contractor may have group policyholders covered by either type of plan. The type or types of group plans that are issued by a carrier will be determined by the Director following consideration of all relevant aspects of plan design, including covered services, copayment or coinsurance provisions, provider network provisions and treatment referral provisions.

(3) A carrier shall apply the following procedures when offering portability plans:

(a) If a carrier is approved to offer only one type of portability plan, the carrier shall offer that type of plan to all eligible individuals;

(b) If a carrier is approved to offer both types of portability plans, the carrier is not required to offer both types of plans to an eligible individual. Rather, the carrier shall offer to an eligible individual the type of portability plan that is most similar to the group plan in which the individual was enrolled. The carrier, however, may elect to offer both types of portability plans to an eligible individual.

(4) For the purpose of this rule, "type" or "types" means a health benefit plan design that is substantially similar to the indemnity-type or health maintenance organization-type of portability plan that has been approved by the Director.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 743.731 & 743.760

Hist.: ID 13-1996(Temp), f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

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1998 Compilation

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 54

INSURANCE POLICIES

Property and Casualty Product Liability

Motor Vehicle Liability Insurance

836-054-0000

Election of Lower Limits for Uninsured Motorist Coverage

(1) This rule is adopted under the authority of ORS 731.244 for the purpose of implementing ORS 742.502.

(2) This rule establishes in **Exhibit 1** an example of the form of statement electing lower limits for uninsured motorist coverage in a motor vehicle liability insurance policy that may be used to comply with the requirement in ORS 742.502 for a statement of election. A form used by an insurer or agent that is in substantial compliance with this rule is considered to be approved by the Department. A form is in substantial compliance if the for contains all of the following elements in any order:

(a) An acknowledgement by the named insured that the named insured was offered uninsured motorist coverage with the limits equal to those for bodily injury liability;

(b) A brief summary, which is not part of the insurance contract, of uninsured and underinsured motorist coverages;

(c) A statement of the price for coverage per insured vehicle with limits equal to the named insured's bodily injury liability limits and the price for coverage per insured vehicle with the lower limits requested by the named insured;

(d) A statement to the effect that the statement shall remain in force until rescinded in writing by a named insured or until such time as motor vehicle bodily injury liability limits are changed; and

(e) Provision for signature of a named insured, to be made at the time of the election, and for the date of signature.

(3) Regarding the summary required in subsection (2)(b) of this rule, if an insurer issuing a policy that refers only to uninsured motorist coverage because uninsured motorist coverage under the policy includes underinsured motorist coverage meeting statutory requirements, the insurer need not use the term "underinsured motorist coverage".

(4) The statement required under subsection (2)(c) of this rule may state the term of coverage to which the prices relate.

(5) The form may include one or both of the following statements in addition to the items required under section (2) of this rule:

(a) A statement to the effect that the form is required by Oregon law or specifically by ORS 742.502; and

(b) A statement to the effect that limits for uninsured motorist coverage cannot be less than the amounts required to comply with financial responsibility requirements under ORS 806.070.

[ED. NOTE:The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 742.502

Stats. Implemented: ORS 742.502(2)

Hist.: ID 5-1994, f. & cert. ef. 5-9-94

Property and Casualty Professional Negligence

836-054-0050

Statutory Authority; and Purpose

(1) OAR 836-054-0050 to 836-054-0065 are adopted pursuant to the general rulemaking authority of the Director of the Department of Insurance and Finance in ORS 731.244, and the specific authority of the Director in ORS 743.770 to require additional information in the claim reports for professional negligence required under ORS 743.770.

(2) The purpose of these rules is to carry out the reporting requirements of ORS 743.770, under which authorized insurers providing professional liability insurance must report each claim of professional negligence against insured professionals to the appropriate licensing board.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 742.400(3)

Hist.: ID 8-1988, f. & cert. ef. 4-14-88

836-054-0055

Definitions

As used in OAR 836-054-0050 to 836-054-0065:

(1) "Professional Liability" means liability arising from injury caused by professional negligence of an insured.

(2) "Professional Liability Policy" means:

(a) Any policy insuring only the insured's legal obligation arising from the professional liability exposure of the insured;

(b) Any other policy for which the premium computation includes a specific charge for the professional liability exposure of the insured; and

(c) Any other policy with an indivisible premium at least one-half of which is for professional liability coverage.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 742.400(3)

Hist.: ID 8-1988, f. & cert. ef. 4-14-88

836-054-0060

Professional Liability Reports From Insurers

Each insurer professional liability policies shall report any claim against an insured for alleged professional negligence to the appropriate licensing board as provided under ORS 743.770.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 742.400(3)

Hist.: ID 8-1988, f. & cert. ef. 4-14-88

836-054-0065

Report Content -- Professional Liability Claim Information

(1) Except as provided in section (2) of this rule, the report required by ORS 743.770 shall be made on form 440-1962, prescribed by **Exhibit 1** to this rule. The report shall be completed according to the instructions for the exhibit. Each insurer shall reproduce the reporting form and instructions in sufficient quantities for its own needs.

(2) The information required under ORS 743.770 may be reported on a reporting form promulgated or approved by the insurance supervisory official of another state if all information required by the instructions for **Exhibit 1** to this rule is shown in a manner directly corresponding to the rules and coding systems specified by the instructions for **Exhibit 1** to this rule.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the Oregon Administrative Rules Compilation. Copies are available from the adopting agency.]

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 742.400(3)

Hist.: ID 8-1988, f. & cert. ef. 4-14-88

Liquor Liability

836-054-0080

Liquor Liability Insurance; Purpose; Statutory Authority

(1) A policy of liability insurance with an indivisible premium at least one-half or which is for liquor liability coverage is a liquor liability policy for purposes of ORS 731.498 and 731.500. Any insurer issuing a policy described in this section is subject to ORS 731.500, which requires insurers providing liquor liability insurance to file annual reports on claims with the Oregon Liquor Control Commission.

(2) This rule is adopted pursuant to the general rulemaking authority of the Director in ORS 731.244 and the specific authority for rulemaking in ORS 731.498, in order to designated insurance policies providing liquor liability insurance in addition to the categories of policies specified in ORS 731.498.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.498(2)(c)

Hist.: ID 8-1988, f. & cert. ef. 4-14-88

Property and Casualty

836-054-0100

Statutory Authority

OAR 836-054-0100 and 836-054-0105 are adopted pursuant to the general rulemaking authority of the Director of the Department of Insurance and Finance in ORS 731.244 and the specific obligation of the Director in ORS 731.490 and 731.493 to adopt rules requiring insurers who are authorized to write property and casualty insurance in this state to report their Oregon loss and expense experiences and data, as required by ORS 731.493.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.490 & 731.493

Hist.: ID 20-1988, f. & cert ef. 12-16-88

836-054-0105

Reporting Requirement; Reporting Form

(1) Each insurer authorized to write property and casualty insurance in the state of Oregon shall file with the Director of the Department of Insurance and Finance by May 31 of each year a report on their loss and expense experiences in Oregon for the preceding calendar year. The first report shall contain information for calendar year 1988 and shall be filed with the Director by May 31, 1989.

(2) An insurer shall make the report required by this rule on Forms 1994, 2056 and 2057 prescribed in **Exhibits 1, 2**, and **3** to this rule. The report must be completed according to the instructions on each form.

(3) Each insurer shall reproduce the reporting forms with the instructions in sufficient quantities for its own needs.

[ED. NOTE: The Exhibit(s) referenced in this rule are not printed in the Oregon Administrative Rules Compilation. Copies are available from the

adopting agency.]

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 731.490 & 731.493

Hist.: ID 20-1988, f. & cert. ef. 12-16-88

Workers' Compensation Large Deductible Provisions

836-054-0201

Statutory Authority and Purpose

OAR 836-054-0201 to 836-054-0210 are adopted pursuant to the general rulemaking authority of the Director of the Department of Consumer and Business Services to specify requirements for large deductible provisions of workers' compensation insurance policies which may be approved according to ORS 742.001 to 742.007

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-054-0205

Definitions

As used in OAR 836-054-0201 to 836-054-0210:

(1) "Insurer" means any insurer authorized to write workers' compensation insurance and includes the State Accident Insurance Fund Corporation.

(2) "Large Deductible" means a provision in a workers' compensation policy, or added by endorsement thereto, which allows a policyholder to be financially responsible for claims incurred under the policy up to a percentage of premium, a stated amount per claim, or other limit specified in the provision in exchange for a prospective premium reduction.

(3) "Workers' Compensation Insurance" means insurance providing coverage for the obligations of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapters 654 and 656, similar laws of the United States, or agreements between states.

(4) "Workers' Compensation Premium Assessment" means the assessment imposed on insurers, self-insured employers, and self-insured employer groups by the Director of the Department of Consumer and Business Services pursuant to ORS 656.612.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

836-054-0210

Required Content of Large Deductible Provisions

An insurer which issues a workers' compensation insurance policy with a large deductible provision must file such provision with the Director for approval as required by ORS 742.003. The provision must satisfy the following requirements:

(1) A large deductible provision must clearly and prominently state that the insured employer must report all workers' compensation insurance claims to the insurer and the insurer retains responsibility to administer claims and to pay all costs and expenses.

(2) A large deductible provision must state that the insurer will delete the provision effective not more than ten (10) days following discovery that an insured employer has on three occasions within the policy period known of but not reported a workers' compensation insurance claim to the insurer or has on any occasion within the policy period made direct payment of claim costs. The provision may further state that the insurer will cancel the policy with notice pursuant to ORS 656.427 or that the insurer will delete the provision retroactively to the date of the offense with penalties stated in the provision. When a large deductible provision is deleted, the premium for any remaining portion of a policy term will be computed using the rating plans applied by the insurer to the policy prior to deductible credits except that any system of expense gradation applied by the insurer to similar policies must be used.

(3) A large deductible provision must specify that the basis for the Workers' Compensation Premium Assessment will be premium earned prior to any premium credits or modifications for the large deductible provision.

(4) A large deductible provision must specify that the basis for any assessments by the Plan Administrator for the Workers' Compensation Insurance Plan specified by OAR 836-043-0001 to 836-043-0090 will be premium earned prior to any premium credits or modifications for the large deductible provision.

(5) A large deductible provision must define explicitly which expenses, if any, will be billed to the employer in addition to direct claim costs and specify whether such expenses are subject to the deductible limits together with direct claim costs or will be billed in addition to deductible amounts.

(6) A large deductible provision must state that the premium credit percentage and amount for the large deductible will be recalculated after final premium audit based on actual premium or exposures and after any retrospective premium adjustments for retrospectively rated policies.

(7) A large deductible provision shall contain an offer for the insurer to provide occupational safety and health loss control consultative services as required by ORS 654.097.

(8) A large deductible provision shall contain minimum eligibility requirements of not less than $750,000 estimated country-wide annual premium prior to large deductible credits or premium credits based on premium size. The minimum deductible limit per claim for each injury or illness may not be less than $75,000. An aggregate limit for deductible amounts for all claims may be specified but may not be less than the deductible limit per claim.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS

Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 58

MOTOR VEHICLE LIABILITY INSURANCE

836-058-0005

Statistical Report of Exclusion of Named Persons

(1) Each insurer issuing motor vehicle liability insurance policies to Oregon residents shall file annually with the Director a statistical report of the number of such policies issued to Oregon residents by the insurer during the preceding year. The report must be filed not later than April 1 of the year following the year being reported. The years for which policy issuance must be reported are 1992, 1993, 1994 and 1995. Each report must show, with respect to the year to which the report applies:

(a) The number of such policies issued with a name driver exclusion endorsement; and

(b) The number of such policies issued without a named driver exclusion endorsement.

(2) The report shall include the name of the insurer, and the name, address and telephone number of the insurer's contact person regarding the report.

(3) The report shall be delivered or mailed to the attention of the Name Driver Exclusion Coordinator, Insurance Division, 440-2 Labor and Industries Building, Salem, OR 97310.

Stat. Auth.: ORS

Stats. Implemented: ORS 1991 OL, Ch 768 §4

Hist.: ID 14-1992, f. & cert. ef. 10-1-92

836-058-0010

Permitted Reasons to Exclude Named Person

An insurer may exclude by name a person other than the named insured from the coverage required by ORS 742.450(2)(a) to be provided in a motor vehicle liability insurance policy issued for delivery in this state, for any of the following reasons:

(1) The excluded person is higher rated than the named insured and the difference between the annualized premium that the named insured would pay on the liability coverage under the policy including the higher rated person and the annualized premium that the named insured would pay on the policy excluding the higher rated person would cause financial hardship as described in this section to the named insured. For the purpose of this section:

(a) A financial hardship is caused only if the difference exceeds $1,000;

(b) Premium owing to rating for a high performance vehicle or a sports car shall be excluded for the purpose of determining whether financial hardship is caused.

(2) The excluded person's Oregon driver's license is suspended pursuant to ORS 809.410(4).

(3) The excluded person's Oregon driver's license is suspended pursuant to ORS 809.410(16).

Stat. Auth.: ORS 731.244 & 742.450

Stats. Implemented: ORS 742.450(6)(b)

Hist.: ID 6-1993, f. & cert. ef. 8-25-93

836-058-0020

Exclusion from Excess Coverage

(1) An insurer who excludes one or more persons as provided by law from any coverage in excess of the coverage required by ORS 742.450(2)(a) to be provided in a motor vehicle liability insurance policy issued for delivery in this state must state in the policy or indorsement the policy limits applicable to the person.

(2) The disclosure requirement of section (1) of this rule does not apply with respect to a person also excluded from coverage under a motor vehicle liability insurance policy under ORS 742.450(6)(a) or OAR 836-058-0010.

Stat. Auth.: ORS 731.244 & 742.031

Stats. Implemented: ORS 742.450(1)-(2) & 742.464

Hist.: ID 6-1993, f. & cert. ef. 8-25-93

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 60

INSURANCE POLICIES (ORS CH. 743)

Credit Life and Credit Health Insurance

836-060-0000

Statutory Authority; Purpose; Effective Date

(1) OAR 836-060-0000 through 836-060-0060 are adopted pursuant to the general rulemaking authority of the Director in ORS 731.244.

(2) The purpose of OAR 836-060-0000 through 836-060-0060 is to protect the interests of debtors and the public by providing a system of rate, policy form and operating standards for the transaction of credit life and credit health insurance in Oregon. These rules interpret and implement ORS 742.005, 743.015, 743.371 to 743.380, 746.160, 746.220, and 746.240.

(3) OAR 836-060-0000 through 836-060-0060 as amended become effective on January 1, 1991, and apply as follows:

(a) Except as otherwise provided in this section, on April 1, 1991, all forms not in compliance with OAR 836-060-0000 through 836-060-0060 as amended become disapproved for use in Oregon. No such form may be issued or delivered after that date unless it has been changed and resubmitted to and approved by the Director, or unless an approved rider has been attached bringing the form into compliance with OAR 836-060-0000 through 836-060-0060 as amended;

(b) Certificates, notices of proposed insurance and premium rates for existing group policies shall conform to OAR 836-060-0000 through 836-060-0060 as amended not later than the anniversary date of the group policy on or next following April 1, 1991;

(c) Any replacement or amendment of a group credit insurance policy existing on November 1, 1990 or any new policy issued after November 1, 1990 in an attempt delay or circumvent application of these rules shall nonetheless be subject to OAR 836-060-0000 through 836-060-0060 as amended. No group credit insurance policy in force in this state prior to January 1, 1991, may be rewritten or redated in order to delay or circumvent the effect of OAR 836-060-0000 through 836-060-0060 as amended;

(d) All forms received for filing on or after January 1, 1991 must comply with OAR 836-060-0000 through 836-060-0060 as amended. No such form may be issued or delivered on or after January 1, 1991 unless the form has been

submitted to and approved by the Director.

(4) These rules, except as provided in OAR 836-060-0041, do not apply to production credit associations, bank agricultural loans or educational loan commitments.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 742.005, 743.015, 743.371 - 743.380, 746.160, 746.220 & 746.240

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; IC 11-1982, f. & ef. 6-23-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0005

Definitions

As used in OAR 836-060-0000 through 836-060-0060:

(1) "Closed-End Credit" means credit other than open-end credit.

(2) "Compensation" means money or anything else of value.

(3) "Credit Health Insurance" means the kind of insurance defined in ORS 743.371 and limited by ORS 743.372.

(4) "Credit Insurance" means credit life insurance or credit health insurance or both.

(5) "Credit Life Insurance" means the kind of insurance defined in ORS 743.371 and limited by ORS 743.372.

(6) "Credit Transaction" means any transaction by the terms of which the repayment of money loaned, or payment for goods, services or properties sold or leased, is to be made at a future date or dates.

(7) "Net Written Premium" means gross written premium minus refunds on termination.

(8) "Indebtedness" means total amount repayable, including principal, interest and finance charges.

(9) "Open-End Credit" means credit extended by a creditor under an agreement in which:

(a) The creditor reasonably contemplates repeated transactions;

(b) The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

(c) The amount of credit that may be extended to the debtor during the term of the agreement, up to any limit set by the creditor, is generally made available to the extent that any outstanding balance is repaid.

Stat. Auth.: ORS Ch. 731, 742, 743, & 746

Stats. Implemented: ORS 742.005, 743.015, 743.371 - 743.380, 746.220 & 746.240

Hist.: IC 40, f. 2-15-68, ef. 4-1-68; IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0011

Rights and Treatment of Debtors

(1) Multiple Plans of Insurance. If a creditor makes available to debtors more than one plan of credit life insurance or more than one plan of credit health insurance, debtors must be informed of all such plans.

(2) Substitution. When a creditor requires credit life insurance, credit health insurance or both as additional security for an indebtedness, the debtor shall be given the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor, or of procuring and furnishing the required coverage through any insurer authorized to transact insurance in this state. The debtor shall be informed by the creditor before the transaction is completed of this right to provide alternative coverage.

(3) Evidence of Coverage. All credit insurance shall be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance. The policy or certificate shall be delivered to the debtor in accordance with ORS 743.377, and shall set forth the information required by ORS 743.377 and other provisions of the Insurance Code.

(4) Claims Processing. All credit insurance claims shall be processed in accordance with ORS 743.380.

(5) Termination of Group Credit Insurance Policy:

(a) If a debtor is covered by a group credit insurance policy providing for the payment of single premiums to the insurer, provision shall be made by the insurer that, in the event of termination of the policy for any reason, insurance coverage with respect to the debtor shall be continued for the entire period for which the single premium was paid, subject to cancellation by the insured person;

(b) If a debtor is covered by a group credit insurance policy providing for the payment of premiums to the insurer on a monthly outstanding balance basis, the policy shall provide that, in the event of termination of the policy for any reason, notice of the termination shall be given to the debtor at least 30 days prior to the effective date of termination, unless replacement of the coverage by the same or another insurer in the same or greater amount occurs without lapse of coverage. This notice shall be given by the insurer or, at the option of the insurer, by the creditor.

(6) Interest on Premiums. If a creditor adds identifiable insurance charges or premiums for credit insurance to an indebtedness, and any direct or indirect finance, carrying, credit or service charge is made to the debtor on such insurance charges or premiums, the creditor shall remit and the insurer shall collect the insurance charges or premiums within 60 days after they are added to the indebtedness.

(7) Renewal or Refinancing of Indebtedness. If an indebtedness is discharged because of renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all such cases of termination prior to scheduled maturity, a refund shall be paid or credited to the debtor as provided in OAR 836-060-0036. In the renewal or refinancing of the indebtedness, the effective date of the insurance coverage with respect to any policy provision shall be considered to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, at least to the extent of the amount and term of the indebtedness outstanding at the time of the renewal or refinancing of the debt.

(8) Maximum Aggregate Provisions. A provision in an individual policy or a group certificate that sets a maximum limit on total payments shall apply only to that individual policy or group certificate.

(9) Voluntary Prepayment of Indebtedness. If a debtor prepays the indebtedness other than as a result of a death payment or a lump-sum disability payment:

(a) Any credit life insurance covering the indebtedness shall be terminated and an appropriate refund of credit life insurance premium shall be paid to the debtor in accordance with OAR 836-060-0036; and

(b) Any credit health insurance covering the indebtedness shall be terminated and an appropriate refund of credit health insurance premium shall be paid to the debtor in accordance with OAR 836-060-0036. If a claim under the coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until

the payment of benefits terminates. No refund need be paid during any period of disability for which credit health insurance benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period.

(10) Involuntary Prepayment of Indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy or by a lump-sum payment of a disability claim under a credit insurance policy covering the debtor, it shall be the responsibility of the insurer that the following are paid to the insured debtor, if living, or to the beneficiary, other than the creditor, named by the debtor, or to the debtor's estate:

(a) In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump-sum total and permanent disability benefit under credit life insurance coverage, an appropriate refund of the credit health insurance premium in accordance with OAR 836-060-0036

(b) In the case of prepayment by a lump-sum payment of a disability claim, an appropriate refund of the credit life insurance premium in accordance with OAR 836-060-0036; and

(c) In either case, the amount of the benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges.

(11) Amounts to be Insured:

(a) Credit life insurance may provide benefits not exceeding the amount of indebtedness outstanding or, at the option of the insurer, not exceeding the amount of indebtedness outstanding less the unearned interest or finance charges;

(b) Credit health insurance may provide benefits not exceeding the amount of outstanding indebtedness inclusive of unearned interest or finance charges.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 743.376 - 743.378, 743.380, 746.220 & 746.240

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0016

Policy Forms and Related Material

(1) Permissible Forms. Credit insurance shall be issued only in the forms described in ORS 743.373.

(2) Rates and Forms Filing Requirements. All credit insurance policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Director as required by ORS 743.015.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 743.015 & 743.373

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0021

Determination of Reasonableness of Benefits in Relation to Premium Charge

(1) General Standard. Under ORS 742.005, benefits provided by credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied, in the opinion of the Director, if the premium develops, or reasonably may be expected to develop:

(a) A loss ratio of not less than 55%, with respect to indebtedness of less than $3,000;

(b) A loss ratio of not less than 60 percent, with respect to indebtedness of $3,000 or more.

(2) With the exception of deviations approved under OAR 836-060-0043, the rates shown in OAR 836-060-0026 and 836-060-0031, as adjusted pursuant to OAR 836-060-0041, shall be conclusively presumed to satisfy the general standards set forth in section (1) of this rule.

(3) Nonstandard Coverage. An insurer which files for approval a form providing coverage more restricted than that described in OAR 836-060-0026 and 836-060-0031 shall demonstrate to the satisfaction of the Director that the premium rates to be charged for such restricted coverage will develop, or reasonably may be expected to develop, a loss ratio not less than that contemplated for standard coverage at the premium rates described in OAR 836-060-0026 and 836-060-0031.

(4) Coverage Without Separate Charge. If no specific charge is made to the debtor for credit insurance, sections (1) to (3) of this rule do not apply. In this case, any premium rates which exceed the premium rate standards set out in OAR 836-060-0026 and 836-060-0031 must be filed with the Director. For purposes of this section, a specific charge is made to the debtor if an identifiable charge for insurance is disclosed in the credit or other instrument furnished the debtor which sets out the financial elements of the credit transactions, or if there is a differential in finance, interest, service or other similar charge made to debtors who are in like circumstances except for their insured or noninsured status.

(5) For the purpose of applying the appropriate rate under OAR 836-060-0026 and 836-060-0031, all loans made by a lender to an insured within a monthly accounting period shall be aggregated.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 742.003 & 742.005(6)(c)

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 26-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0026

Credit Life Insurance Rates

(1) This section establishes premium rates for credit life insurance for the insured portion of an indebtedness, when the indebtedness is an amount less than $3,000. Unless data submitted to the Director justify a higher rate in the Director's opinion, credit life insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, when the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall not exceed the rates ("prima facie" rates) set forth in subsections (a) and (b) of this section. Subsections (c), (d) and (e) of this section prescribe the corresponding "prima facie" premium rates for other types of credit life insurance benefits. The prima facie premium rates are as follows:

(a) $.77 per month per $1,000 of outstanding insured indebtedness, if premiums are payable on a monthly outstanding balance basis;

(b) If premiums are payable on a single premium basis and the amount of the insurance decreases in equal monthly amounts, the prima facie rates per $100 of initial insured indebtedness shall equal:

(A) $.50 per year on credit terms of 63 months or less; and

(B) On credit terms over 63 months

$$\frac{-}{(n+1)}{20}$$

times $.77, where n is the credit term in months. The rates so calculated are to be immediately rounded to two-decimal precision, i.e. to the nearest cent. Accordingly, the rate for a four-month term is exactly $.16 for an 8-month term is exactly $.34, for a 12-month term is exactly $.50, for a 36-month term is $1.50, for 60-month term is exactly $2.50 and for 120-month term is exactly $4.67.

(c) If premiums are payable on a single premium basis and the benefit provided is level term, the prima facie rate is $.91 per $100 of insured indebtedness per year of term. The rate for a fractional part of a year shall be calculated pro rata and immediately rounded to two-decimal precision, i.e. to the nearest cent. Accordingly, the rate for a 4-month term is exactly $.30 for an 8-month term is exactly $.61;

(d) The joint coverage rate shall be 165% of the rounded rate for single person coverage. Accordingly, the rate for an 8-month decreasing term is exactly $.56, and the rate for an 8-month level term is exactly $1.01;

(e) If coverage is a combination of level term and decreasing term with equal decrements, the rate shall be a combination of the appropriate rate for level term and the appropriate rate for decreasing term with equal decrements;

(f) For coverage for outstanding indebtedness when only the principal is insured and the interest is paid on a scheduled basis to provide equal monthly repayments of indebtedness (simple interest loans), the premium shall be actuarially consistent with other premiums calculations described in this rule;

(g) For other benefits, except for benefits described in subsection (e), section (3) of this rule, rates shall be actuarially consistent with the rates specified in this section.

(2) This section establishes premium rates for credit life insurance for the insured portion of an indebtedness, when the indebtedness is an amount of $3,000 or more. Unless data submitted to the director justify a higher rate in the Director's opinion, credit life insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, when the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall not exceed the rates ("prima facie" rates) set forth in subsections (a) and (b) of this section. Subsections (c), (d) and (e) of this section prescribe the corresponding "prima facie" premium rates for other types of credit life insurance benefits. The prima facie premium rates are as follows:

(a) $.70 per month per $1,000 of outstanding insured indebtedness. If premiums are payable on a monthly outstanding balance basis;

(b) If premiums are payable on a single premium basis and the amount of the insurance decreases in equal monthly amounts, the prima facie rates per $100 of initial insured indebtedness shall equal:

(A) $.45 per year on credit terms of 63 months or less; and

(B) On credit terms over 63 months

$$\frac{-}{(n+1)}$$

times $.70, where n is the credit term in months. The rates so calculated are to be immediately rounded to two-decimal precision, i.e. to the nearest cent. Accordingly, the rate for a 4-month term is exactly $.15, for an 8-month term is exactly $.30, for a 12-month term is exactly $.45, for a 36-month term is exactly $1.35, for a 60-month term is exactly $2.25 and for a 120-month term is exactly $4.21.

(c) If premiums are payable on a single premium basis and the benefit provided is level term, the prima facie rate is $.82 per $100 of insured indebtedness per year of term. The rate for a fractional part of a year shall be calculated pro rata and immediately rounded to two-decimal precision, i.e. to the nearest cent. Accordingly, the rate for a 4-month term is exactly $.27; for an 8-month term is exactly $.55;

(d) The joint coverage rate shall be 165% of the rounded rate for single person coverage. Accordingly, the rate for an 8-month decreasing term is exactly $.50, and the rate for an 8-month level term is exactly $.91;

(e) If coverage is a combination of level term and decreasing term with equal decrements, the rate shall be a combination of the appropriate rate for level term and the appropriate rate for decreasing term with equal decrements;

(f) For coverage for outstanding indebtedness when only the principal is insured and the interest is paid on a scheduled basis to provide equal monthly repayments of indebtedness (simple interest loans), the premium shall be actuarially consistent with other premiums calculations described in this rule;

(g) For other benefits, except for benefits described in subsection (3)(e) of this rule, rates shall be actuarially consistent with the rates specified in this section.

(3) The premium rates in sections (1) and (2) of this rule shall apply to credit life insurance policies issued with or without evidence of insurability, and offered to all debtors, Such policies:

(a) Shall not contain exclusions other than suicide within six months following the effective date of coverage for the insured person. If a suicide exclusion is used, the exclusion shall not be effective for more than six months following the effective date of coverage for the insured person. With respect to an exclusion under this subsection:

(A) The effective date of coverage for the insurance applicable to an indebtedness or to the portion of an indebtedness that is $3,000 or less is the date on which the coverage was first issued;

(B) The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account made when the total outstanding indebtedness, including the advance or charge, exceeds $3,000, is the date on which the advance or charge is posted to the plan account.

(b) Shall not contain age restriction other than age restrictions making ineligible for coverage debtors 66 or over at the time the indebtedness is incurred or debtors having attained age 66 or over on the maturity date of the indebtedness;

(c) When written in connection with an open-end credit plan, may exclude classes of debtors determined by age from the classes eligible for insurance by providing for the cessation of insurance or reduction in the amount of insurance upon attainment of a specified age not less than age sixty-six;

(d) When written in connection with closed-end credit plans and open-end credit plans in which the amount of insurance is based on or limited to the outstanding unpaid balance, shall not contain a provision excluding or denying a claim for death resulting from a preexisting condition except for those conditions for which the insured debtor received medical diagnosis or treatment within six months preceding the effective date of coverage and which directly contributed to the death of the insured debtor within six months following the effective date of coverage. For purposes of this subsection:

(A) The effective date of coverage for the insurance applicable to an indebtedness or to the portion of an indebtedness

that is $3,000 or less is the date on which the coverage was first issued;

(B) The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account made when the total outstanding indebtedness, including the advance or charge, exceeds $3,000, is the date on which the advance or charge is posted to the plan account.

(e) May contain additional benefits to policyholders and their debtors, such as dismemberment, partial disability and other benefits of small economic value to the consumer, but an insurer shall not pass on the charge for such coverage to the debtor so as to increase the total rate to exceed the rate established by this rule.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 742.003 & 742.005(6)(c)

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0031

Credit Health Insurance Rates

(1) This section establishes premium rates for credit health insurance for the insured portion of an indebtedness, when the indebtedness is an amount less than $3,000. Unless data submitted to the Director justify a higher rate in the Director's opinion, credit health insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall not exceed the rates ("prima facie" rates) set forth in subsections (a) and (b) of this section. Subsections (c), (d) and (e) of this section prescribe the corresponding "prima facie" premium rates for other types of credit health insurance benefits. The prima facie premium rates are as follows:

(a) As set forth in Table 1, if premiums are payable on a single premium basis for the duration of the coverage;

(b) As set forth in Table 1, if premiums are payable on a monthly outstanding insured indebtedness basis;

(c) The actuarial equivalent of the rates specified in subsections (a) and (b) of this section, if the coverage provided is a constant maximum indemnity for a given period of time;

(d) An appropriate combination of the premium rate for a constant maximum indemnity for a given period of time and the premium rate for a maximum indemnity which decreases in even amounts per month, if the coverage provided starts as a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month;

(e) For credit health insurance on an open-end credit account, per $1,000 of outstanding insured indebtedness, the following rates shall apply to the following minimum benefits plans:

(A) 14-day nonretroactive plan -- $2.29

(B) 30-day nonretroactive plan -- $1.93

(C) 14-day retroactive plan -- $2.60

(D) 30-day retroactive plan -- $2.39

(f) For other benefits, except for benefits described in subsection (h), section (3) of this rule, rates shall be actuarially consistent with the rates specified in this section;

(g) Under open-end or closed-end credit plans, the outstanding insured indebtedness rate shall be the rate applicable to the aggregate amount of the loan;

(h) For critical period credit health coverage, maximum rates shall be computed by using the conversion ratios based on the **1974 Basic Tables of Credit A & H Claim Costs** published by National Association of Insurance Commissioners, **NAIC Proceedings, 1975 Volume 1, pp. 676-691**.

(2) This section establishes premium rates for credit health insurance for the insured portion of an indebtedness, when the indebtedness is an amount of $3,000 or more. Unless data submitted to the Director justify a higher rate in the Director's opinion, credit health insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall not exceed the rates ("prima facie" rates) set forth in subsections (a) and (b) of this section. Subsections (c), (d) and (e) of this section prescribe the corresponding "prima facie" premium rates for other types of credit health insurance benefits. The prima facie premium rates are as follows:

(a) As set forth in Table 2, if premiums are payable on a single premium basis for the duration of the coverage;

(b) As set forth in Table 2, if premiums are payable on a monthly outstanding insured indebtedness basis;

(c) The actuarial equivalent of the rates specified in subsections (a) and (b) of this section, if the coverage provided is a constant maximum indemnity for a given period of time;

(d) An appropriate combination of the premium rate for a constant maximum indemnity for a given period of time and the premium rate for a maximum indemnity which decreases in even amounts per month, if the coverage provided starts as a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month;

(e) For credit health insurance on an open-end credit account, per $1,000 of outstanding insured indebtedness, the following rates shall apply to the following minimum benefits plans:

(A) 14-day nonretroactive plan -- $2.12

(B) 30-day nonretroactive plan -- $1.79

(C) 14-day retroactive plan -- $2.41

(D) 30-day retroactive plan -- $2.22

(f) For other benefits, except for benefits described in subsection (h), section (3) of this rule, rates shall be actuarially consistent with the rates specified in this section;

(g) Under open-end or closed-end credit plans, the outstanding insured indebtedness rate shall be the rate applicable to the aggregate amount of the loan;

(h) For critical period credit health coverage, maximum rates shall be computed by using the conversion ratios based on the **1974 Basic Tables of Credit A & H Claim Costs** published by National Association of Insurance Commissioners, **NAIC Proceedings, 1975 Volume 1, pp. 676-691**.

(3) The premium rates in sections (1) and (2) of this rule shall apply to credit health insurance policies issued with or without evidence of insurability, offered to all eligible debtors. Such policies:

(a) Shall not contain a provision excluding or denying a claim for disability resulting from preexisting conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six months preceding the effective date of the debtor's coverage and which caused loss within the six months following the effective date of coverage;

(b) Shall not contain any other provision that excludes or restricts liability in the event of disability caused in a specified manner, except that the policy may contain provisions excluding or restricting coverage in the event of normal pregnancy and intentionally self-inflicted injuries;

(c) May contain an "actively at work test" only if the test applies solely when coverage is issued. Such a test shall not require that the debtor be employed more than 30 hours per week or deny coverage because the debtor is unemployed solely due to seasonal layoff;

(d) Shall not contain age restrictions other than age restrictions only making ineligible for coverage debtors 66 or over at the time the indebtedness is incurred or debtors who will have attained age 66 or over on the maturity date of the indebtedness;

(e) Shall contain a daily benefit equal in amount to one-thirtieth of the monthly benefit payable under the policy for the indebtedness;

(f) Shall contain a definition of "disability" providing that during the first 18 months of disability the insured shall be unable to perform the duties of the insured's occupation at the time the disability occurred, and thereafter the duties of any occupation for which the insured is reasonably fitted by education, training, or experience. This subsection shall not apply to lump-sum disability coverage;

(g) When written in connection with an open-end credit plan, may exclude from the classes eligible for insurance classes of debtors determined by age by providing for the cessation of insurance or reduction in the amount of insurance upon attainment of a specified age not less than age sixty-six;

(h) May contain other additional benefits to policyholders and their debtors, such as dismemberment, partial disability and other benefits of small economic value to the consumer, but an insurer shall not pass on the charge for such coverage to the debtor so as to increase the total rate to exceed the rate established by this rule;

(i) Shall not contain a requirement of regular physician care unless the care is medically necessary for determination of continued disability.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 742.003 & 742.005(6)(c)

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0036

Refund Formulas

(1) An insurer shall file for approval by the Director its refund formulas prior to their use. The following methods are considered appropriate for the plans described:

(a) Pro Rata Method. The prorata unearned gross premium method shall be used for level term credit life insurance or credit health insurance whereunder the insured is covered for a constant maximum indemnity for a given period of time, after which the maximum indemnity begins to decrease in even amounts per month, and credit insurance coverage under which premiums are collected from the debtor on a basis other than the single premium basis;

(b) Actuarial method. A refund of unearned premium may be made as provided in this subsection. The amount of the refund shall be not less than the total premium, less the greater of:

(A) Ten percent of the premiums or $75, whichever is less; or

(B) The premium earned to the installment due date of the loan nearest the date of prepayment, for the periods of time the loan balances were actually outstanding. For purposes of refund computations under this paragraph, the installment due date of the loan preceding the date of prepayment shall be considered to be nearest if prepayment occurs 15 days or less after that installment date. If prepayment occurs more than 15 days after the preceding installment due date, the next succeeding installment due date shall be considered to be nearest to the date of prepayment.

(c) Any method that develops refunds that are at least as favorable to the debtor as refunds based on the actuarial method described in subsection (b) of this section.

(2) In the event of termination, no charge for credit insurance may be made for the first 15 days of a loan month, and a full month may be charged for 16 days or more of a loan month.

(3) The refund formula shall be set forth in the individual policy or group certificate.

(4) The requirement of ORS 743.378 that refund formulas be filed with the Director is fulfilled by inclusion of the refund formulas in the individual policy or group certificate filed with the Director.

(5) No refund of $1 or less need be made.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 743.378

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0041

Experience Reports

(1) Each insurer transacting credit insurance in this state shall submit experience reports as provided in this rule for the experience period of each class of business.

(2) Classes of business for this purpose are as follows:

(a) Credit unions;

(b) Commercial and savings banks;

(c) Finance companies;

(d) Motor vehicle dealers;

(e) Other sales finance;

(f) Production credit associations and bank agricultural loans; and

(g) All others.

(3) The experience reports shall be submitted in the manner prescribed by Insurance Division **Credit Insurance Experience Report Forms A, B, B1, B2, C1 and C2**, and **Instructions** thereto. Insurers shall reproduce the forms for use according to their needs. The experience reports shall be submitted not later than June 1 of each year. These reports

may be on a calendar year experience.

(4) The experience reports required by this rule replace all other annual reports to the Director of credit insurance experience, except for reports required in the annual financial statement prescribed by the Director in accordance with the recommendations of the National Association of Insurance Commissioners. The experience reports required by this rule are separate and distinct from the annual financial statement and are not for use in determining the financial condition of an insurer.

(5) On a triennial basis, the Director may review the loss ratio standards set forth in OAR 836-060-0021 and the prima facie rates set forth in OAR 836-060-0026 and 836-060-0031 and determine therefrom the rate of expected claims on a statewide basis, compare the rate of expected claims with the rate of actual claims for the preceding triennium determined from the incurred claims and earned premiums at prima facie rates reports under this rule, and publish the adjusted actual statewide prima facie rates to be used by insurers during the next triennium. If published, the rates must reflect the difference between:

(a) Actual claims based on experience; and

(b) Expected claims based on the loss ratio standards set forth in OAR 836-060-0021 applied to the prima facie rates set forth in OAR 836-060-0026 and 836-060-0031.

NOTE: The Forms and Instructions referred to in this rule may be obtained from the adopting agency.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 742.005(6)(c)

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0043

Use of Rates - Direct Business Only

(1) An insurer that files rates or has rates on file that are not in excess of the prima facie rates shown in OAR 836-060-0026 and 836-060-0031, to the extend adjusted pursuant to OAR 836-060-0041 may use those rates without further proof of their reasonableness except as may be required by the Director.

(2) An insurer may file for approval of and may use rates that are higher than the prima facie rates shown in OAR 836-060-0026 and 836-060-0031, to the extent adjusted pursuant to OAR 836-060-0041, if it can be expected that the use of such higher rates will result in a ratio of claims incurred to premiums earned (assuming the use of such higher rates) that is commensurately higher, depending on the upward deviation, for those accounts to which the higher rates apply and that the upward deviations will not result on a statewide basis for that insurer of a ratio of claims incurred to premiums earned of less than the expected loss ratio underlying the current prima facie rate developed or adjusted pursuant to OAR 836-060-0041. The insurer must justify the rates by showing its compensation structure, including compensation to lenders and other producers. If rates higher than the prima facie rates shown in OAR 836-060-0026 and 836-060-0031, to the extent adjusted pursuant to OAR 836-060-0041, are filed for approval, the filing shall specify the account to which the rates apply. Such rates may be applied on an equitable basis approved by the Director only to one or more accounts of the insurer for which the experience has been less favorable than expected.

(3) This section establishes approval periods of deviated rates, as follows:

(a) A deviated rate shall be in effect for a period of time not longer than the experience period used to establish such rate (i.e. one year, two years or three years). An insurer may file for a new rate before the end of a rate period, but not more often than once during any twelve-month period. A deviated rate expires at the end of the rate period unless refiled and

approved again by the Director;

(b) Notwithstanding section (1) of this rule, if an account changes insurers, the succeeding insurer may use the rate approved to be used for the account by the prior insurer only if the rate is filed by the succeeding insurer and approved for use on the account for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on such account, if sooner.

(4) An insurer may at any time use a rate for an account that is lower than its filed rate without notice to the Director.

(5) When an insurer charges rates that are higher than the prima facie rates specified in OAR 836-060-0026 for credit life insurance or OAR 836-060-0031 for credit health insurance, the aggregate monetary amount of all compensation to any person shall not exceed that which would have been payable had the prima facie rates set forth in OAR 836-060-0026 or 836-060-0031 been charged.

(6) For purposes of this rule:

(a) "Experience" means "earned premiums" and"incurred claims" during the experience period;

(b) "Experience Period" means the most recent period of time for which experience is reported, but not for a period longer than three full years. For purposes of an individual policy, a year is a calendar year. For purposes of a group policy, a year is either a calendar year or policy year, at the option of the insurer;

(c) "Incurred Claims" means total claims paid during the experience period, adjusted for the change in claim service.

Stat. Auth.: 731, 742, 743 & 746

Stats. Implemented: ORS 742.005(6)(c) & 743.015

Hist.: ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0046

Supervision of Credit Insurance Operations

(1) Each insurer transacting credit insurance in this state shall be responsible for conducting periodically a thorough review of creditors with respect to the insurer's credit insurance business with such creditors, to assure compliance with the Oregon Insurance Code and OAR 836-060-0000 through 836-060-0060.

(2) The insurer shall maintain written records of these reviews for review by the Director.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 743.377, 743.378, 743.380 & 746.160

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0055

Prohibited Transactions

The following insurer practices in connection with the sale or placement of credit insurance, or as an inducement thereto, shall constitute unfair methods of competition under ORS 746.160 or unfair or deceptive practices injurious to

the insurance buying public under ORS 746.240:

(1) The offer or grant by an insurer to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract.

(2) Agreement by an insurer to deposit with a bank or other financial institution money or securities of the insurer, with the design or intent that this deposit shall affect or take the place of a deposit of money or securities which otherwise would be required of the creditor by the bank or the other financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(3) Deposit by an insurer of money or securities with a creditor, bank or other financial institution without interest or at lesser rate of interest than is currently being paid to other depositors of like amounts. This section shall not be construed to prohibit the maintenance by an insurer of those demand deposits or premium deposit accounts as are reasonably necessary for use in the ordinary course of the insurer's business.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 746.160 & 746.240

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

836-060-0060

Disclosure

(1) When a premium or identifiable charge is payable by a debtor for credit insurance coverage offered by a creditor, disclosure shall be made to the principal debtor, at the time the insurance is applied for, of the optional nature of the coverage, the eligibility requirements, and the policy limitations and exclusions. These disclosures may be the federal Truth-in-Lending disclosure accompanied by a notice of proposed insurance or the insurance policy or certificate. The disclosure may be made pursuant to the loan disclaimer requirements of the federal Truth-in-Lending law or regulations adopted thereunder, a similar disclosure requirement that is audited by an agency of a state or the federal government, accompanied by a notice of proposed insurance or the insurance policy or certificate. If disclosure is not thus made, disclosure must be given in the form and wording of the disclosure form set forth in **Exhibit 1** to this rule. The insurer may modify the disclosure form required under this section as appropriate for the loan involved. Before using the modified disclosure form, the insurer must obtain approval of the form from the Director.

(2) When the term of a loan is not the same as the term of the insurance, the policy or certificate must disclose prominently, in bold letters, the limit to the coverage.

Stat. Auth.: ORS Ch. 731, 742, 743 & 746

Stats. Implemented: ORS 743.015, 743.376, 743.377 & 746.240

Hist.: IC 7-1982, f. 2-12-82, ef. 6-1-82; Repealed by IC 13-1982, f. 11-30-82, ef. 12-1-82; IC 1-1983, f. 1-28-83, ef. 2-1-83; ID 24-1990, f. 12-28-90, cert. ef. 1-1-91

EXHIBIT 1

(OAR 836-060-0060)

DISCLOSURE FORM OPTIONAL CREDIT INSURANCE

Credit life insurance and credit health insurance provide protection for both the buyer and seller.

You are entitled to a copy of the policy or certificate of insurance within thirty days after credit is extended.

You ARE NOT required to buy credit life insurance or credit health insurance from any particular insurance company or agent. You may use existing policies if insurance is required as additional security.

If you buy credit life insurance, the proceeds will be used to reduce or pay off your unpaid loan or indebtedness when you die. Any insurance proceeds in excess of the amount required to pay off the loan will be paid to your beneficiary or estate.

If you buy credit health insurance, the proceeds will be used to reduce or pay off your unpaid loan or indebtedness if you become incapacitated.

READ your policy or certificate CAREFULLY for what the policy DOES NOT cover. For example: Some policies do not cover the total loan amount or the entire period of coverage. Some policies do not pay disability benefits unless you are disabled for 14 or 30 days or if you have a preexisting condition. Some policies will not provide coverage if you are age 66 or more or when you reach 66. See the policy for details on these matters.

You may not be eligible for credit health insurance unless you now work at least thirty hours per week, unless unemployed solely due to seasonal lay-off.

By initialing below, the customer, debtor or lessee acknowledges acceptance or refusal of credit life or credit health insurance.

ACCEPTS CREDIT LIFE INSURANCE

DECLINES CREDIT LIFE INSURANCE

ACCEPTS CREDIT HEALTH INSURANCE

DECLINES CREDIT HEALTH INSURANCE

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 62

VENDOR'S SINGLE INTEREST POLICIES AND MOTOR VEHICLE PHYSICAL DAMAGE ONLY POLICIES

836-062-0001

Statutory Authority; Effective Date

(1) OAR 836-062-0001 to 836-062-0010 are adopted pursuant to the general rulemaking authority of the Director under ORS 731.244.

(2) Not later than December 15, 1989, each insurer shall file with the Director a listing of all policy forms that comply with OAR 836-062-0005 or 836-062-0010. Any form to which OAR 836-062-0005 or 836-062-0100 applies but does not comply with either rule becomes disapproved for use in Oregon and may not be used after that date unless it has been resubmitted to and approved by the Director.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 742.005(2), 742.023(1)(f) & 746.240

Hist.: ID 9-1989, f. & cert. ef. 10-23-89

836-062-0005

Motor Vehicle Physical Damage Only Policies; Required Notice

(1) An insurer providing motor vehicle property damage only coverage on a domestic risk, upon issuance of coverage, shall give notice of the limited nature of the coverage as provided in this section to the purchaser of the motor vehicle to which the coverage applies. The insurer shall display the notice on the face page of the policy, the group or master contract or any other document issued by the insurer to the purchaser as evidence of insurance coverage. Except as provided in section (2) of this rule, the notice shall be in bold face type of not less than 12-point with a lower case unspaced alphabet length of not less than 120-point, or of not less than 10-point if the notice is in a contrasting color, and shall state:

"WARNING: THIS COVERAGE DOES NOT PROVIDE BODILY INJURY AND PROPERTY DAMAGE LIABILITY INSURANCE AND DOES NOT COMPLY WITH ANY FINANCIAL RESPONSIBILITY LAW

OR ANY OTHER LAW MANDATING MOTOR VEHICLE INSURANCE COVERAGE."

(2) An insurer may satisfy the notice requirement under section (1) of this rule by use of a notice provision that substantially complies with the notice provision set forth in section (1) of this rule, if the alternative notice provision is approved by the Director prior to use.

(3) For purposes of this rule, a policy is a motor vehicle physical damage only policy if it insures solely against the loss of or damage to any motor vehicle designed primarily for use upon a highway.

(4) The notice requirement under this rule may be met by the attachment of a sticker or by a stamp that contains the required warning. Other devices that contain the required warning may be used if approved by the Director prior to use.

(5) The agent selling the coverage to which this rule applies shall require the purchaser of the coverage to sign a receipt acknowledging that the purchaser has read and understands the warning required under section (1) of this rule. The receipt shall be retained by the agent or insurer until the end of the sixth month after the termination date of the coverage to which the receipt applies.

(6) This rule applies to motor vehicle physical damage only policies on individually owned private passenger vehicles including pickup and panel trucks and station wagons that are not used as a public or livery conveyance for passengers or rented to others, and does not apply to motor vehicle physical damage only policies on commercial fleets.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 742.005, 742.023 & 746.240

Hist.: ID 9-1989, f. & cert. ef. 10-23-89; ID 15-1996, f. & cert. ef. 11-12-96

836-062-0010

Vendor Single Interest Policies; Required Notice

(1) An insurer providing vendor's single interest coverage shall cause notice of the limited nature of the coverage to be given as provided in this rule to the borrower to whom the policy, certificate or other document giving evidence or notice of insurance coverage is issued. The notice shall be displayed on the face page of the policy, certificate or other document, or enclosed therewith. Except as provided in section (2) of this rule, the notice of the limited nature of the coverage shall be in bold face type of not less than 12-point with a lower case unspaced alphabet length of not less than 120-point or of not less than 10-point if the notice is in a contrasting color, and shall state:

"WARNING: THIS IS A LIMITED POLICY THAT PROTECTS ONLY THE LENDER'S INTEREST IN THE INSURED PROPERTY. THE POLICY DOES NOT PROVIDE BODILY INJURY AND PROPERTY DAMAGE LIABILITY INSURANCE AND DOES NOT COMPLY WITH ANY FINANCIAL RESPONSIBILITY LAW OR ANY OTHER LAW MANDATING MOTOR VEHICLE INSURANCE COVERAGE."

(2) An insurer may satisfy the notice requirement under section (1) of this rule by use of a notice provision that substantially complies with the notice provision set forth in section (1) of this rule, if the alternative notice provision is approved by the Director prior to use.

(3) This rule applies to all policies of personal property insurance placed on personal property that protect only the single interest of the vendor or lender. A policy protects only the single interest of the vendor or lender if it protects against loss or damage to personal property of a debtor for the following purposes:

(a) To secure repayment of the amount borrowed from the vendor or lender;

(b) To protect the vendor's or lender's interest in the property; and

(c) To protect the interest in the amount of the actual cash value of the collateral, the cost of repair or the loan balance, whichever is less.

(4) The notice requirement under this rule may be met by the attachment of a sticker or separate piece of paper or by a stamp that contains the required warning. Other devices that contain the required warning may be used if approved by the Director.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 742.005(2), 742.023(1)(f) & 746.240

Hist.: ID 9-1989, f. & cert. ef. 10-23-89

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 71

INSURANCE AGENTS GENERALLY

Agents, Adjusters and Insurance Consultants

Licensing Generally

836-071-0101

License Application; Required Information

(1) In addition to information required under ORS 744.001, an applicant for a license shall provide the following information relating to the applicant, as applicable on the application form:

(a) Date and place of birth;

(b) Duration of employment in insurance. Include the beginning and ending dates and the names and addresses of each employer and prior places of business in the insurance industry;

(c) All states and provinces of Canada in which the applicant currently holds a license to engage in the transaction of insurance, or has held such a license within ten years prior to the date of the application;

(d) Any assumed business name or alias ever used;

(e) Whether any firm or corporation of which the applicant is or has been a member, officer or director has ever filed for bankruptcy or been adjudged a bankrupt; and

(f) If the applicant is a firm or corporation, the name of all current officers, directors and stockholders who own more than ten percent of any class of equity security of the applicant.

(2) The applicant shall include with the application a clear front view photograph, not larger than 3" by 5" and taken within the past 12 months. The photograph is not required if the applicant is currently licensed in Oregon or has been licensed in Oregon within 24 months prior to the date of the application.

(3) An applicant for a resident license who is or has been licensed as a resident agent, adjuster or insurance consultant in another state or a province of Canada within five years prior to the date of application shall include with the application a statement that the resident license is inactive or no longer valid from the insurance department of the state or province in which the applicant is or was last authorized to transact insurance.

(4) An applicant for a non-resident license who is licensed as a resident agent, adjuster or insurance consultant in another state or province of Canada shall include with the application a statement of current licensure from the insurance department of the state or province in which the applicant was authorized to transact insurance as a resident licensee. The statement must indicate that the applicant has a current license for the class or classes of insurance that are being applied for in Oregon. The statement must be dated not earlier than the 90th day prior to the date of application.

(5) An applicant may voluntarily furnish the Social Security number of the applicant as provided in the application form, for use by the Director as an identification number in maintaining records and reporting grades or examination scores and for use by other government agencies to carry our their statutory duties. Refusal to disclose the Social Security number will not result in the denial of any individual right, benefit or privilege provided by law.

Stat. Auth.: ORS 731.244 & 744.001

Stats. Implemented: ORS 744.001 & 744.002

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 15-1996, f. & cert. ef. 11-12-96

836-071-0105

Additional Application Information

During the review of an application, the Director may require court documents, letters of recommendation and any other information that the Director determines will assist consideration of the application.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0110

Fingerprints

All fingerprints furnished to the Director by an applicant for a license shall be forwarded to the Identification Division, Oregon State Police for processing and search.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0115

Satisfaction of Qualifications for Classes of Insurance

An applicant must satisfy all applicable qualifications for each class of insurance applied for within a license category before the applicant may be issued a license.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0117

Managing General Agents; Amount of Claims Adjustment or Payment for Purposes of Statutory Definition

For the purpose of establishing under ORS 744.300 whether a person is acting as a managing general agent, the amount of $10,000 is the amount of claims that the Director must determine under ORS 744.300(3)(b)(A).

Stat. Auth.: ORS 731.244, 744.300, 744.306, 744.313 & 744.314

Hist.: ID 6-1992, f. & cert. ef. 3-26-92

836-071-0120

Examination Procedure

(1) To take an examination, an application must register with the examination administrator in advance of the examination. The applicant may register for an examination only if the Director has first approved the application of the applicant.

(2) An examination eligibility notice expires on the 180th day after the date of issuance.

(3) The administrator of the examination may require photographic identification of the applicant at the examination site.

(4) To be admitted to the examination site, an applicant must submit to the examination administrator either of the following as proof of satisfactory completion of required training:

(a) A signed certificate of insurance pre-examination training taken at a school registered under OAR 836-071-0190. The signed certificate must include the applicant's name, the classes of insurance for which training was received, the school name, the date on which the training was completed and the signature of a person authorized by the school to sign such certificates;

(b) Proof of completion of the required pre-examination insurance training at an accredited college or university.

Stat. Auth.: ORS 731.244, 731.804, 744.001, 744.003, 744.066, 744.069, 744.075, 744.535, 744.619 & 744.621

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91

836-071-0125

Completion of Application

The Director may reject a license application if it is has not been completed by the 90th day after its filing.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0127

Examination Scores

(1) For the purpose of obtaining authorization to transact a category or class of insurance, an applicant passes an examination for the class or category when the applicant obtains a score of 70 percent or higher.

(2) An applicant for a surplus lines agent's license must take a written examination approved by the Director and must achieve a score of 70 percent or higher.

Stat. Auth.: ORS 731.244, 731.804, 744.001, 744.003, 744.066, 744.069, 744.075, 744.535, 744.619 & 744.621

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91

836-071-0130

License Renewal

(1) A licensee applying for renewal must do the following, as applicable:

(a) Submit a completed renewal application, on a form provided by the Director. If mailed, the renewal application must be postmarked by the United States Postal Service not later than the license expiration date;

(b) Submit the renewal fee;

(c) Submit a statement of current license status from the insurance, department of the state of residence of the licensee, if the licensee is a non-resident licensee;

(d) Submit continuing education documentation as required by OAR 836-071-0220.

(2) The Director may allow a licensee not more than 30 days to submit missing information on the application form if the fees and continuing education documentation have been submitted on or before the expiration date.

(3) The Director may request on the renewal application any information requested on the original application for a license.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0135

Renewal of Expired License

The following provisions govern the renewal of an expired license as authorized under ORS 744.009:

(1) The expiration date of an expired license that is renewed under this rule shall be the same as the expiration date of the initial license.

(2) To renew an expired license as an agent, the applicant must show completion of the continuing education credits required as of each renewal date occurring since the most recent renewal of the license.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0140

License Amendment

(1) An applicant for an amendment to a license shall apply in the manner provided for application for the initial license under ORS 744.001.

(2) The Director may waive the requirement for fingerprints or photographs from an agent who applies for amendment to a license.

Stat. Auth.: ORS 731.244, 731.804, 744.001, 744.003, 744.066, 744.069, 744.075, 744.535, 744.619 & 744.621

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91

836-071-0145

Amended License Issuance

(1) When the Director determines that an applicant for an amendment to a license satisfies all applicable requirements, the Director shall issue to the applicant a license incorporating the amendment.

(2) The expiration date of a license issued under this rule shall be the same date as the expiration date of the initial license.

Stat. Auth.: ORS 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0148

Extended License Expiration Date, Agents Called into Active Military Duty

(1) The expiration date of the license of a licensee who is ordered by a branch of the armed forces of the United States into active military duty is extended as provided in this rule. The extended expiration date is established for a license as follows:

(a) By adding the number of days the licensee served on active duty to the date on which the licensee is released from active duty, if the license would otherwise have expired during the period of active duty; or

(b) By adding the number of days the licensee served on active duty to the date on which the license of the licensee expires, if the license would otherwise have expired after the date on which the licensee is released from active duty.

(2) The extended expiration date established under section (1) of this rule is the last day of the month in which the final day of the added period occurs. The date so established shall also be the expiration date for purposes of subsequent

renewals of the license.

(3) The fee, continuing education and other applicable requirements for renewal that would have applied for the normal expiration date of a license of a licensee described in section (1) of this rule apply for the extended expiration date. A licensee applying for renewal under this rule shall include with the renewal application either a copy of documentation by the branch of the armed forces in which the licensee served that shows the period served on active duty or an affidavit, signed by the applicant, that states the period served on active duty. The affidavit must be made on a form provided by the Director.

(4) This rule applies only to licensees who leave active duty under honorable conditions. This rule does not apply to regular and routine reservist training periods of service.

Stat. Auth.: ORS 731.244, 744.007 & 744.008

Stats. Implemented: ORS 744.007 & 744.008

Hist.: ID 10-1997, f. & cert. ef. 10-8-97

836-071-0150

Errors and Omissions Insurance; Insurance Consultants; Managing General Agents

(1) The amount of insurance for which an insurance consultant must maintain a certificate of errors and omissions insurance with the Director as required by ORS 744.635 is $500,000 claims made or per occurrence.

(2) The amount of insurance for which a managing general agent as described in ORS 744.300 must maintain a certificate of errors and omissions insurance with the Director as required by ORS 744.303 is $500,000 claims made or per occurrence.

(3) A managing general agent or an insurance consultant may obtain insurance required by ORS 744.303 or 744.635 from an insurer other than an authorized insurer if the insurer does not control or is not controlled by, or is not under common control with, the managing general agent or insurance consultant, whether directly or indirectly through one or more intermediaries, and if:

(a) The insurer is an eligible surplus lines insurer pursuant to the requirements of ORS 735.400 to 735.495 and the insurance is procured by a surplus lines licensee;

(b) The insurer is an authorized insurer in the state of domicile of the insurance consultant or managing general agent for whom the insurance is obtained; or the state of domicile of the applicant for either such license; or

(c) The insurance is procured from an Oregon surplus lines insurer that is eligible in the state of domicile of the insurance consultant or managing general agent, or applicant for either such license, if all requirements of this subsection are satisfied. The insurance for purposes of this subsection must be confirmed by the signature of an Oregon surplus lines agent. The Oregon surplus lines agent must also affirm in writing that the Oregon surplus lines agent will be the agent for service of process for any action or proceeding involving the insurance consultant or managing general agent and an Oregon resident.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-071-0160

mediary Managers

(1) The amount of insurance for which an intermediary manager must maintain a certificate of errors and omissions insurance with the Director as required by ORS 744.818, is $500,000 claims made or per occurrence.

(2) An intermediary manager may obtain insurance required by ORS 744.818, form an insurer other than an authorized insurer if the insurer does not control or is not controlled by, or is not under common control with, the intermediary manager, whether directly or indirectly through one or more intermediaries, and if:

(a) The insurer is an eligible surplus lines insurer pursuant to the requirements of ORS 735.400 to 735.495 and the insurance is procured by a surplus lines licensee;

(b) The insurer is an authorized insurer in the state of domicile of the intermediary manager for whom the insurance is obtained; or the state of domicile of the applicant for the license; or

(c) The insurance is procured from an Oregon surplus lines insurer that is eligible in the state of domicile of the intermediary manager or applicant for the license, if all requirements of this subsection are satisfied. The insurance for purposes of this subsection must be confirmed by the signature of an Oregon surplus lines agent. The Oregon surplus lines agent must also affirm in writing that the Oregon surplus lines agent will be the agent for service of process for any action or proceeding involving the intermediary manager and an Oregon resident.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 744.818

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 15-1996, f. & cert. ef. 11-12-96

Training and Examinations

836-071-0175

Model Curriculum Adopted

The Director adopts the Oregon Model Insurance Curriculum, May 1, 1991 a copy of which is available from the Insurance Division.

Stat. Auth.: ORS 731.244, 731.804, 744.001, 744.003, 744.066, 744.069, 744.075, 744.535, 744.619 & 744.621

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91

836-071-0180

Agent Pre-Examination Requirements

(1) An applicant for a license as an agent may take an examination for the license only if the applicant first qualifies for the examination by:

(a) Satisfying preexamination training requirements of section (2) of this rule and the training requirement of section (10) of this rule; or

(b) Satisfying the experience requirements of section (6) of this rule and the training requirement of section (10) of this

rule.

(2) An applicant may qualify for the examination by taking preexamination training meeting the requirements of section (3) of this rule according to either of the following methods:

(a) Attendance at classroom lectures supervised and conducted by an instructor; or

(b) Attendance at the showing or playing of a previously videotaped or audiotaped lecture, if student check-in and check-out are supervised and a course instructor is present or available to answer student questions.

(3) Preexamination training shall consist of not less than:

(a) 40 hours in basic principles of property and casualty insurance, for authority to transact general lines insurance;

(b) 30 hours in basic principles of life insurance, for authority to transact life insurance; and

(c) 12 hours in basic principles of health insurance, for authority to transact health insurance.

(4) For the purposes of sections (2) and (3) of this rule, one hour of training shall consist of not less than 50 minutes of instruction.

(5) An applicant may not satisfy the training requirements established in this rule by unsupervised training or by self-study.

(6) An applicant may satisfy experience requirements for the examination by either of the methods described in this section. As provided in section (7) of this rule, an applicant may substitute successful completion of coursework to obtain an industry recognized designation for all or part of the experience requirements. The methods for satisfying experience requirements are as follows:

(a) Obtaining and showing proof of three years of verifiable experience as an unlicensed person performing the duties and activities described in OAR 836-071-0280(1) or (2) in the class or classes of insurance for which application is made, but only if any part of the experience has occurred within two years of the date of application for the agent license in this state; and

(b) Obtaining and showing proof of three years of licensure as a resident agent or insurance broker in another state or a province of Canada:

(A) If the applicant has been so licensed within two years of the date of application for the agent license in this state; and

(B) If the applicant is not otherwise exempt from taking the examination under ORS 744.085.

(7) An applicant may substitute successful completion of coursework required for obtaining an industry-recognized designation described in this section for all or a part of the number of years of experience required under section (6) of this rule in the class or classes of insurance for which application was made. The following are the designations, the amount of experience for which the coursework may be substituted and the class or classes of insurance to which the coursework may apply:

(a) Accredited Advisor in Insurance (AAI) designation of the American Institute of Property and Liability Underwriters, Inc.: Three years' experience credit/general lines;

(b) Accredited Customer Service Representative (ACSR) designation of the Independent Insurance Agents Association: Two years' experience credit/general lines;

(c) Associate in Risk Management (ARM) designation of the American Institute of Property and Liability Underwriters, Inc.: Three years' experience credit/general lines;

(d) Certified Insurance Counselor (CIC) designation of the Society of Certified Insurance Counselors: Three years' experience credit/general lines;

(e) Certified Professional Service Representative (CPSR) designation of the Professional Insurance Agents Association: Two years' experience credit/general lines;

(f) Registered Health Underwriter (RHU) designation of the National Association of Health Underwriters in partnership with Northeastern University: Three years' experience credit/health;

(g) Certified Financial Planner (CFP) designation of the College for Financial Planning: Three years' experience credit/life lines;

(h) Life Underwriters Training Council (LUTCF) designation of the Life Underwriters Training Council: Three years' experience credit/life and health lines;

(i) Chartered Financial Consultant (ChFC) designation of the American College of Life Underwriter: Three years' experience life and health lines;

(j) Fellow Life Manager Institute (FLMI) designation: Three years' experience life and health lines;

(k) Certified Professional Insurance Women (CPIW) designation: Two years' property and casualty lines; and

(l) An industry designation determined by the Director, by virtue of the coursework, to provide experience at least comparable to experience obtained by coursework for an industry designation specifically referred to in this section.

(8) Pretraining experience claimed under section (6) of this rule is verifiable only if:

(a) The applicant's employer submits to the Division a completed Division Qualification Form that includes a description of all the pretraining experience claimed by the applicant; and

(b) The Division is able to contact the employer to verify the information contained in the Qualification Form.

(9) Proof of completion of a training course for an industry designation under section (7) of this rule must be evidenced by a certificate of completion or notice of a passing examination score by the organization sponsoring the training.

(10) Each applicant for a license as an agent must obtain not less than eight hours of training in the **Oregon Insurance Code** and administrative rules.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244 & 744.075

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94

836-071-0185

Qualification of Agents Selling Variable Annuity Contracts and Policies

(1) No person shall solicit, place or procure variable annuity contracts or policies, unless the person, in addition to qualifying as a licensed life insurance agent, has completed to the Director's satisfaction an examination of the National Association of Securities Dealers (NASD) that is Series 1, Series 6, Series 7, Series 8, Series 24, Series 26 or Series 40.

(2) The Director may delete the requirement under section (1) of this rule if the Director determines that the examinations are no longer given. Each examination series referred to in section (1) of this rule is subject to review by

the Director for the purpose of determining whether the examination series continues to be sufficient for testing applicants' knowledge of variable annuity contracts and policies. If the Director determines that an examination series is insufficient in that regard, the Director may disapprove it.

Stat. Auth.: ORS 731.244, 731.804, 744.001, 744.003, 744.066, 744.069, 744.075, 744.535, 744.619 & 744.621

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91

836-071-0190

Registration of a School

(1) Each school, other than a community college or four-year college or university, offering an insurance instruction program shall register with the Director in order to provide pre-examination training for applicants for agent licenses. Each school shall apply for registration annually on a form provided by the Director.

(2) The application shall contain:

(a) The business name, main business address and business telephone number of the school and the name of an individual employed by the school whom the Director may contact;

(b) A detailed description of the school's insurance training program that shall, for each part, include the course outline and list of source materials, instructor's lesson plans, student outline, proposed student attendance record forms, proposed student progress record forms and enrollment contract form including refund policy;

(c) The names of persons authorized to certify records or statements regarding training taken by applicants;

(d) A list of principal officers and directors if the school is a firm or corporation;

(e) A certification that the training offered or proposed to be offered is at least the equivalent of the Model Curriculum under OAR 836-071-0175.

(3) A registered school shall notify the Director of any change of its address, telephone number or contact person within 30 days after the change.

(4) Promotional material advertising insurance pre-examination training published by the registered school shall state that the school is registered with the Insurance Division and that registration does not imply endorsement by the Insurance Division.

(5) A registered school shall retain for each training course the attendance and course outlines for a period of three years after the conclusion of the course.

(6) A registered school is subject to audit by the Director for purposes of verifying compliance with OAR 836-071-0180.

(7) Subject to revocation of registration under OAR 836-071-0195, a registration expires on the second January 1 following the date of registration.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0195

Revocation of Registration of a School; Reinstatement

(1) The registration of an insurance school providing pre-examination training may be revoked by the Director if the Director determines that:

(a) The insurance training program as registered is not being taught; or

(b) Students who have not maintained a satisfactory attendance record or have not completed course work have been certified by the school for the agent license examination.

(2) A school whose registration is revoked may apply for reinstatement. The school must demonstrate to the Director's satisfaction that the school has taken appropriate action to correct the conditions that were the basis of the revocation.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

Continuing Education

836-071-0210

Statutory Authority; Purpose

OAR 836-071-0210 to 836-071-0250 are adopted under the authority of ORS 731.244 and 744.119 for the purpose of implementing ORS 744.119, relating to continuing education for agents. The purpose of OAR 836-071-0210 to 836-071-0250 is to establish requirements and standards for the program for licensees.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0215

Continuing Education Requirements for Agents; Hours; Credit for Experience and Coursework

(1) Each resident agent is responsible for obtaining the credit hours required by this rule by enrolling in courses approved by the Director that serve the agent's professional needs. The following minimum continuing education requirements apply to resident agents as a condition of renewing a license as agent:

(a) During the first year that an agent holds an agent license, the agent must complete 24 hours of continuing education;

(b) For each two year renewal period occurring during the second through the fifth years that an agent holds an agent license, the agent must complete 48 hours of continuing education;

(c) For each two year renewal period occurring after the fifth year that an agent holds an agent license, the agent must complete 24 hours of continuing education;

(d) If an agent has received the designation of Chartered Property and Casualty Underwriter or Chartered Life

Underwriter:

(A) During the first year that the agent holds an agent license, the agent must complete 12 hours of continuing education; and

(B) For each two year renewal period occurring after the first year of licensure, the agent must complete 24 hours of continuing education; and

(e) For each two year renewal period occurring after the first year of licensure, an agent who renews a license on or after January 1, 1998, must include in the applicable required hours of completed continuing education:

(A) At least three credit hours of continuing education on the subject of Oregon statutes and administrative rules, including recent changes; and

(B) At least two credit hours of continuing education of the subject of professional ethics for insurance agents.

(2) For the purpose of satisfying minimum continuing education requirements:

(a) A resident agent who qualified for examination for a license by experience or by completion of coursework to obtain an industry-recognized designation as provided in OAR 836-071-0180 may count the experience or coursework as equivalent to having held the agent license for three years;

(b) A resident agent previously licensed as an agent in Oregon or in another state may count the period of prior licensure on a year for year basis;

(c) A resident agent licensed prior to June 1, 1994, may apply to the Director to count the agent's verifiable experience performing the duties and activities described in OAR 836-071-280(1) or (2) during the period prior to licensure for purposes of continuing education, as provided in this subsection. An agent must have obtained at least three years of such experience in the class or classes of insurance in which the agent is licensed. Such experience when verified may be counted as equivalent to three years of licensure in addition to the period of actual licensure;

(d) A resident agent licensed prior to June 1, 1994, may apply to the Director to count the agent's successful completion of coursework required for obtaining an industry-recognized designation described in OAR 836-071-0180(7), if obtained prior to licensure, for purposes of continuing education, as provided in this subsection. The years of experience assigned to the coursework under OAR 836-071-0180(7), when verified, may be counted as equivalent to years of licensing in addition to the period of actual licensure. Such coursework in total may be counted as equivalent to not more than three years of licensing; and

(e) Experience described in subsection (c) of this section and coursework described in subsection (d) of this section may be counted together as equivalent to not more than three years of licensing.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0220

Continuing Education; Documentation

(1) For the purpose of furnishing evidence of completion of a course for which an agent claims credit, the agent shall submit the documentation applicable to the course as follows:

(a) For a registered course taken for academic credit, an agent shall submit a transcript, certificate of completion or grade or course completion report, whichever is issued by the institution offering the course, or a copy thereof. For purposes of this subsection, a course is taken for academic credit if it is offered by a community college or four-year college or university, and the agent is given academic credit for the course by such an institution;

(b) For coursework taken for the purpose of obtaining a nationally-recognized insurance industry designation, the agent shall submit a transcript, certificate of completion or grade or course completion report, whichever is issued by the entity granting the designation;

(c) For a registered course that is not offered for academic credit, an agent shall submit the certificate of completion issued by the provider, or a copy thereof. The certificate must include a statement of the hours of credit, the name of the agent, the date of the course, the course registration number, the authorized signature of the provider and the title of the course. The authorized signature may be made by rubber stamp or other facsimile if the stamped or facsimile signature is in a contrasting color to the print of the certificate. An agent who submits a copy of a certificate must retain the original certificate for six months after the date of submittal, for the purpose of enabling verification by the Director;

(d) For a course that is not offered for academic credit and is not registered when taken by an agent, an agent must comply with the requirements of OAR 836-071-0250.

(2) An agent who submits a copy of documentation required under this rule must submit the original document upon request by the Director for the purpose of verification.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0225

Continuing Education; Standards for Granting Credit Hours

(1) Subject to the subject matter requirements of OAR 836-071-0230, an agent may receive credit for continuing education for a course taken for academic credit, for a course registered under OAR 836-071-0240 or a course certified under OAR 836-071-0250:

(a) For not more than the credit hours authorized by the Director;

(b) Only if an hour includes at least 50 minutes of instruction or study;

(c) For class hours in which an agent is an instructor of a course if the course meets the continuing education requirements of an agent attending it. Credit may be taken by an agent with respect to a course only once in each renewal period in which the agent instructs the course;

(d) For not more than eight credit hours in any given day;

(e) Only if the hour for which credit is taken was completed during the license period immediately preceding the renewal date;

(f) For a course taken through independent study, but only as provided in section (4) of this rule.

(2) An agent may take credit for a course only if the agent has successfully completed the course before the agent applies for renewal or reinstatement. For the purpose of taking credit for a course other than one taken through independent study, an agent successfully completes the course if the agent is present for the full approved time and has

signed in and out on the attendance register for the course.

(3) An agent may not take continuing education credit for:

(a) Hours devoted to preparation for a course; when the agent is acting as an instructor for the course;

(b) Travel time;

(c) Time exceeding the actual class time;

(d) Unplanned or incidental learning experiences;

(e) Any course not completed;

(f) Any course repeated within a two year period; or

(g) Any course during which the agent is absent more than 5 minutes for each hour of credit granted, or is absent more than 20 minutes from the course as a whole.

(4) For purposes of subsection (1)(f) of this rule, a course is taken through independent study if the course is designed to allow each student to take the course at the student's own pace on an individual basis. An agent may claim credit for an independent study course if the provider and the course are both registered with the Director when the course is taken, if the agent passes an examination by a score of 70 percent or higher and if the proctor of the examination affirms and the provider certifies completion and passage as provided in this section. If the independent study course is a textbook, the examination must be conducted as a closed book examination. The examination for an independent study course need not be proctored if the course is computerized and includes safeguards ensuring that the agent cannot review the study material while taking the examination and if the examination has safeguards ensuring that the agent cannot change answers after completing the examination. Proctor affirmation and provider certification shall be made as follows:

(a) The proctor must affirm by affidavit, on an affidavit form approved by the Director, that the agent took the examination for the course without assistance from the textbook or from any person. The proctor must disclose in the affidavit the proctor's name, address, telephone number and the proctor's position or connection with the agent, such as a continuing education school or a librarian, and the proctor's registration number, if the proctor is required to be registered under section (7) of this rule. The provider must retain the affidavit with the examination. A proctor affidavit is not required if the independent study course is taken from a provider that offers a nationally recognized insurance industry designation.

(b) If the provider determines that the agent completed and passed the examination, the provider may issue the certificate of completion. The provider shall date the certificate according to the date on which the provider received the examination for grading and shall state on the certificate that to the best of the provider's knowledge the agent passed the examination.

(5) The provider of a course shall issue a certificate of completion of the course to each qualifying agent not later than the 15th day after the date on which an agent completes a course or not later than the 15th day after the date on which the Director approved the course, whichever date is later. The period for issuance of a certificate does not apply to a provider who discloses to the agent in writing, when the agent pays for or registers for the class, the date by which or the time period within which the certificate will be issued.

(6) A provider shall notify the Director immediately of any change in authorized signers for certificates.

(7) A person may act as a proctor for one or more independent study courses under section (4) of this rule only if the person is registered as a proctor with the Insurance Division. A person applying for registration must submit the name, address and telephone number of the person; the location or locations at which examinations will be proctored; the fee or fees that will be charged, if any, for the proctoring service; and whether the person will proctor examinations for the general agent population. There is no registration fee. If the person will proctor independent study course examinations

for other than the general agent population, the person must specify for whom the proctoring will be done. The registration requirement under this section does not apply to city, county and state public libraries, state colleges and universities, private colleges and universities other than those that are owned by or operated primarily for the insurance industry, law offices or currently licensed certified public accountants.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97; ID 4-1997, f. 4-25-97, cert. ef. 6-1-97

836-071-0230

Continuing Education; Course Qualification Guidelines

(1) An agent may receive credit for a course on one or more of the following general subject matters if the course also meets the requirements of OAR 836-071-0225:

(a) Rating;

(b) Insurance fundamentals;

(c) Tax laws related to the license class;

(d) Policy contents;

(e) Proper uses of insurance products;

(f) Oregon Insurance Code and administrative rules;

(g) Technical information related to the insurance license classes of general lines, life and health;

(h) Insurance law;

(i) Insurance policies and coverage;

(j) Contract law;

(k) Insurance needs;

(l) Insurance risk management;

(m) Ethics;

(n) Estate planning;

(o) Pension plans;

(p) Financial planning;

(q) Accounting;

(r) Finance;

(s) General underwriting principles;

(t) Prevention of errors and omissions;

(u) Any other subject matter that the Director determines will enhance the ability of an agent to provide insurance services to the public effectively.

(2) An agent may not receive credit for the following types of courses:

(a) A course designed solely to prepare a person for a license examination;

(b) A course in mechanical, office or business skill, including but not limited to typing, speed reading or the use of calculators or other machines or equipment;

(c) A course in sales promotion;

(d) A course in motivation, salesmanship, stress management, time management, psychology, communication or writing;

(e) A course relating solely to office management, client relations or improving the operations of the agent's business;

(f) A course in personnel management or recruiting;

(g) Any product not available for sale to Oregon consumers;

(h) Securities, other than variable life and variable annuities.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0235

Provider Registration

(1) A provider of continuing education courses must register with the Director in order to register courses under OAR 836-071-0240. A provider must register on a form provided by the Director. The registration of a provider shall include the provider's business name, main business address, all addresses in this state at which courses are conducted, the business telephone number and the name of a contact person. If a provider is a firm or corporation or a trade association, registration shall also include the names of all principal officers.

(2) A provider shall notify the Director of any change in the address, telephone number or contact person of the provider within 30 days after any such change takes effect.

(3) Subject to revocation of registration under OAR 836-071-0245, a provider registration expires on the second January 1 following the date of registration.

(4) A provider is subject to rejection of registration by the Director if the provider fails to meet any requirement of OAR 836-071-0215 to 836-071-0250 applicable to the provider or to courses offered by the provider, or if any of its employees or contractors who supervise or conduct and certify completion of a course:

(a) Has a history of noncompliance with insurance statutes or rules; or

(b) Has had an agent license or other insurance license revoked, suspended or refused because of violations of or

noncompliance with insurance statutes or rules.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0240

Course Registration

(1) A provider registered under OAR 836-071-0235 shall apply to the Director for registration of each course to be offered by the provider for continuing education credit. Application for registration shall be made on a form provided by the Director and shall include the name of the provider, the provider registration number assigned by the Department, the course title and credit hours suggested by the provider for the course. The provider shall include the course outline with the registration application and shall submit any other information requested by the Director. The course outline must show instruction in 50-minute periods.

(2) A registered provider shall provide the Director with the meeting times and places of a course, whether registered or not, not later than the seventh day before the date that the course is given.

(3) Credit may not be given for a course until the Director approves the registration application. Credit may be granted retroactively for a course meeting that occurs before the registration application is approved, if notice of the meeting is given as required under section (2) of this rule.

(4) A registered provider of lecture courses shall maintain an accurate record of each course offered, instructors and student attendance records for not less than three years after the date of completion of the course .

(5) The provider of an independent study course shall maintain examination results and proctor affidavits for not less than three years after the date of course completion.

(6) The registration of a course expires on the last day of the 24th month after the date the course is registered.

(7) Each course registration application is subject to review by the Director for the purpose of evaluating and assigning credit hours and determining compliance with requirements of course content under OAR 836-071-0230. The Director may reject a course for registration or terminate a course's registration if the Director determines that the course does not so comply.

(8) A registered provider shall include a statement in all material published by the provider to advertise or promote insurance license continuing education that the provider and courses are registered with the Insurance Division and that registration does not imply endorsement by the Insurance Division.

(9) A registered provider shall resubmit a registered course for review and approval whenever the provider substantially changes the content of the course as registered.

(10) A provider shall notify the Director immediately of a cancellation or a change of date, time or location of a scheduled class.

(11) A provider of an independent study course shall notify all vendors of the provider's course materials when credit hours for the course have changed or when the course is discontinued.

(12) The Director shall investigate complaints relating to courses, providers or instructors.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0242

Provider Trade Practices

(1) A provider shall not engage in false, misleading or deceptive advertising.

(2) A provider must disclose in writing the charges for a course to each agent applying to take the course, prior to enrollment of the agent.

(3) If a provider cancels a course for any reason, the provider must refund all charges in full unless the refund policy is clearly described in the enrollment application for the course.

(4) A registered provider shall ensure that each registered course and each course for which registration is sought provides students with current and accurate information.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0245

Revocation of Provider Registration

(1) The Director may revoke the registration of a provider if a course does not meet the requirements of OAR 836-071-0225 and 836-071-0230 or if the provider violates OAR 836-071-0242.

(2) A provider whose registration has been revoked under this rule may apply to the Director for reinstatement of the registration not sooner than the 60th day after revocation.

(3) The Director may reinstate a revoked registration if the Director determines, from proof furnished to the Director, that the conditions responsible for the revocation have been corrected.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

836-071-0250

Credit for Unregistered Courses

(1) An agent may apply for credit as provided in this rule for a course that is not offered for academic credit and is not registered. In order to apply for credit, the agent must submit to the Director an application on a form provided by the

Director and substantiation of the course as provided in this rule. The application and substantiation must be submitted not later than the 90th day after the date of completion of the course.

(2) If an unregistered course is on a subject permitted under OAR 836-071-0230, the agent must substantiate to the Director's satisfaction that the course meets the requirements of OAR 836-071-0225 and 836-071-0230 and that the agent attended and completed the course. To make the substantiation, the agent must submit documentation of the course and proof of attendance provided by the provider concerning the course. The documentation may include, by way of example only, an outline of the course or course materials, workbooks or other materials issued by the provider that show the course work. The Director may request any other information as well, such as times allotted to the parts of the course.

(3) If an unregistered course is not on a subject permitted under OAR 836-071-0230, the agent must substantiate to the Director's satisfaction that the course meets the requirements of OAR 836-071-0225, that the course contributes to the agent's professional competence and will benefit the insurance-buying public and that the agent attended and completed the course. To make the substantiation, the agent must submit documentation provided by the provider concerning the course. The documentation may include, by way of example only, an outline of the course or course materials, workbooks or other materials issued by the provider that show the course work, or proof of passing the final examination for the course or a letter, certificate or other documentation of completion from the provider. The Director may request any other information as well, such as times allotted to the parts of the course.

(4) The application and substantiation required under this rule are subject to review by the Director for the purpose of determining whether to certify the course for credit and evaluating and assigning credit hours. The Director may certify the course, or may reject it if the Director determines that the course does not meet applicable requirements.

Stat. Auth.: ORS 731.244 & 744.119

Stats. Implemented: ORS 744.119

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97

Regulation Generally

836-071-0275

Certificate of Deposit in Lieu of Trust Account

For purposes of ORS 744.227, evidence of a certificate of deposit kept by an agent is satisfactory:

(1) If the evidence is a written statement of verification issued by the institution issuing the certificate to the agent; and

(2) If the statement shows the date of renewal, if any, and verifies that the certificate is valid as of the date of the request by the Director for verification of the certificate.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0280

Permitted and Prohibited Activities of Insurance Personnel Exempt from Agent License Requirement

For purposes of ORS 744.057:

(1) An unlicensed person who performs administrative, clerical or technical duties and is employed by an agent may engage in any activity described in this section, subject to review by the agent or an agent employed by the agent if review is required under this section, if the unlicensed person engages in the activity under the supervision of the agent and on the premises of the agent's business. The unlicensed person may:

(a) Disclose rates to the insurance-buying public, but only if the rates are reviewed by the agent prior to submission to the insurer;

(b) Fill out an application for insurance if the application is reviewed by the agent prior to submission to the insurer;

(c) Accept or receive an insurance premium;

(d) Provide information to current policyholders addressing existing policy terms;

(e) Take requests for changes on in-force policies;

(f) Obtain information needed from insureds;

(g) Receive claim information directly from insureds and claimants;

(h) Engage in telephone marketing or making appointments, but only to the extent that the person may obtain policy expiration dates; and

(i) Transmit insurance policies to insureds.

(2) An unlicensed person who performs administrative, clerical or technical duties and is employed by an insurer may engage in any activity described in this section. The unlicensed person may:

(a) Disclose rates to the insurance-buying public;

(b) Fill out an application for insurance;

(c) Accept or receive an insurance premium;

(d) Provide information to current policyholders addressing existing policy terms;

(e) Take requests for changes on in-force policies;

(f) Obtain information needed from insureds;

(g) Receive claim information directly from insureds and claimants;

(h) Engage in telephone marketing or making appointments, but only to the extent that the person may obtain policy expiration dates;

(i) Transmit insurance policies to insureds; and

(j) Analyze, interpret and resolve policy coverage questions regarding a claim.

(3) An unlicensed person who performs administrative, clerical or technical duties and is employed by an agent may not:

(a) Solicit insurance. For purposes of this subsection, solicitation of insurance includes, by way of example only, selling or attempting to sell insurance, evaluation and recommendation of coverages, analyzing exposures and inquiring about

additional coverages;

(b) Bind coverage; or

(c) Interpret policy coverages.

Stat. Auth.: ORS 731.244 & 744.057

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94

836-071-0285

Agent Review of Applications

An agent who permits an unlicensed person to fill out an application for insurance as authorized under OAR 836-071-0280 must indicate on the office copy of the application that the agent reviewed the application, giving the date of the review.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0287

Transaction of Group Life, Health Insurance by Agent without Appointment

(1) Subject to section (2) of this rule:

(a) An agent licensed to transact life or health insurance, or both such classes, may solicit group insurance authorized under the license of the agent for an insurer with whom the agent does not hold an appointment; and

(b) The insurer may issue proposals based on the solicitation by the agent.

(2) If an agent under section (1) of this rule submits to the insurer an application for group coverage based on the solicitation, the insurer may not issue the coverage unless the insurer enters a written contract of appointment with the agent and, not later than the 15th day after the insurer enters the contract, files the written notice of the appointment with the Director as provided in ORS 744.155. The insurer shall not pay commission to the agent before filing the notice.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 744.051

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 15-1996, f. & cert. ef. 11-12-96

836-071-0295

Transaction of Insurance by Individual Agent for Appointed Firm or Corporate Agent

An individual agent affiliated by employment or contract with a firm or corporate agent that is appointed by an insurer may transact insurance for the insurer without an appointment from the insurer. An individual agent may so transact insurance only with respect to the classes of insurance endorsed on the license of the individual agent. For purposes of

this rule, an individual agent is affiliated with a firm or corporate agent if the individual agent under the contract is authorized to transact insurance in the name of the firm or corporate agent.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0297

Managing General Agents

(1) An agent may transact general lines insurance with an insurer with whom the agent does not hold an appointment if the agent places the insurance through a firm or corporate agent appointed by the insurer and:

(a) The appointed agent has a contract with the unappointed agent that specifies the binding authority, if any, and fiduciary responsibility of the unappointed agent, including ownership and payment of the premiums, but does not authorize the unappointed agent to act in the name of the appointed agent; and

(b) The appointed agent obtains at least 90 percent of its premium under contractual agreement with unappointed agents that are not affiliated with the firm or corporate agent.

(2) This rule does not apply to the transaction of insurance by an individual agent affiliated with a firm or corporate agent as provided in OAR 836-071-0295.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0300

Requirement of Contract with or Employment of Licensee

A firm or corporate licensee may engage in a category or class of insurance through an individual licensee as authorized under ORS 744.022 only if the firm or corporate licensee employs or has entered a contract with the individual licensee.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0310

Agents, Adjusters and Insurance Consultants

An agent authorized to transact health insurance in Oregon may receive a referral fee from the Oregon Medical Insurance Pool, established under ORS 735.600 to 735.650, for referring prospective insureds to the Pool, without being appointed as an agent by the Pool or its administering insurer or otherwise being authorized to act as an agent of the Pool, its governing board or its administering insurer.

Stat. Auth.: ORS Ch. 731 & 744

Hist.: ID 14-1990(Temp), f. & cert. ef. 6-29-90; ID 22-1990, f. 12-20-90, cert. ef. 12-26-90

836-071-0315

Managing General Agents; Dollar Amounts Governing Settlement Authority Procedures Under Contract with Insurer

For the purpose of the requirement of the written contract between a managing general agent and an insurer established under ORS 744.306, if the contract permits the managing general agent to settle claims on behalf of the insurer:

(1) The amount established by the Director for purposes of ORS 744.306(4)(b)(A) is $10,000.

(2) The amount established by the Director for purposes of ORS 744.306(4)(c) is $10,000.

Stat. Auth.: ORS 731.244, 744.300, 744.306, 744.313 & 744.314

Hist.: ID 6-1992, f. & cert. ef. 3-26-92

836-071-0320

Managing General Agents; Designation of Associations of Actuaries

For purposes of ORS 744.313, the Director determines the following associations of actuaries to have established adequate professional standards for membership:

(1) The American Academy of Actuaries.

(2) The Casualty Actuarial Society.

(3) The Society of Actuaries.

(4) The Canadian Institute of Actuaries.

Stat. Auth.: ORS 731.244, 744.300, 744.306, 744.313 & 744.314

Hist.: ID 6-1992, f. & cert. ef. 3-26-92

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 74

INSURANCE DIVISION TRUST ACCOUNTS

836-074-0005

Statutory Authority; Effective Date

(1) OAR 836-074-0005 to 836-074-0050 are adopted under the general rulemaking authority of the Director of the Department of Insurance and Finance under ORS 731.244 for the purpose of carrying out ORS 744.225.

(2) OAR 836-074-0005 to 836-074-0050 become effective January 1, 1988, and apply to all premium funds received by agents on and after January 1, 1988.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0010

Definitions

As used in OAR 836-074-0005 to 836-074-0050:

(1) "Agent" includes any person who is licensed by the Department as an agent.

(2) "Premium Fund" and "Premium Funds" means any premium or other consideration received from or on behalf of an insured for the purpose of effecting or purchasing insurance, and includes return premiums, return premium credits, policy fees and premium taxes.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0015

Director's Enforcement Authority

The Director may apply any sanction for violation of ORS 744.225 that the Director may apply for any other violation of the Insurance Code or rules adopted thereunder.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0017

Exemptions

OAR 836-074-0005 to 836-074-0050 do not apply to:

(1) An agent who is exclusively a salaried employee of an insurer.

(2) An agent who sells only industrial life insurance, as that term is defined in ORS 731.166.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0020

Premium Funds Trust Account

(1) Except as otherwise provided in OAR 836-074-0025, an agent shall deposit in one or more premium funds trust accounts all premium funds received by the agent under the agent's license. Each trust account:

(a) Of a resident agent must be located in this state unless the Director gives written permission to the agent to keep the account in another state. In applying for permission, the agent must give written justification for keeping the account outside this state;

(b) Of a nonresident agent must be located in this state or the state of residence of the agent unless the Director gives written permission to the agent to keep the account in another state. In applying for permission, the agent must give written justification for keeping the account in the other state.

(2) An agent shall maintain each trust account in one or more of the following forms:

(a) In the form of a checking account, demand account, savings account or other account in a state or national bank or savings bank, a state or federal savings association or a state or federal credit union. A trust account under this subsection must be insured by the United States Government or an agency or instrumentality thereof. However, such insurance need not exceed $100,000 for each account or the amount at any time in the account, whichever is less;

(b) In the form of an account that solely invests, either directly or through an investment fund, in any or all of the following instruments: United States government bonds and Treasury certificates or other obligations for which the full faith and credit of the United States are pledged for payment of principal and interest, repurchase agreements collateralized by securities issued by the United States and bankers acceptance;

(c) In the form of an account in an open-end investment company registered under the Investment Company Act of 1940 that:

(A) Limits its portfolio investments to United States-dollar denominated instruments that the board of directors determines present minimal credit risks and that are either of high quality as determined by a nationally recognized statistical rating organization or, in the case of an instrument that is not rated, of comparable quality as determined by the board of directors; and

(B) May not purchase any instrument with a remaining maturity of greater than one year or maintain a dollar-weighted average portfolio maturity that exceeds 120 days.

(3) Premium funds may be placed in an account under section (2) of this rule only if the premium funds are readily available from the account for payments when due.

(4) Each check or other instrument drawn on a trust account must clearly identify that it is drawn on an insurance premium funds trust account.

(5) An agent must make each trust account of the agent accessible to the Director for purposes of examination and audit.

(6) A trust account may be interest-bearing.

(7) For the purpose of OAR 836-074-0005 to 836-074-0050, all premium funds received by an agent on or under any policy of insurance are received in the fiduciary capacity of the agent.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0025

Deposit and Payment of Funds

An agent shall deposit and pay premium funds received as provided in this rule. When deposit is required, the agent shall deposit the funds not later than the seventh day after they are received. When a payment is owed to an insured, the agent shall pay the premium funds not later than the 30th day after the receipt of the funds. The following provisions also apply to the deposit and payment of premium funds:

(1) A return premium and the agent's share of any premium funds required to be refunded, including unearned commissions, shall be deposited and paid to the insured or other person entitled to the funds. When a return premium is paid in the form of a credit to the account of an agent, the agent shall deposit the equivalent of the credit in money into the account.

(2) When an agent receives a payment of premium funds in the form of an instrument, such as a check, made payable to an insurer, another agent, a surplus line agent or a premium finance company, the agent may forward the instrument directly to the payee without depositing the instrument in the trust account, if that can be done without endorsement or alteration. Such a payment need not be accounted for with respect to the trust account.

(3) Except as otherwise provided in this section, when an agent receives a payment of premium funds in the form of cash or an instrument requiring endorsement by the agent, the agent shall deposit the premium funds in the trust account or endorse and forward the instrument to the insurer, another agent, the surplus lines agent or the premium finance company that is entitled to the premium funds received. An agent:

(a) Need not deposit premium funds that are paid in cash if the agent does not maintain a premium trust account because the agent does not engage in transactions for which a trust account must be established, and if the agent complies with all of the following requirements:

(A) Upon receiving the cash, the agent must give the payor a receipt showing the amount of money received, the date on which the money was received, the policy number and the name of the policyholder;

(B) Within 72 hours after receiving the cash, the agent must convert the cash into a guaranteed negotiable instrument, such as a money order, certified check or cashier's check, that is made out to the insurer and forward the money order or check to the insurer;

(C) The agent must keep records of such moneys so received and forwarded.

(b) May deposit the premium funds under procedures established by the insurer entitled to the funds if the procedures meet the requirements of this section and the insurer has given those procedures to the agent in writing. Such other procedures must:

(A) Recognize that the agent is receiving premiums directly on behalf of the insurer;

(B) Direct the agent to give adequate receipts on behalf of the insurer;

(C) Require deposit of the proceeds into the account of the insurer.

(4) An agent may remove gross commissions from the trust account and pay them to the operating account of the agent.

(5) An agent shall not pay out premium funds from a trust account to pay premiums that have not been paid into the trust account.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0030

Advancing Return Premiums

An agent may advance return premiums from funds of the agent other than from a trust account of the agent, in anticipation of receiving a credit for the return premium from the insurer. When the agent credits the return premium to the trust account, the agent may transfer the advanced credit out of the trust account.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0035

Other Permissible Funds

(1) An agent may not deposit in a premium fund trust account any funds other than premium funds, except as follows:

(a) Funds reasonably sufficient to pay bank charges;

(b) Funds that an agent determines to be prudent for advancing premiums or establishing reserves for the paying of return premiums;

(c) Funds for contingencies that may arise in the course of receiving and transmitting premiums.

(2) An agent may deposit in a premium fund trust account any premium funds produced in another state. However, premium funds produced in another state must be deposited and paid in the same manner as premium funds under OAR 836-074-0025.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0040

Interest on Trust Funds

Unless an agent and the insurer agree to the contrary, interest earned in a premium funds trust account may be retained by the agent and:

(1) Used to offset bank charges; or

(2) Removed to the operating account of the agent.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0045

Accounting Records; Inspection

(1) An agent shall establish and maintain records and an appropriate accounting system for all premium funds received by the agent as provided in this rule.

(2) Unless otherwise authorized by the Director, a resident agent shall establish and maintain the records and accounting system in this state. A resident agent may establish the records and system in another state if the Director gives written permission to the agent to do so. In applying for permission, the agent must give written justification for keeping the records and system outside this state.

(3) Unless otherwise authorized by the Director, a nonresident agent shall establish and maintain the records and

accounting system in this state or in the state of residence of the agent. A nonresident agent may establish the records and system in another state if the Director gives written permission to the agent to do so. In applying for permission, the agent must give written justification for keeping the records and system in the other state.

(4) An agent shall make the records available in this state for inspection by the Director during regular business hours upon demand.

(5) An agent shall make the records available with respect to any premium funds received for a period of three years following the date of the policy expiration.

(6) An agent may use any accounting system that effectively isolates each trust account from any operating accounts. A recordkeeping system, whether electronic or manual, must provide an audit trail so that details underlying the summary data, such as invoices, checks and statements, may be identified and made available on request. The system must provide the means of tracing any transaction back to its original source or forwarded to final entry such as is accomplished by a conventional double-entry bookkeeping system. When an automatic data processing system is used, the agent shall make a description of the system available for review by the Director.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0047

Examinations and Audits

(1) The Director may examine or audit any trust account and any accounting records of premium funds as the Director determines necessary.

(2) The examination or audit shall be performed at the expense of the agent, when the trust account or accounting records are located outside this state.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0048

Other Trust Account Requirements

OAR 836-074-0005 to 836-074-0050 do not prohibit an insurer from establishing requirements applicable to trust accounts of agents of the insurer, if the requirements are more restrictive than the provisions of OAR 836-074-0005 to 836-074-0050.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

836-074-0050

Single Account for Affiliated Persons

(1) An agent that is a firm or corporation may use one premium fund trust account for the funds received by an affiliated person operating under its license.

(2) An affiliated person of an agent that is a firm or corporation may deposit the premium fund that the affiliated person received in the capacity of an affiliated person directly to the deposit account of the firm or corporation with which the person is affiliated.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 744.225

Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 75

THIRD PARTY ADMINISTRATORS

836-075-0000

Third Party Administrators; License Application; Required Information

An applicant for a third party administrator license shall provide the following:

(1) On the application form provided by the Director, information relating to the organizational form of the applicant as follows:

(a) The name under which the applicant will transact business as a third party administrator;

(b) The principal place of business at which the applicant will transact business as a third party administrator, including the street and mailing addresses and telephone number;

(c) The organizational form of the applicant (corporation, partnership, sole proprietorship);

(d) All assumed business names and other names under which the applicant will transact business as a third party administrator;

(e) Whether the applicant has ever had a judgment entered against the applicant for fraud, and whether any insurer, agent or other person claims the applicant to be indebted to it, together with the details of any such indebtedness;

(f) Whether any license of the applicant to act in any occupational or professional capacity has ever been refused, revoked or suspended in this or any other state, and whether the applicant has otherwise ever been the subject of a complaint to a professional licensing board or agency. If the applicant's answer is affirmative in any respect, the applicant must also provide the name and address of the licensing board or agency, the date of the complaint or the action taken against the license, a description of the nature of the complaint or the reason for the action taken against the license, and, with regard to a complaint, a description of the licensing board or agency's disposition of the complaint;

(g) Whether the applicant has ever filed for bankruptcy or been adjudged a bankrupt;

(h) All states and provinces of Canada in which the applicant currently holds a license or certificate of authority to transact business as a third party administrator, or has held such a license or certificate within ten years prior to the date of the application;

(i) The names, addresses, official positions and professional qualifications of the individuals who are responsible for the conduct of affairs of the administrator, including all members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership or association; shareholders holding directly or indirectly ten percent or more of the voting securities of the administrator; and any other person who exercises control or influence over the affairs of the administrator;

(j) The name and telephone number of a contact person who is knowledgeable about preparation of the annual financial statements or reports required under section (4) of this rule.

(2) An appointment of the Director, on the application, as agent for service of process, if the third party administrator will be a nonresident licensee.

(3) Biographical information for each owner, partner, director and officer of the applicant, on the Biographical Affidavit form designed by the National Association of Insurance Commissioners.

(4) The following documents, which must accompany the application under section (1) of this rule:

(a) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, share-holder agreement and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(c) Annual financial statements or reports for the two most recent years, which prove that the applicant is solvent, and such information as the Director may require in order to review the current financial condition of the applicant;

(d) A statement describing the business plan, including information on staffing levels and activities proposed in this state and nationwide. The plan must provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, recordkeeping and underwriting;

(e) Evidence that the applicant has a fiduciary account established in a federally- or state-insured financial institution. An applicant that is an agent licensed under ORS Chapter 744 need not comply with this subsection if the applicant is in compliance with ORS 744.225 with respect to the premiums, charges and return premiums referred to in ORS 744.730;

(f) Evidence of insurance coverage required by ORS 744.726;

(g) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an agent licensed by the Director for solicitation and taking of applications. Any applicant that intends directly to solicit insurance contracts or to otherwise act as an insurance agent must provide proof that it has a license as an insurance agent in this state.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.706

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-075-0010

Completion of Application

The Director may reject a third party administrator license application if it has not been completed by the 90th day after its filing.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.706

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-075-0020

Amendment of License Application Information

A third party administrator shall notify the Director in writing when the third party administrator changes its principal place of business. The notice shall include the following:

(1) The new street address, including city and state.

(2) The new mailing address, if different.

(3) The new telephone number.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.006, 744.716 & 744.724

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-075-0030

Third Party Administrator License Renewal

(1) A third party administrator applying for renewal of the license must do the following, as applicable:

(a) Submit a completed renewal application on a form provided by the Director. If mailed, the renewal application must be postmarked by the United States Postal Service not later than the license expiration date;

(b) Submit the renewal fee.

(2) The Director may allow a third party administrator not more than 30 days to submit missing information on the renewal application form, if the fees have been submitted on or before the expiration date.

(3) The Director may require on the renewal application any information required with regard to an original application for a license.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.712(3)

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-075-0040

Annual Report Requirements

(1) A third party administrator shall include in the annual report required in ORS 744.738 the balance sheet and income statement of the third party administrator for the immediately preceding calendar year. The balance sheet and income statement must each be verified by two of its officers, if the third party administrator is a corporation, or by two of its partners, if the third party administrator is a partnership. Each annual report must be filed not later than March 1 of each year.

(2) The first annual report required under this rule shall be filed not later than March 1, 1993.

(3) If the annual report of a third party administrator is for a year other than a calendar year, the third party administrator may file the following instead of an annual report on a calendar year basis:

(a) The annual report of the third party administrator that is most current as of March l; and

(b) The interim financial statement most current as of March 1.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.738

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-075-0050

Exemptions from Third Party Administrator License Requirements

(1) This rule is adopted under the authority of ORS 731.244 and 744.704 for the purpose of establishing exemptions under and implementing ORS 744.704(1)(p). The persons described in this rule are exempt from the licensing requirement for third party administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740.

(2) The Department of Human Resources and any organization contracting with the Department of Human Resources for that portion of its business covered under a contract with the Department are exempt.

(3) A health care provider that contracts with an insurer to provide health care services to insurance plan enrollees and is compensated for such services on a prepaid, capitated or similar basis is exempt when the insurer and the provider operate under a written agreement that includes all of the conditions specified in this section. For the purpose of this section, a "health care provider" or "provider" means a licensed health care practitioner or a group of such practitioners, a licensed health care facility or group of such facilities and any similar health care organization. The conditions required to be included in the agreement are as follows:

(a) The primary contractual responsibility of the provider is the delivery of health care services to insurance plan enrollees and the administrative duties performed by the provider for the insurer are in support of the delivery of health care services;

(b) The administrative duties performed by the provider for the insurer are limited to the adjusting or settling of claims for insurance plan enrollees and the insurer retains responsibility for providing competent administration of its programs;

(c) The insurer performs all functions that pertain to soliciting and effecting coverage, underwriting, collecting premiums, determining plan benefits, determining premium rates and securing any reinsurance for the insurer's obligations;

(d) The rules pertaining to the adjusting or settling of claims are provided in writing by the insurer to the provider;

(e) The insurer at least annually conducts a review of the claims-related activities performed by the provider for the

insurer to ensure that those operations are in compliance with subsection (b) of this section;

(f) The provider allows the insurer access to the administrative books and records of the provider that document the claims-related activities performed for the insurer for the purpose of assuring the proper administration of claims, and the insurer agrees to make those books and records available for examination by the Director in accordance with ORS 731.300, 731.304 and 731.308;

(g) The provider allows the insurer access to the relevant financial books and records of the provider that will enable the insurer to determine the financial ability of the provider to fulfill its responsibilities under the agreement, and both parties assure that confidentiality of financial and patient records is maintained in accordance with applicable federal and state requirements;

(h) The insurer makes certain that the administrative books and records of the provider that document the claims-related activities performed for the insurer are maintained by the provider in accordance with prudent standards of insurance record-keeping and that such books and records are maintained by the provider for a period of not less than five years from the date of their creation; and

(i) The conditions applicable to the provider in subsections (f) and (h) of this section must not be terminated upon a termination of the agreement, whether by rescission or otherwise.

Stat. Auth.: ORS 731.244 & 744.304

Stats. Implemented: ORS 744.704

Hist.: ID 1-1992, f. & cert. ef. 1-27-92; ID 8-1996, f. & cert. ef. 5-29-96

836-075-0060

ERISA Exemption Registration

(1) A person who is required by ORS 744.714 to register with the Director annually, verifying the person's status as qualifying under ORS 744.704(1)(L) for the exemption from the licensing requirement for third party administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740, shall register with the Director annually. In the registration, the person shall certify that the person qualifies for the exemption because of the person's status and shall inform the Director:

(a) Of the person's name, business address, mailing address if different from the business address, and telephone number; and

(b) Whether the person is acting solely as an administrator of one or more single employers, union-bargaining (Taft-Hartley) plans, rural electric cooperatives or other bona fide employer benefit plans established by an employer or an employee organization, or both, for which the **Insurance Code** is preempted pursuant to the Employee Retirement Income Security Act of 1974.

(2) If the Director determines that a person does not qualify for the exemption under ORS 744.704(1)(L), the person must obtain the license required under ORS 744.702 in order to transact business as a third party administrator.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.704(1)(l) & 744.714

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

836-075-0070

Errors and Omissions Insurance; Third Party Administrators

(1) The amount of insurance for which a third party administrator as described in ORS 744.702 must maintain a certificate of errors and omissions insurance with the Director as required by ORS 744.726 is $500,000 claims made or per occurrence.

(2) A third party administrator may obtain insurance required by ORS 744.726 from an insurer other than an authorized insurer if the insurer is not an affiliate, as that term is defined in ORS 744.700, of the third party administrator, and if:

(a) The insurance is procured by an Oregon surplus lines licensee from an insurer that is an eligible surplus lines insurer pursuant to the requirements of ORS 735.400 to 735.495;

(b) The insurer is an authorized insurer in the state of domicile of the third party administrator or license applicant; or

(c) The insurance is procured from a surplus lines insurer that is eligible in the state of domicile of the third party administrator or license applicant, if all requirements of this subsection are satisfied. The insurance for purposes of this subsection must be confirmed by the signature of an Oregon surplus lines agent who also affirms in writing that the Oregon surplus lines agent will be the agent for service of process for any action or proceeding involving the third party administrator and an Oregon resident.

Stat. Auth.: ORS 731.244, 744.303, 744.635, 744.704, 744.706, 744.712 & 744.726

Stats. Implemented: ORS 744.726

Hist.: ID 1-1992, f. & cert. ef. 1-27-92

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 80

TRADE PRACTICES

Replacement of Life Insurance and Annuities

836-080-0001

Statutory Authority; Purpose; Applicability

(1) OAR 836-080-0001 to 836-080-0025 are adopted pursuant to the general rulemaking authority of the Insurance Commissioner in ORS 731.244 and the specific authority in ORS 746.085(1).

(2) The purpose of OAR 836-080-0001 to 836-080-0025 is to protect the insurance-buying public in insurance transactions involving the replacement of life insurance or annuities by:

(a) Regulating the communication of relevant information between replacing and existing insurers;

(b) Increasing the opportunity for individuals to make more informed decisions regarding the replacement of life insurance and annuities; and

(c) Reducing the opportunity for misrepresentation and incomplete disclosures.

(3) OAR 836-080-0001 to 836-080-0025 shall apply to all transactions involving the replacement of existing life insurance or annuities except when such transactions also involve:

(a) Credit life insurance;

(b) Group life insurance or group annuities;

(c) An application to an existing insurer that issued the existing life insurance or annuity and a contractual change or a conversion privilege is being exercised;

(d) Proposed life insurance or annuity that is to replace life insurance or annuity under a binding or conditional receipt issued by the same company;

(e) Transactions where the replacing insurer and the existing insurer are the same, or are subsidiaries or affiliates under

common ownership or control; provided, however, agents proposing replacement shall comply with the requirements of OAR 836-080-0025(1); or

(f) Registered Contracts but only to the extent that such contracts shall be exempt from the requirements of OAR 836-080-0022(2) requiring provision of policy summary or ledger statement information; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required in lieu thereof.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.085(1)

Hist.: IC 8-1984, f. 10-26-84, ef. 12-1-84

836-080-0005

Definitions

(1) "Replacement" means any transaction in which new life insurance or a new annuity is to be purchased, and it is known or should be known to be proposing agent or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance or annuity has been or is to be:

(a) Lapsed, forfeited, surrendered, or otherwise terminated;

(b) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(c) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(d) Reissued with any reduction in cash value; or

(e) Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding twenty-five percent (25%) of the loan value set forth in the policy.

(2) "Credit Life Insurance" means life insurance issued in connection with a specific loan or other credit transaction on the life of the insured as debtor and naming the creditor either as the beneficiary or as a collateral assignee.

(3) "Group Life Insurance or Group Annuities" means life insurance or annuities provided under a group life insurance policy or a policy whose cost is borne in whole or in part by the insured's employer or by an association of which the insured is a member.

(4) "Direct-Response Sales" means any sale of life insurance or annuity where the insurer does not utilize an agent in the sale or delivery of the policy.

(5) "Existing Insurer" means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of "replacement".

(6) "Existing Life Insurance or Annuity" means any life insurance or annuity in force, including life insurance under a binding or conditional receipt or a life insurance policy or annuity that is within an unconditional refund period.

(7) "Replacing Insurer" means the insurance company that issues or proposes to issue a new policy or contract which is a replacement or existing life insurance or annuity.

(8) "Registered Contract" means variable annuities, investment annuities, variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account, or any other contracts issued by life insurance companies which are registered with the Federal Securities and Exchange Commission.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.085(1)

Hist.: IC 39, f. 12-4-67, ef. 3-1-68; IC 8-1984, f. 10-26-84, ef. 12-1-84

836-080-0020

Duties of All Insurers

Each insurer shall:

(1) Inform its field representatives or other personnel responsible for compliance with this rule of the requirements of this rule; and

(2) Require with or as a part of each completed application for life insurance or annuity a statement signed by the applicant as to whether such proposed insurance or annuity will replace existing life insurance or annuity.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.085(1)

Hist.: IC 39, f. 12-4-67, ef. 3-1-68; IC 8-1984, f. 10-26-84, ef. 12-1-84

836-080-0022

Duties of Insurers That Use Agents

Each insurer that uses an agent in a life insurance or annuity sale shall:

(1) Require with or as part of each completed application for life insurance or annuity, a statement signed by the agent as to whether he or she knows replacement is or may be involved in the transaction.

(2) Where a replacement is involved:

(a) Require from the agent along with the application for life insurance or annuity:

(A) A copy of the Notice provided the applicant pursuant to OAR 836-080-0025(2)(a); and

(B) A copy of the list of all the applicant's existing life insurance and/or annuity to be replaced as obtained pursuant to OAR 836-080-0025(2)(b). Such existing life insurance or annuity shall be identified by name of insurer, insured and contract number. If a number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(b) Send to each existing insurer a written communication including:

(A) A notification of the replacement or proposed replacement;

(B) The identification information obtained pursuant to OAR 836-080-0022(2)(a); and

(C) A Policy Summary, as defined in OAR 836-051-0010(8), contract summary or ledger statement containing policy data on the proposed life insurance or annuity. Cost indices and equivalent level annual dividend figures need not be included in the Policy Summary or ledger statement. The information in paragraphs (A) through (C) of this subsection shall be sent within three (3) working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner.

(3) The replacing insurer shall maintain evidence of the Notice, the Policy Summary or any ledger statements used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced. Evidence that all requirements were met shall be maintained for at least three years or until the conclusion of the next succeeding regular examination by the Insurance Department of its state of domicile, whichever is earlier.

(4) The replacing insurer shall provide in its policy or in a separate written notice which is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of twenty days commencing from the date of delivery of the policy.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.085(1)

Hist.: IC 8-1984, f. 10-26-84, ef. 12-1-84

836-080-0023

Duties of Insurers with Respect to Direct Response Sales

(1) If in the solicitation of a direct response sale, the insurer did not propose the replacement, and a replacement is involved, the insurer shall send to the applicant with the policy a Notice as described in **Exhibit 1** or other substantially similar form previously approved by the Insurance Commissioner. In such instances, the insurer may delete the references to signatures from **Exhibit 1.**

(2) If the insurer proposed the replacement, it shall:

(a) Provide to applicants or prospective applicants with or as part of the application a Notice as described in **Exhibit 1** or other substantially similar form previously approved by the Insurance Commissioner;

(b) Request from the applicant with or as part of the application, a list of all existing life insurance or annuity to be replaced and properly identified by name of insurer and insured;

(c) Comply with the requirements of OAR 836-080-0022(2)(b) if the applicant furnishes the names of the existing insurers, and the requirements of OAR 836-080-0022(3), except that it need not maintain a replacement register.

[ED. NOTE: The Exhibit referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.085(1)

Hist.: IC 8-1984, f. 10-26-84, ef. 12-1-84

836-080-0025

Duties of Agents

(1) Each agent who initiates an application shall submit to the insurer to which the application for life insurance or annuity is presented, with or as part of each application:

(a) A statement signed by the applicant as to whether the proposed life insurance or annuity will replace existing life insurance or annuity; and

(b) A signed statement as to whether the agent knows replacement is or may be involved in the transaction.

(2) Where a replacement is involved, the agent shall:

(a) Present to the applicant, not later than at the time of taking the application, an "Important Notice to Applicant Regarding Replacement of Life Insurance or Annuity" in the form as described in **Exhibit 1**, or other substantial similar form previously approved by the Insurance Commissioner. The Notice shall be signed by both the applicant and the agent and left with the applicant;

(b) Obtain with or as part of each application a list of all existing life insurance and/or annuity to be replaced and properly identified by name of insurer, the insured and contract number. If a contract number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed;

(c) Leave with the applicant the original or a copy of all written or printed communications used for presentation to the applicant including those required by subsections (2)(a) and (b) of this rule; and

(d) Submit to the replacing insurer along with the application:

(A) A copy of the Notice provided the applicant pursuant to subsection (2)(a) of this rule; and

(B) A copy of the list of all the applicant's existing life insurance and/or annuity to be replaced as obtained pursuant to subsection (2)(b) of this rule.

[ED. NOTE: The Exhibit referenced in this rule is not printed in the OAR Compilation. Copies are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.085(1)

Hist.: IC 39, f. 12-4-67, ef. 3-1-68; IC 8-1984, f. 10-26-84, ef. 12-1-84

Unfair Discrimination Based on Sex or Marital Status

836-080-0050

Authority; Purpose and Scope

This rule is issued under the Commissioner's general rulemaking authority set forth in ORS 731.244(2). The purpose of this rule is to identify particular insurance practices involving distinctions between men and women, or between married and unmarried individuals, that will be regarded as unfair discrimination which violates ORS 746.015.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.015(1)

Hist.: IC 61, f. 12-2-74, ef. 1-1-75

836-080-0055

Unfair Discrimination Identified

Distinctions based on sex or marital status made in the following matters will be regarded as unfair discrimination:

(1) The availability of a particular insurance policy.

(2) The availability of a particular amount of insurance or set of coverage delimiting factors.

(3) The availability of a particular policy coverage or type of benefit, except for those relating to physical characteristics unique to one sex.

(4) The premium for a particular policy, unless demonstrably based on reasonable supporting data.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.015(1)

Hist.: IC 61, f. 12-2-74, ef. 1-1-75

Trade Practices (ORS Chapter 746)

General

(ORS 746.005 to 746.270)

836-080-0105

Statutory Authority; Purpose; Effective Date

(1) OAR 836-080-0105 to 836-080-0155 are adopted pursuant to the general rulemaking authority of the Commissioner in ORS 731.244 to aid in the effectuation of ORS Chapter 746, especially the enforcement of ORS 746.015, 746.075, 746.160(3), and 746.240, as well as the effectuation and enforcement of ORS 737.205 to 737.348, 742.003, 742.005, 742.009 and other related provisions of the Oregon Insurance Code.

(2) The purpose of OAR 836-080-0105 to 836-080-0155 is to regulate the content and use of participation provisions in commercial lines of property and casualty insurance policies so as to prevent misrepresentations and other unfair practices relating to future dividends, to prevent unfair and coercive practices in the allocation and payment of dividends, and to effectuate the statutes governing ratemaking, classification of risks, and approval of policy forms, with respect to commercial lines of property and casualty insurance issued on the participating basis.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Insurance Division.]

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS Ch. 746, 746.015, 746.075, 746.160 & 746.240

Hist.: IC 69, f. & ef. 7-20-76; ID 15-1996, f. & cert. ef. 11-12-96

836-080-0110

Applicability

OAR 836-080-0105 to 836-080-0155:

(1) Apply to all authorized insurers, whether stock, mutual, or reciprocal, and to the State Accident Insurance Fund.

(2) Apply to those forms of property and casualty insurance known by custom as "commercial lines"; and do not apply to other lines or forms of insurance.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0115

Definitions

As used in OAR 836-080-0105 to 836-080-0155, unless the context requires otherwise:

(1) "Dividend statement" has the meaning given the term by OAR 836-080-0130.

(2) "Insurer" has the meaning given the term by ORS 731.106 and includes the State Accident Insurance Fund.

(3) "Issue" when referring to an insurance policy includes "renew" and "endorse".

(4) "Participating policy" means a policy that grants participation rights to the policyholder.

(5) "Participation" means the right of a policyholder to share in the distribution of profits or other assets of the insurer, whether or not the right is conditional or limited by other provisions.

(6) "Policy" has the meaning given the term by ORS 731.122, and the term includes endorsements and the agreements between the State Accident Insurance Fund and individual contributing employers by which the Fund provides workmen's compensation coverage.

(7) "Policyholder" means a person who owns or has an interest in a policy and the term includes a prospective policyholder.

(8) "Prospective policyholder" includes a policyholder who is considering the renewal or discontinuance of an existing policy.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0120

Statement as to Participation Required Upon Request Before Delivery of Policy; Provision Required in Participating Policy; Contents of Provision

(1) Upon the request of a policy-holder to an insurer, the policyholder is entitled to receive a written statement, before the policy is delivered, specifying whether the policy is or is not a participating policy.

(2) If the insurer intends the policy to grant participation rights to policyholders, the policy shall contain a provision designated "Participation Provision". The participation provision shall include the following wording or substantially equivalent wording approved by the Commissioner: "It is unlawful in Oregon for an insurer to promise to pay policyholder dividends for any unexpired portion of the policy term or to misrepresent the conditions for dividend payment. Dividends will be due and payable only for a policy period that has expired, and only if declared by and under conditions prescribed by the Board of Directors of the Insurer."

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. 7-20-76, ef. as follows: Sec. (1), 7-20-76; Sec. (2), 1-1-77

836-080-0125

Prohibited Representations Regarding Participation Rights

Prior to the declaration of a dividend, an insurer shall not represent, orally or in writing, that the insurer agrees or will agree:

(1) To pay a specified amount as a dividend; or

(2) To a formula that fixes, or to factors that fix or can be used to fix:

(a) The amount of a dividend;

(b) The percentage of premium that will be paid as a dividend; or

(c) The amount or percentage of premium to be retained by the insurer after payment of dividends.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0130

Dividend Statement Permitted; Required to Be Written; Prohibited and Permitted Advice

(1) An insurer may advise a policy holder of the kinds of information the insurer expects to take into consideration in determining whether to declare a dividend and the amount thereof. Any such advice is considered a "dividend statement" as the term is used in this section. A dividend statement shall not, however, be of such a nature as to make it possible to determine, directly or indirectly:

(a) The amount of a dividend;

(b) The percentage of premium that will be paid as a dividend; or

(c) The amount or percentage of premium to be retained by the insurer after payment of dividends.

(2) A dividend statement shall be in writing. It shall include a statement that is identical to the wording of the participation provision that OAR 836-080-0120 requires to be included in the policy. Such statement shall appear ahead of and have at least equal prominence with the advice regarding dividends permitted under section (1) of this rule. A dividend statement also shall contain with equal prominence the following wording or substantially equivalent wording approved by the Commissioner: "Furthermore, it is an unlawful rebate and a violation of the Oregon Insurance Code for an insured or a representative of an insured knowingly to accept a dividend pursuant to a promise to pay policyholder dividends if the promise is made before the policy is issued or if the promise is made for any unexpired portion of a policy period."

(3) A dividend statement may describe the rates or amounts of dividends previously declared or paid on similar policies, or the scales or schedules previously used to determine the rates or amounts of dividends. However, such a description shall also set forth the period covered by the policies on which such dividends were paid and state that past dividend performance is not a guarantee of future dividend performance.

(4) A dividend statement may set forth a time schedule according to which the insurer intends to declare or pay a dividend, if any.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. 7-20-76, ef. 1-1-77

836-080-0135

Dividend Rights Accrue Upon Declaration of Dividends; Contents of Dividend Declaration Resolution

(1) The right of a policyholder to a dividend, or to a determination of whether any dividend will be paid to the policyholder or the amount of a dividend that will be paid to the policyholder, shall not accrue unless the board of directors or other governing body of the insurer:

(a) Determines that the insurer has a surplus from which the dividend may lawfully be paid; and

(b) Declares the dividend by resolution adopted after the expiration of the policy period for which the dividend was earned.

(2) The resolution declaring a policyholder dividend for a group of policies shall:

(a) Identify by policy inception or expiration dates the policies to which the declaration is applicable;

(b) Specify the policy period for which the dividend is payable; and

(c) Specify the dividend plans, scales, tables, formulas, schedules, and factors applied, or to be applied, to determine whether any dividends will be paid and the amounts of dividends to be allocated to individual policies.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0140

Unfair Discrimination in Allocation of Dividends Prohibited; Criteria for Allocation; Prima Facie Evidence of Unfair Discrimination

(1) An insurer shall not unfairly discriminate in the allocation of dividends.

(2) The dividend plans, scales, tables, formulas, schedules and factors specified in the dividend declaration may provide for allocation of dividends at a fixed percentage of premiums, or may provide for variations in the percentage of premium paid as dividends or other variations in determining the amounts of dividends. The variations may be based on loss or expense factors, or on any other reasonable considerations, such as risk size, risk location, or industry or trade hazard classification, which have a probable effect on losses or expenses.

(3) Failure to apply in a consistent manner the plans, scales, tables, formulas, schedules, and factors adopted and specified in a dividend declaration is prima facie evidence of unfair discrimination. However, a variation from procedures set forth in a dividend statement that was provided to a policyholder prior to inception of the policy will not of itself be considered unfairly discriminatory.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0145

Unfair Forfeiture of Dividend for Failure to Renew Prohibited

An insurer shall not reduce or deny a policyholder dividend because of the policy-holder's refusal to accept renewal of the policy or another policy from the same insurer. A reasonable change in the time schedule for computing or paying a policyholder dividend will not of itself be considered a reduction or denial of the dividend, or unfairly discriminatory, if:

(1) The change is applied uniformly to the policyholders in like circumstances; and

(2) The nature of the change is set forth in a dividend statement that was provided to the policyholder before the inception of the policy for which the change is made.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0150

Policyholder Dividend Rights of Group Members and Dividend Group Policyholders; Reduction or Denial Without Prior Advice Prohibited; "Dividend Group" Defined; Standards for Dividend Groups

(1) When used in this section:

(a) "Group" means a collection of insurance buyers who are members of a common organization and who are treated collectively by an insurer for determining insurance dividends; and

(b) "Laws of the group" means the articles of incorporation, bylaws, agreements of association, rules, or regulations of the organization to which members of a group belong.

(2) An insurer shall not issue a policy to a group or to any members of a group, unless:

(a) The grouping has been approved by the Commissioner in accordance with ORS 746.145 or 746.150, whichever section applies; and

(b) The laws of the group comply with section (3) of this rule.

(3) The laws of the group shall provide that a distribution of funds derived from a policyholder dividend will not be reduced or denied to any member of the group:

(a) Except for reasons stated in the laws of the group; and

(b) Unless the insurer has given a copy of the stated reasons to the member or the policyholder before issuance of the policy for which the reduction or denial is made.

(4) The Commissioner will approve dividend groups of persons or risks covered by an insurer for insurance other than workers' compensation insurance only if:

(a) The grouping is made up of homogeneous risks;

(b) The grouping is made under the auspices of an organization which has existed for at least two years and was formed for purposes other than obtaining insurance;

(c) The grouping is likely to bring about substantial improvement in loss prevention or claims handling; and

(d) Information is filed with the Commissioner about eligibility for participation in the grouping and the system for allocating dividends among the participants.

(5) Within 60 days of receiving a group dividend proposal, the Commissioner shall notify the insurer whether the proposal has been approved or disapproved, stating the basis for such action.

Stat. Auth.: ORS 731.244 & 746.145

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. 7-20-76, ef. 1-1-77; IC 1-1984, f. 1-18-84, ef. 2-1-84; ID 16-1990(Temp), f. & cert. ef. 7-3-90; ID 5-1991, f. & cert. ef. 4-25-91

836-080-0155

False or Deceptive Publications by Insurer Prohibited

An insurer shall not knowingly adopt, or cause or permit to be issued, circulated or used, any representation, plan, schedule, letter, or advertising material of any kind stating or implying that the insurer has acted or will in the future act in any manner at variance with OAR 836-080-0105 to 836-080-0155.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1), 746.075, 746.160(3) & 746.240

Hist.: IC 69, f. & ef. 7-20-76

836-080-0205

Statutory Authority; Purpose; Applicability

(1) OAR 836-080-0205 to 836-080-0250 are adopted by the Insurance Commissioner pursuant to his general rulemaking authority in ORS 731.244, to aid in the proper effectuation of ORS 746.230.

(2) The purpose of these rules is to define certain minimum standards the violation of which will be considered to constitute unfair claims settlement practices within the purview of ORS 746.230.

(3) These rules apply with respect to all insurance except fidelity and surety bonds and title insurance. These rules apply to workers' compensation insurance only as provided in OAR 836-080-0250. These rules are not exclusive, and the Commissioner may also consider other acts not herein specified to be violations of ORS 746.230.

(4) These rules do not in any way expand or limit or otherwise change the procedural or substantive rights, or both, of claimants as provided in the Oregon Revised Statutes.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 746.230

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; ID 12-1992, f. & cert. ef. 7-1-92

836-080-0210

Definitions

As used in OAR 836-080-0205 to 836-080-0240, unless the context requires otherwise:

(1) "Claim file" includes, but is not limited to, microfilm files, computer information systems and other types of files, containing information on individual claims without necessarily containing hard copies of documents.

(2) "Claimant" includes first party claimants and third party claimants, the designated legal representatives of such claimants and members of a claimant's immediate family who are designated for this purpose by the claimant.

(3) "First party claimant" means a person asserting a right to payment under an insurance policy arising out of the occurrence of the contingency or loss covered by the policy.

(4) "Insurer" includes any person authorized to represent the insurer with respect to a claim who is acting within the scope of the person's authority.

(5) "Investigation" means the activities of an insurer directly or indirectly related to the determination of liabilities under coverages provided by an insurance policy.

(6) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy, to an insurer by a claimant which reasonably apprises the insurer of the facts pertinent to the claim.

(7) "Third party claimant" means any person asserting a claim against any person insured under an insurance policy.

(8) "Crash parts" are motor vehicle replacement parts, sheet metal or plastic, which constitute the visible exterior of the vehicle, including inner and outer panels, and are generally repaired or replaced as the result of a collision.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; IC 8-1986, f. & ef. 12-30-86

836-080-0215

Claim Files

An insurer's claim files shall contain the information pertaining to each claim in sufficient detail that pertinent events and their dates can be reconstructed.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230(1)(d)

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80

836-080-0220

Misrepresentation and Other Prohibited Claim Practices

An insurer shall not:

(1) Fail to fully disclose to a first party claimant all pertinent benefits, coverages and other provisions of an insurance policy under which the claim is asserted.

(2) Conceal from a first party claimant any insurance policy benefits, coverages or other provisions that are pertinent to the claim.

(3) Deny a claim on the grounds of the claimant's failure to exhibit the relevant property without proof of the insurer's demand and the claimant's unfounded refusal.

(4) Except where there is such time limit specified in the policy, make statements, written or otherwise, that require a claimant to give written notice of loss or proof of loss within a specified time and that seek to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the specified time limit prejudices the insurer's rights.

(5) Request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) Issue checks or drafts in partial settlement of a loss or claim under a specific policy coverage that contain language releasing the insurer or its insured from its total liability.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230(1)(a), (f), (j) & (m)

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80

836-080-0225

Required Claim Communication Practices

An insurer shall:

(1) Within 20 working days after it receives notification of claim, acknowledge the notification or pay the claim. An appropriate and dated notation of the acknowledgement shall be included in the insurer's claim file.

(2) Within 15 working days of receipt of an inquiry from the Commissioner about a claim, furnish the Commissioner with an adequate response.

(3) Make an appropriate reply, within 20 working days of receipt, to all other pertinent communications about a claim from a claimant that reasonably indicate a response is expected.

(4) Upon receiving notification of claim from a first party claimant, promptly provide necessary claim forms, instructions and assistance that is reasonable in the light of the information possessed by the insurer, so that the claimant can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this section within 20 working days of receipt of notification of a claim will constitute compliance with section (1) of this rule.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230(1)(b) & (e)

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80

836-080-0230

Standard for Prompt Claim Investigation

An insurer shall complete its claim investigation within 45 days after its receipt of notification of claim, unless the investigation cannot reasonably be completed within that time.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230(1)(c)

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80

836-080-0235

Standards for Prompt and Fair Settlements -- Generally

(1) An insurer shall, within 20 working days after its receipt of properly executed proofs of loss from a first party claimant, advise the claimant of the acceptance or denial of the claim. An insurer shall not deny a claim on the grounds of a specific policy provision, condition or exclusion unless the denial includes reference to the provision, condition or exclusion. A claim denial must be in writing, with either a copy or the capability of reproducing its text included in the insurer's claim file.

(2) If a claim is denied for reasons other than those described in section (1) of this rule and is made by any other means than in writing, an appropriate notation shall be made in the insurer's claim file.

(3) If an insurer needs more time to determine whether the claim of a first party claimant should be accepted or denied,

it shall so notify the claimant within 20 working days after receipt of the proofs of loss, giving the reason more time is needed. Forty-five days from the date of such initial notification and every 45 days thereafter while the investigation remains incomplete, the insurer shall notify the claimant in writing of the reason additional time is needed for investigation.

(4) An insurer shall not fail to settle claims of first party claimants on the grounds that responsibility for payment should be assumed by others, except as may be provided otherwise by the provisions of the insurance policy issued by the insurer.

(5) If an insurer continues negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or policy time limit, the insurer shall give the claimant written notice that the time limit may be expiring and may affect the claimant's rights. The notice shall be given to first party claimants not less than 30 days before, and to third party claimants not less than 60 days before, the date on which the insurer believes the time limit may expire.

(6) An insurer shall not make a statement that indicates that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time, unless the statement is given for the purpose of notifying the third party claimant of the provision of a relevant statute of limitations.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230(1)(a)-(f), (m) & 746.240

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80

836-080-0240

Standards for Prompt and Fair Settlements -- Automobile Insurance

(1) When an automobile insurance policy provides for the adjustment and settlement of collision or comprehensive coverage total losses on the basis of actual cash value or replacement with like kind and quality, the following rules shall apply:

(a) The insurer may elect to offer a specific, comparable and available replacement automobile, with all applicable taxes, license fees (at least pro rata for the unexpired term of the replaced automobile's license) and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy. The offer and any rejection of the offer must be documented in the insurer's claim file;

(b) The insurer may elect to make a cash settlement based upon the actual cost to purchase a comparable automobile, including all applicable taxes, license fees (at least pro rata for the unexpired term of the replaced automobile's license) and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. Such cost shall be determined by:

(A) The cost of a comparable automobile in the local market area of the insured, if such an automobile is available in that area; or

(B) One of two or more cost quotations obtained by the insurer, for a comparable automobile, from two or more qualified dealers located within the local market area of the insured, if a comparable automobile is not available in that area.

(c) The insurer may elect to settle the loss on a basis that is allowable under the policy but deviates from the rules given in subsections (a) and (b) of this section, if the deviation is supported by documentation in the insurer's claim file giving particulars of the condition of the automobiles involved. Any deductions from the cost of a comparable automobile, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount, and shall

be in an appropriate amount. The basis for the settlement shall be fully explained to the claimant.

(2) Where the issue of liability is reasonably clear, an insurer shall not recommend that a third party claimant make claim under the claimant's own insurance policy solely for the recommending insurer to avoid paying a claim.

(3) An insurer shall not require unreasonable travel of a claimant to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a repair shop.

(4) An insurer shall, upon a first party claimant's request, include the claimant's deductible in the insurer's demands under its subrogation rights. Subrogation recoveries shall be shared at least on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered by the claimant. No deduction for expenses may be made from the deductible recovery unless an outside attorney is retained to collect such recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney.

(5) If an insurer or body shop prepares an estimate of the cost of automobile repairs, the estimate shall be in the amount for which the damage may reasonably be expected to be satisfactorily repaired. If crash parts manufactured by anyone other than the original manufacturer are to be supplied or installed, the estimate shall identify each such part in a clearly understandable manner. The insurer or body shop shall give a copy of the written estimate to the claimant.

(6) As provided in ORS 746.280, an insurer shall not require that a particular person make the repairs to the first party claimant's automobile as a condition for recovery under the claimant's policy. An insurer shall not make such a requirement for the repair of a third party claimant's automobile as a condition for claim payment.

(7) When the amount claimed as automobile damage is reduced because of betterment or depreciation, all information used as the basis for the reduction shall be contained in the insurer's claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of betterment or depreciation.

(8) The Insurance Commissioner shall have the right to impose a fine not exceeding the sum of $2,000 for each violation of this provision or $10,000 in the aggregate for all such offenses within any three-month period.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.230(1)(c)-(d), (f), 746.240 & 746.280

Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; IC 8-1986, f. & ef. 12-30-86

836-080-0250

Workers' Compensation Insurance Unfair Claim Settlement Practices Standards

For the purposes of ORS 746.230(1)(d), the following applies to a workers' compensation insurer:

(1) The insurer is required to conduct a "reasonable" investigation based on all available information in ascertaining whether to deny a claim. A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensbility would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(2) In determining whether an investigation is reasonable, the Director will only look at information contained in the claim record at the time of denial. The insurer may not relay on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 746.230(1)(d)

Hist.: ID 12-1992, f. & cert. ef. 7-1-92

836-080-0305

Statutory Authority; Purpose; Applicability

(1) OAR 836-080-0305 to 836-080-0370 are adopted by the Director of the Department of Consumer and Business Services pursuant to the general rulemaking authority in ORS 731.244, to aid in the effectuation of ORS 746.045, 746.055, 746.160 and 746.240.

(2) The purpose of these rules is to define certain fair trade practice standards for title companies, the violation of which will be considered to constitute a practice prohibited by ORS 746.045, 746.055, 746.160(3) or 746.240.

(3) These rules are intended to regulate the marketing activities of title companies involving only intermediaries. These rules do not limit the Director's authority to determine that other activities of title companies with any person constitute violations of ORS 746.045, 746.055, 746.160(3) or 746.240.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0310

Definitions

As used in OAR 836-080-0305 to 836-080-0370, unless the context requires otherwise:

(1) A person "affiliated" with a title company means a person who controls, is controlled by, or is under common control with the title company; or a person who is an owner, director, officer or employee of such a person and acts in such representative capacity. As used in this section, an owner is a person who owns or controls a ten percent or more interest.

(2) "Intermediary" means:

(a) A person who is engaged to any extent in any of the following business activities, other than a title company or a person affiliated with the title company giving the thing of value:

(A) Acting as an agent, broker, representative or attorney in fact or at law of a person who buys or sells an interest in real property, or who lends or borrows money secured by an interest in real property;

(B) Buying, selling or exchanging interests in real property;

(C) Developing or subdividing real property;

(D) Building residential or commercial structures on real property;

(E) Making loans secured by interests in real property;

(F) Auctioning the sale of real property;

(G) Accommodating or facilitating exchanges in real property; or

(H) Providing real property transaction settlement services.

(b) A person who is an owner, director, officer or employee of a person described in subsection (2)(a) of this rule;

(c) A individual who resides in the same household of an individual described in subsection (2)(a) of this rule; or

(d) A trade association of persons described in subsection (2)(a) of this rule.

(3) "Give" means to transfer to another person; or cause another person to receive, retain, use or otherwise benefit from; without receiving equivalent consideration in return.

(4) "Net cost to the title company" means the actual costs directly incurred by the title company to give a thing of value to an intermediary, less any money received by the title company from an intermediary as payment or reimbursement for the thing of value within 30 calendar days after the intermediary received the thing of value, except for the following costs:

(a) Fixed operating costs:

(b) Labor costs; and

(c) Reasonable compensation for the use of an employee's private motor vehicle.

(5) "Thing of value" means anything that has a monetary value including but not limited to any of the following:

(a) An advertisement, which for purposes of this section, without limitation:

(A) Means a representation about any product, service, equipment, facility or activity or any person who makes, distributes, sells, rents, leases or otherwise makes available such a product, service, equipment, facility or activity, when the representation:

(i) Is communicated to a person that, to any extent, by content or context, informs the recipient about such a product, service, equipment, facility or activity;

(ii) Recognizes, honors or otherwise promotes such a product, service, equipment, facility or activity; or

(iii) Invites, advises, recommends or otherwise solicits a person to participate in, inquire about, purchase, lease, rent or use such a product, service, equipment, facility or activity.

(B) Includes a representation promoting only an intermediary, promoting only a title company through the use of a testimony or endorsement by an intermediary, or promoting both an intermediary and a title company; and

(C) Includes a display of pictures of intermediaries purporting to identify intermediaries that have referred clients to the title company;

(b) The creation of a compensating balance, which for purposes of this section means the depositing of funds in a financial institution for the purpose of inducing the institution to extend credit or loan funds to any person other than the depositor;

(c) An extension of a line of credit, which for purposes of this section means the extension of any credit outside of an open account for the ordinary services of a title company, but does not include the acceptance of an indemnity as to unfiled construction liens that are insured against under a title insurance policy;

(d) A monetary advance, which for purposes of this section means the advance of funds for the purpose of paying an obligation of an intermediary or an obligation that a financial institution requires to be paid, other than payment of governmental recording, search or filing fees, and payment at the request of the escrow agent or financial institution of

taxes and assessments prior to the completion of the related sale, lease or loan transaction;

(e) A product;

(f) A service; or

(g) The use of a facility.

(6) "Trade association" means an association of persons, a majority of whom are intermediaries. The term does not include a chamber of commerce or an economic development association.

(7) "Title company" means:

(a) A title insurer;

(b) A title insurance agent; or

(c) A person who is an owner, director, officer, or employee of a title insurer or title insurance agent and acts in such representative capacity. As used in this subsection, an owner means a person who owns or controls a ten percent or more interest in the title insurer or title insurance agent.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 11-1988, f. & cert. ef. 6-14-88; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0315

Providing Things of Value to Intermediaries Generally Prohibited

(1) A title company shall not, directly or indirectly, give or attempt to give any thing of value to an intermediary unless permitted by OAR 836-080-0320 to 836-080-0340. If more than one provision of OAR 836-080-0320 to 836-080-0340 applies, a title company may give a thing of value to an intermediary pursuant to only one provision.

(2) A title company shall also be considered to give a thing of value to an intermediary when the thing of value is given by a person affiliated with the title company.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; IC 3-1983, f. 5-10-83, ef. 6-1-83; ID 11-1988, f. & cert. ef. 6-14-88; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0320

Miscellaneous Things of Value

A title company may give a thing of value, except money, to an intermediary if the net cost to the title company is $2 or less per thing of value or individual receiving the thing of value, whichever is applicable, and if the thing of value is used only by the intermediary and not further distributed to other persons, except that the intermediary may distribute the thing of value to other persons if the thing of value is:

(1) Printed information about the title company or a person affiliated with the title company;

(2) Any service or product offered by the title company or a person affiliated with the title company; or

(3) Any business activity of the title company or a person affiliated with the title company.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0325

Business Development Activities

(1) A title company may give a thing of value to an intermediary in connection with an activity sponsored only by the title company if the net cost to the title company is $75 or less per individual attending, when five or fewer individuals actually attend and when one of the individuals is an employee of the title company.

(2) A title company may give a thing of value to an intermediary in connection with an activity sponsored only by the title company if the net cost to the title company is $10 or less per individual reasonably expected to attend, when six or more individuals actually attend and when one of the individuals is an employee of the title company.

(3) A title company may give a thing of value to an intermediary in connection with an activity sponsored only by the title company if the activity occurs at the title company's new or substantially remodeled office and the net cost to the title company is $25 or less per individual reasonably expected to attend. The title company shall notify the Director in writing at least 30 calendar days before the activity occurs that it intends to sponsor the activity, a description of the new office or extent of any remodeling, the number of individuals invited and reasonably expected to attend and the expected cost of the activity.

(4) A title company may give a thing of value to an intermediary in connection with an activity sponsored only by the title company if the activity occurs within 90 calendar days before or after the title company's first and each tenth anniversary of commencing title insurance or escrow business and the net cost to the title company is $25 or less per individual reasonably expected to attend. The title company shall notify the Director in writing at least 30 calendar days before the activity occurs that it intends to sponsor the activity, an explanation of when the title company commenced business, the number of individuals invited and reasonably expected to attend and the expected cost of the activity.

(5) A title company may give a thing of value to a trade association in response to a general solicitation of the entire membership of the trade association if the net cost to the title company is $50 or less.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; IC 6-1984, f. 10-15-84, ef. 11-1-84; ID 11-1988, f. & cert. ef. 6-14-88; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0335

Gifts

(1) A title company may give a plant or flowers to an intermediary in connection with an open house of a new or substantially remodeled office of the intermediary if the net cost to the title company is $50 or less.

(2) A title company may give a thing of value to an intermediary as a condolence if the net cost to the title company is $50 or less.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0337

Real Property Information

(1) A title company may give to an intermediary information about a specific parcel of real property located in Multnomah, Clackamas or Washington County, or in any other county in which one or more real property data bases providing information about specific parcels of real property are available on a commercially available software program, if

(a) The cost to the title company, including but not limited to labor and materials, is $10 or less per request; and

(b) The information is obtained only from a title plant, a local government, or from a commercially available real property database, or a combination of such sources.

(2) A title company may give to an intermediary information about a specific parcel of real property located in any county if:

(a) The information consists only of a map, a copy of one document of record, and any tax, assessment or other information related to the real property obtained from a title plant, or from a local government accessed from microfiche, microfilm or a computer terminal located in the title company, or a combination of such sources; and

(b) The information is about three or fewer specific parcels of real property.

(3) A title company may distribute the information described in section (1) or (2) of this rule in any form and in any manner unless specified otherwise by the title company's title insurance rate manual approved by the Director pursuant to ORS 737.320. Nothing in this rule allows a title company to provide the means of access to such information to an intermediary for less than reasonably equivalent consideration.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0340

Assistance in Qualifying a Subdivision

(1) A title company may do the following things for an intermediary that is a subdivider or developer to help qualify a subdivision for approval by a state or local government:

(a) Advance the normal county recording and filing fees;

(b) Help the subdivider or developer obtain the information necessary to complete the forms required by the state or local government;

(c) Help a subdivider or developer obtain the signatures necessary to file or record the subdivision plat with the state or local government; and

(d) Forward an item to the state or local government after the title company receives the item.

(2) As used in section (1) of this rule:

(a) "Developer" means a person who is a developer as defined in ORS 92.305 or 94.004, or a person who engages in the development of more than one commercial or industrial real property construction projects; and

(b) "Subdivider" means a person who is a subdivider as defined in ORS 92.305, or a person who acquires five or more unimproved lots or tracts of a filed subdivision for the purpose of resale or lease.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 11-1988, f. & cert. ef. 6-14-88; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0345

Automatic Change in Monetary Limits

All monetary limits in OAR 836-080-0305 to 836-080-0337 will automatically change, without the necessity of amending such rules, by the percentage change from year to year in the Portland Standard Statistical Metropolitan Area Consumer Price Index for all urban consumers, all items (Base 1982=100), or its equivalent as determined by the Director. The Director shall calculate the changes and notify each title company of such changes by December 1 of each year. The changes shall be effective on January 1 of the immediately following year.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0355

Title Insurer Responsible for Violations by Agent

A title insurer also violates OAR 836-080-0315 when a title insurance agent of the title insurer engages in conduct that violates OAR 836-080-0315, the title insurer knows that the conduct violates OAR 836-080-0315, the title insurer knows that the conduct is occurring or is about to occur, and the title insurer fails to request, in writing within 10 calendar days after first knowing that the conduct is occurring or is about to occur, that the title insurance agent immediately discontinue the conduct.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0360

Use by Title Company of an Intermediary's Office

A title company shall not have an employee work in a workspace owned, leased or

rented by an intermediary unless all of the following apply with respect to the space:

(1) The space is separate from and can be secured against access by other occupants of the premises.

(2) The consideration paid, if any, for the space is not more than the prevailing rate for similar space in the market area.

(3) The space is open to the conduct of business with all persons.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: IC 3-1980, f. 7-7-80, ef. 8-1-80; ID 9-1996, f. 6-25-96, cert. ef. 7-1-96; Renumbered from 836-080-0330

836-080-0365

Filing Escrow Rates Required

A title company shall file with the Director in writing each rate to be charged for escrow services and the effective date of such rate before the date the title company uses such rate. A title company shall also file a list of all escrow rates to be charged when it files a new or changed escrow rate.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

836-080-0370

Instruction of Title Company Employees About Rules Required

(1) A title company shall give a copy of OAR 836-080-0305 to 836-080-0370 to each employee who markets or performs any service offered by the title company.

(2) A title company shall instruct each employee described in section (1) of this rule about the content of the rules as follows:

(a) In the case of each employee employed on the effective date of OAR 836-080-0305 to 836-080-0370, within 60 calendar days after that date; and

(b) In the case of each employee employed after the effective date of OAR 836-080-0305 to 836-080-0370, within 30 calendar days after the date the employee commences work.

Stat. Auth: ORS 731.244

Stats. Implemented: ORS 746.045, 746.055, 746.160 & 746.240

Hist.: ID 9-1996, f. 6-25-96, cert. ef. 7-1-96

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 81

TRADE PRACTICES -- GENERAL PROVISIONS

836-081-0005

Statutory Authority; Purpose; Definitions

(1) OAR 836-081-0005 to 836-081-0010 are adopted by the Insurance Commissioner pursuant to his general rulemaking authority in ORS 731.244.

(2)(a) The purpose of these rules is to identify particular practices that will be regarded as making an unfair discrimination in the availability of insurance, in violation of ORS 746.015. These rules do not limit the Commissioner's authority to determine that other practices relating to insurance availability are unfairly discriminatory;

(b) These rules do not concern the making and use of insurance rates. Under ORS 737.310, which applies to most lines of property and casualty insurance, the making and use of rates that are unfairly discriminatory is prohibited. Under ORS 746.015, unfair discrimination in the application of rates is prohibited;

(c) These rules do not prohibit the use of other risk selection criteria that reasonably can be related to the rates and policy forms used by the insurer.

(3) For the purpose of these rules:

(a) "Availability of insurance" includes all terms, conditions, and types of coverage under insurance policies;

(b) "Insurer", when used in connection with several insurers in a group under common ownership or control, refers to the group of insurers collectively rather than individually.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1)

Hist.: IC 2-1978, f. 5-22-78, ef. 6-1-78

836-081-0010

Unfair Discrimination -- Insurance Other Than Life or Health Insurance

(1) Insurer decisions on the availability of insurance for individuals, other than life or health insurance, that are based on one of the following characteristic will be regarded as unfair discrimination:

(a) Age of individuals;

(b) Sex;

(c) Marital status (i.e., single, married, separated, divorced);

(d) Race or color;

(e) Creed;

(f) National origin;

(g) Ancestry;

(h) Occupation, if lawful, unless the occupation significantly increase the degree of hazard. This paragraph does not apply in the case of an insurer that limits its market to one occupation or several related occupations;

(i) Change of occupation, unless the frequency of change is significant;

(j) Change of domicile, unless the frequency of change is significant or the change significantly increases the degree of hazard or the expense of administering policy benefits;

(k) Previous rejection, cancellation or nonrenewal of insurance by another insurer;

(l) Change of insurer;

(m) Lack of previous insurance, unless such was after August 31, 1978 and was in violation of law.

(2) A combination of several such characteristics may be the basis for such decisions only if the combination significantly increases the degree of hazard.

Stat. Auth.: ORS Ch. 731 & 746

Stats. Implemented: ORS 746.015(1)

Hist.: IC 2-1978, f. 5-22-78, ef. 6-1-78

Unfair Discrimination on the Basis of Blindness or Partial Blindness

836-081-0020

Statutory Authority; Purpose; Applicability

(1) OAR 836-081-0020 to 836-081-0030 are adopted pursuant to the general rulemaking authority of the Insurance Commissioner in ORS 731.244 as an aid in effectuation of ORS 746.015(2).

(2) The purpose of OAR 836-081-0020 to 836-081-0030 is to protect members of the insurance-buying public who are blind or partially blind from unfair discrimination by insurers by identifying specific acts or practices which are prohibited by ORS 746.015(2) when engaged in solely on the basis of blindness or partial blindness.

(3) OAR 836-081-0020 to 836-081-0030 shall apply to all insurance transactions.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.015(2)

Hist.: IC 1-1985, f. & ef. 2-1-85

836-081-0030

Unfair Discrimination Acts or Practices

The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of blindness or partial blindness.

NOTES:

-1- With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons.

-2- Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his/her eyesight.

-3- However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.015(2)

Hist.: IC 1-1985, f. & ef. 2-1-85

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 82

DISCONTINUANCE AND REPLACEMENT OF GROUP COVERAGE

836-082-0050

Statutory Authority

OAR 836-082-0055 is adopted by the Director of the Department of Insurance and Finance pursuant to the authority of the Director:

(1) To carry out the prohibition in ORS 746.015 against unfair discrimination in the availability of insurance and in the terms or conditions of insurance policies;

(2) To aid in the carrying out of ORS 742.005(3), which requires the Director to disapprove a form requiring the Director's approval if in the Director's judgment, its use would be prejudicial to the interests of the insurer's policyholders; and

(3) To aid in the carrying out of ORS 742.005(4), which requires the Director to disapprove a form if the Director finds it contains unjust, unfair or inequitable provisions.

Stat. Auth.: ORS Ch. 731, 742 & 746

Stats. Implemented: ORS 742.005(3)-(4) & 746.0015(1)

Hist.: ID 13-1990, f. 6-12-90, cert. ef. 7-1-90

836-082-0055

Continuance of Group Health Insurance Coverage in Situations Involving Replacement

(1) This rule:

(a) Indicates the insurer responsible for liability when one insurer's group health policy or contract providing coverage for hospital or medical services or expenses replaces a policy or contract of similar benefits of another insurer;

(b) Indicates which policy or contract provides coverage for a policyholder when an insurer replaces a group health insurance policy or contract with a policy or contract of similar benefits.

(2) An insurer of a prior policy or contract is liable as follows:

(a) If the insurer of the prior policy or contract is not the insurer of the succeeding policy, the insurer of the prior policy or contract shall remain liable as provided in ORS 743.529 with respect to an individual who is hospitalized on the date of termination of a prior policy or contract, and otherwise only to the extent of its accrued liabilities and extensions of benefits;

(b) If the insurer for the prior policy or contract and the succeeding policy or contract is the same, the insurer shall remain liable under the prior policy or contract only to the extent of its accrued liabilities and extensions of benefits.

(3) Except as ORS 743.529 otherwise applies to an individual who is hospitalized on the date of termination of the prior policy, if an individual was validly covered under the prior plan on the date of discontinuance and is a member of the class or classes of individuals eligible for coverage under the succeeding plan, the individual shall be eligible for coverage under the succeeding plan without regard to actively-at-work or nonconfinement provisions. Any reference under this section to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding plan's coverage becomes effective. The following provisions govern such coverage:

(a) Except as provided for preexisting conditions in section (5) of this rule, the minimum level of benefits to be provided by the succeeding plan shall be the applicable level of benefits of the succeeding plan reduced by any benefits payable by the prior plan;

(b) Such coverage must be provided under the succeeding plan until the date on which the individual's coverage would terminate in accordance with the succeeding plan provisions applicable to individual termination of coverage, such as termination of employment or eligibility as a dependent.

(4) Section (3) of this rule does not apply with respect to an individual who is excluded under the succeeding policy because the individual is otherwise covered under another policy with similar benefits.

(5) In the case of a pre-existing conditions limitation included in the succeeding plan, the level of benefits applicable to pre-existing conditions of persons become covered by the succeeding plan in accordance with section (3) of this rule during the period of time this limitation applies under the succeeding plan may be either:

(a) The benefits of the succeeding plan determined without application of the pre-existing conditions limitation, reduced by any benefits actually paid or payable by the prior plan; or

(b) The benefits of the prior plan reduced by any benefits actually paid or payable by the prior plan.

(6) The insurer of the succeeding plan, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits, whether the prior plan is its own or was issued by another insurer. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior plan during the calendar year in which the succeeding plan becomes effective. However, the credit shall apply or be given only to the extent the expenses are recognized under the terms of the succeeding plan and are subject to a similar deductible provision.

(7) In any situation in which a determination of the prior insurer's benefit is required, it shall be the responsibility of the claimant to furnish evidence of the terms of the prior plan and of claim payments by the prior insurer.

Stat. Auth.: ORS Ch. 731, 742 & 746

Stats. Implemented: ORS 742.005(3)-(4) & 746.0015(1)

Hist.: ID 13-1990, f. 6-12-90, cert. ef. 7-1-90

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 85

TRADE PRACTICES

PRACTICES INJURIOUS TO PUBLIC OR FREE COMPETITION

Midterm Cancellation, Midterm Premium Increases, and Nonrenewal Notice

836-085-0001

Statutory Authority; Purpose; Applicability

(1) OAR 836-085-0001 to 836-085-0050 are adopted pursuant to the general rulemaking authority of the Director of the Department of Insurance and Finance in ORS 731.244, to aid in the proper effectuation of ORS 737.330, 746.160 and 746.240.

(2) The purpose of OAR 836-085-0001 to 836-085-0050 is to protect the insurance-buying public in insurance transactions involving termination, renewal or nonrenewal, or premium increases on contracts of insurance by:

(a) Regulating the grounds for midterm cancellation of an insurance policy;

(b) Prohibiting midterm increases in premium;

(c) Increasing the opportunity for policyholders to shop for replacement or substitute insurance;

(d) Reducing the opportunity for breach of policy bargain, misrepresentation by omission or untimely disclosure, and unfair discrimination among insureds; and

(e) Increasing the opportunity for agents to freely compete.

(3) OAR 836-085-0001 to 836-085-0050 shall apply to all forms of commercial insurance that are subject to filing under ORS 737.330 on risks or operations in this state, except for:

(a) Commercial liability insurance as defined in ORS 731.074, and comprehensive or package policies that include commercial liability insurance coverage;

(b) Reinsurance;

(c) Wet marine and transportation insurance;

(d) Marine and transportation insurance;

(e) Health Insurance;

(f) Life Insurance;

(g) FAIR plans and automobile assigned risk insurance;

(h) Workers' Compensation and employers' liability insurance;

(i) Nuclear liability insurance;

(j) Fidelity and surety insurance;

(k) Hazardous waste and environmental impairment insurance;

(l) Aviation insurance;

(m) Commercial automobile liability insurance;

(n) Any commercial insurance policy that has not been previously renewed if the policy has been effect less than 60 days at the time notice of cancellation is mailed or otherwise delivered;

(o) Any policy issued by a surplus lines insurer.

(4) OAR 836-085-0001 to 836-085-0050 are not exclusive. The Director may also consider other provisions of the Insurance Code to be applicable to the circumstances or situations addressed herein. Policies may provide terms more favorable to policyholders than are required by these rules. The rights provided by these rules are in addition and do not prejudice any other rights the policyholder may have at common law, under statutes or other Oregon Administrative Rules.

Stat. Auth.: ORS Ch. 731, 737 & 746

Stats. Implemented: ORS 737.330, 742.005(3)-(4), 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & ef. 12-1-87; ID 21-1988, f. & cert. ef. 12-16-88

836-085-0005

Definitions

As used in OAR 836-085-0001 to 836-085-0050, unless the context required otherwise:

(1) "Cancellation" means termination of a policy at a date other than its expiration date.

(2) "Expiration Date" means the date upon which coverage under a policy ends. For a policy written for a term longer than one year or with no fixed expiration date, "expiration date" means the annual anniversary date of the policy.

(3) "Premium" means the contractual consideration charged to an insured for insurance for a specified period of time regardless of the timing of actual charges.

(4) "Renewal" or "Renew" means the issuance of, or the offer to issue by an insurer, a policy succeeding a policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & ef. 12-14-87

836-085-0010

Midterm Cancellation

(1) A policy of commercial insurance may not be cancelled by the insurer prior to the expiration date of the policy, except on one or more of the following grounds:

(a) Nonpayment of premium, which means the failure or inability of the named insured to discharge any obligation in connection with the payment of premium on a policy of commercial insurance, whether the payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit;

(b) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim under the policy;

(c) Substantial increase in the risk of loss after insurance coverage has been issued or renewed, including but not limited to an increase in exposure due to rules, legislation or court decision;

(d) Failure to comply with reasonable loss control recommendations;

(e) Substantial breach of contractual duties, conditions or warranties;

(f) Determination by the Director that the continuation of a line of insurance or class of business to which the policy belongs will jeopardize a company's solvency or will place the insurer in violation of the insurance laws of Oregon or any other state;

(g) Loss or decrease in reinsurance covering the risk.

(2) Cancellation of a commercial policy that includes provisions of the standard fire insurance policy under ORS 742.206 to 742.242 and is written as a single coverage shall not be effective until at least 30 days after the insured receives a written notice of cancellation. Cancellation of a commercial policy that does not include provisions of the standard fire insurance policy shall not be effective until at least 10 working days after the insured receives a written notice of cancellation. The notice in either case shall state the effective date of and the reason for cancellation and shall inform the insured of the hearing rights established by OAR 836-085-0011.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 737.330, 742.005, 746.160 & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & cert. ef. 12-14-87; ID 21-1988, f. & cert. ef. 12-16-88; ID 8-1990, f. & cert. ef. 5-4-90; ID 15-1996, f. & cert. ef. 11-12-96

836-085-0011

Hearing on Cancellation

Within 30 days after receiving a notice of cancellation under OAR 836-085-0010, an insured may request a hearing before the Director. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence given by the insurer in its notice of cancellation. The burden of proving the reason for cancellation shall be upon the insurer.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: ID 8-1987, f. & cert. ef. 12-14-87

836-085-0015

Longterm Cancellation

If a policy is issued for a term longer than one year, and for additional consideration a premium is guaranteed, the insurer may not refuse to renew the policy or increase the premium for the term of that policy.

Stat. Auth.: ORS Ch. 731, 737 & 746

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & cert. ef. 12-14-87; ID 21-1988, f. & cert. ef. 12-16-88

836-085-0025

Renewal With Altered Terms

(1) If the insurer offers or purports to renew the policy, but on terms less favorable to the insured or at higher rates, the new terms or rates may take effect on the renewal date if the insurer provides 30 days' written notice to the insured and to the agent, if any. If the insurer does not provide such notice, the insured may cancel the renewal policy within 30 days after receipt of such notice. Earned premium for period of coverage, if any, shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, any premium increase or changes in terms shall be effective immediately following the prior policy's expiration date.

(2) Nonrenewal of a policy shall not be effective until at least 30 days after the insured received a written notice of nonrenewal. If, after an insurer provides a notice of nonrenewal as described in this section, the insurer extends the policy 90 days or less, and additional notice of nonrenewal is not required with respect to the extension. For purposes of this section, "nonrenewal" means the refusal of an insurer to renew a policy at its expiration date.

(3) Section (1) of this rule does not apply:

(a) If the change is a form, rate or plan filed with the Director and applicable to the entire line of insurance or class of business to which the policy belongs; or

(b) To a premium increase based on the altered nature or extent of the risk insured against.

Stat. Auth.: ORS Ch. 731, 737 & 746

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; IC 6-1985, f. 11-29-85, ef. 12-1-85; ID 8-1988, f. & cert. ef. 12-14-87; ID 21-1988, f. & cert. ef. 12-16-88

836-085-0035

Cancellation or Nonrenewal Notice

(1) If a risk sharing plan exists under ORS Chapter 735 for the kind of coverage cancelled or nonrenewed, notice of cancellation or nonrenewal required under OAR 836-085-0010(2) is not effective unless the notice contains adequate instructions to the policyholder and if one exists, the agent for applying for insurance through a risk sharing plan under ORS Chapter 735.

(2) Adequate instructions under section (1) of this rule must direct the policyholder to the agent of the notifying insurer for assistance or, if no agent exists, must provide that the insurer will directly assist in submission of the application.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & ef. 12-14-87

836-085-0040

Cancellation for Nonpayment of Premium

OAR 836-085-0035 does not apply if the ground for cancellation or nonrenewal is nonpayment of the premium and if the notice so states.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & ef. 12-14-87

836-085-0045

Unfair Trade Practices

(1) Failure of an insurer to comply with OAR 836-085-0010 to 836-085-0050 constitutes an unfair trade practice under ORS 746.240.

(2) Midterm premium increase or a policy coverage reduction attempted or executed in nonconformance with ORS 737.330 or 743.006 constitutes an unfair trade practice under ORS 746.240.

(3) Block Cancellations or Nonrenewals of entire lines of insurance or withdrawal of classes of business are presumed to be unfairly discriminatory and constitute an unfair trade practice under ORS 746.240, unless prior authorization is received.

(4) Termination of an appointed agent, or an attempt of such termination, solely to achieve block cancellation or nonrenewal of entire lines of insurance or other such instant reunderwriting of an agency book of business shall be presumed to constitute an unfair trade practice under ORS 746.240 an unfair trade practice detrimental to free

competition under ORS 746.160.

(5) Any nonrenewal will be expected to be for justifiable cause; and:

(a) Inability to substantiate justifiable cause for nonrenewal will be subject to Insurance Division review; and

(b) Unjustified nonrenewals of such frequency as to indicate a general business practice shall be presumed to constitute an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: IC 2-1985(Temp), f. 5-31-85, ef. 6-15-85; IC 4-1985, f. & ef. 9-19-85; ID 8-1987, f. & ef. 12-14-87

836-085-0050

Proof of Notice

A post office certificate of mailing to the named insured at the named insured's last-known address shall constitute conclusive proof that the named insured received the notice of cancellation or nonrenewal on the third calendar day after the date of the certificate of mailing.

Stat. Auth.: ORS Ch. 731

Stats. Implemented: ORS 746.045, 746.055, 746.160(3) & 746.240

Hist.: ID 8-1987, f. & ef. 12-14-87

836-085-0055

Cancellation of Commercial Package Policies

A commercial package policy that includes commercial liability insurance coverage is subject to ORS 742.702, governing cancellation of commercial liability insurance policies. For purposes of this rule, "commercial liability insurance" has the meaning given that term in ORS 731.074.

Stat. Auth.: ORS Ch. 731 & 742

Stats. Implemented: ORS 742.702

Hist.: ID 8-1990, f. & cert. ef. 5-4-90

Practices Injurious to Insurance-Buying Public

Use of Motor Vehicle Reports in Private Passenger

Automobile Rating and Underwriting, and Use of Blanket

Exclusionary Endorsements

836-085-0101

Statutory Authority; Purpose; Applicability

(1) OAR 836-085-0101 to 836-085-0120 are adopted pursuant to the general rulemaking authority of the Director of the Department of Insurance and Finance in ORS 731.244 and specific authority of ORS 737.310, 743.009, 746.015 and 746.240, for carrying out the purposes of ORS 743.800 to 743.835, and to aid in giving effect to the legislative policy expressed in ORS 806.010 respecting mandatory motor vehicle liability insurance.

(2) The purpose of OAR 836-085-0101 to 836-085-0120 is to protect the automobile insurance-buying public from unreasonable premium increases by prohibiting use of policy provisions excluding coverage for a specific classification of drivers.

(3) OAR 836-085-0101 to 836-085-0120 apply to all liability policies delivered or issued for delivery to individuals in this state on a private passenger motor vehicle, as that term is defined in ORS 743.800.

Stat. Auth.: ORS Ch. 731, 737, 743 & 746

Stats. Implemented: ORS 737.310, 742.005, 742.450 & 746.015

Hist.: IC 8-1985, f. 12-3-85, ef. 1-1-86; ID 8-1987, f. & ef. 12-14-87; ID 21-1988, f. & cert. ef. 12-16-88

836-085-0115

Unfair Discrimination -- Use of Blanket Exclusionary Provisions

(1) Use by an insurer of policy provisions excluding or limiting the amount, extent or kind of private passenger motor vehicle coverage because of the age of a person operating the insured vehicle constitutes unfair discrimination.

(2) Notwithstanding section (1) of this rule, coverage may be excluded while the insured automobile is being driven by any driver under 25 years of age. Such driver exclusion shall not apply to:

(a) The named insured;

(b) Any person related by blood, marriage or adoption, if named in the policy application and declaration page of the policy;

(c) Agents or employees of the named insured;

(d) A person operating the insured automobile because of the physical or mental condition of another person caused by an accident or sudden illness or by being under the influence of intoxicants, and rendering the person incapable of operating the insured vehicle. The exemption under this subsection applies only for the period of time, not to exceed three hours, that is required to return the incapacitated person to the primary residence of the incapacitated or to take the incapacitated person to medical treatment.

(3) Such coverage exclusion does not apply to:

(a) Uninsured motorist insurance;

(b) Underinsured motorist insurance, if any;

(c) Personal injury protection benefits to those persons required to be insured pursuant to ORS 743.800 to 743.835;

(d) Liability insurance while the insured car is being operated on a military base or reservation;

(e) Protection of a lienholder's interest under collision or comprehensive insurance.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 737.310, 742.005, 742.450 & 746.015

Hist.: IC 8-1985, f. 12-3-85, ef. 1-1-86; ID 8-1987, f. & ef. 12-14-87

836-085-0120

Unfair Trade Practices

Failure of an insurer to comply with OAR 836-085-0115 constitutes an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 731 & 743

Stats. Implemented: ORS 737.310, 742.005, 742.450 & 746.015

Hist.: IC 8-1985, f. 12-3-85, ef. 1-1-86; ID 8-1987, f. & ef. 12-14-87

Practices Injurious to Public or Free Competition

836-085-0201

Statutory Authority; Purpose; Applicability; Effective Date

(1) OAR 836-085-0201 to 836-085-0230 are adopted pursuant to the specific authority of ORS 737.322, and the general rulemaking authority of the Director in ORS 731.244, to carry out ORS 746.240 and the orderly administration of ORS Chapter 737 with respect to the workers' compensation experience rating system and its supporting statistical plan.

(2) The purpose of OAR 836-085-0201 to 836-085-0230 is to amend the authorized workers' compensation experience rating system for timely apprising insured employers of their premium modification factors so the employers of their premium modification factors so the employers can make necessary adjustments in the cost of goods or services sold.

(3) OAR 836-085-0201 to 836-085-0230 apply to all workers' compensation policies delivered or issued for delivery to employers in this state.

(4) OAR 836-085-0201 to 836-085-0230 become effective January 20, 1988.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2) & 746.240

Hist.: ID 3-1988, f. & cert. ef. 1-20-88

836-085-0205

Definitions

As used in OAR 836-085-0201 to 836-085-0230, unless the context requires otherwise:

(1) "Experience Rating" means the prospective modification of a workers' compensation insurance premium according to the **Experience Rating Plan Manual** of the National Council on Compensation Insurance filed with the Director, or an alternative plan otherwise authorized pursuant to OAR 836-042-0015(6)(b).

(2) "Insurer" means any person authorized to write workers' compensation insurance in this state and includes the State Accident Insurance Fund Corporation.

(3) "Modification Factor" means the numerical result of an experience rating calculation.

(4) "Normal Anniversary Rating Date" means the date the rates and experience rating modification for an individual employer changes, as established by the rating organization.

(5) "Premium" means the contractual amount charged to an insured for insurance for a specified period of time, regardless of the timing of actual charges.

(6) "Rating Plan" means any set of rules and values filed with the Director of the Department of Insurance and Finance and used by an insurer to calculate premiums.

(7) "Statistical Plan" means the uniform statistical plan for workers' compensation insurance statistics as prescribed by OAR 836-042-0045.

(8) "Tentative Experience Modification Endorsement" is the form of prior notice to the employer of the tentative modification factor calculation by the insurer for use in policy issuance.

(9) "Workers' Compensation Insurance" means insurance providing coverage for the obligation of an employer arising from illness or injury to workers whether such obligation is imposed by ORS Chapter 656 of this state, similar laws of the United States or agreements between states.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Insurance Division.]

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2)

Hist.: ID 3-1988, f. & cert. ef. 1-20-88

836-085-0210

Adjustment for Experience of Employer; Calculation of Tentative Modification Factors

For purposes of OAR 836-085-0201 to 836-085-0230:

(1) An insurer shall adjust for experience of an employer by multiplying the insurance premium by the modification factor.

(2) An insurer shall calculate tentative modification factors in accordance with experience data known or discoverable by the insurer and in accordance with the provisions and formulas of the experience rating plan authorized by OAR 836-042-0015(6).

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2)

Hist.: ID 3-1988, f. & cert. ef. 1-20-88

836-085-0215

Insurer Implementation of Employer Experience Rating Modifications

(1) An insurer may apply to a policy for an individual employer as of the policy inception date, or as of the normal anniversary rating date, if different, the experience rating modification factors for the employer received by the insurer from the rating organization within 90 days from the inception of the policy or normal anniversary rating date, if the insurer has provided a tentative experience modification endorsement in compliance with OAR 836-085-0210, or normal anniversary rating endorsement, to the insured at policy issuance.

(2) An insurer shall not apply to a policy for an individual employer the individual employer experience rating modification factors received by the insurer from the rating organization after 90 days from the inception of the policy, or normal anniversary rating date, if different, until a date at least 30 days after the insurer has provided notice to the individual employer of the experience rating modification factor by endorsement. Prior to that date, the insurer may apply to the policy a tentative experience rating endorsement issued in compliance with OAR 836-085-0210.

(3) An insurer shall not apply to a policy of an individual employer the employer experience rating modification factors received by the insurer from the rating organization if application of the procedures in sections (1) and (2) of this rule will result in implementation of the factors less than 90 days before the expiration date of subsequent anniversary rating date of the policy. However, the insurer shall provide written notice of the inapplicable experience rating modification to the employer. Notwithstanding sections (1), (2) and (3) of this rule, any employer experience rating modification factors received by the insurer from the rating organization prior to policy or rating period expiration that results in a premium reduction to that employer shall be applied to the policy as of the inception date of that policy or the applicable anniversary rating date.

(5) This rule applies to intrastate and interstate experience rating modification factors.

(6) This rule does not apply to experience rating modification factors that result from changes in the ownership of the insured operation.

(7) If an employer is a client of a worker leasing company, as established under ORS 656.850, the provisions of this rule are modified as follows:

(a) Sections (1), (2) and (3) of this rule apply if the leasing company has filed a worker leasing notice naming the client with the Workers' Compensation Department and the insurer within 30 days of the date leased workers were first provided to the client;

(b) When the leasing company files the worker leasing notice with its insurer for an experience rated client 31 or more days after the date leased workers were first provided to the client, an insurer may apply an experience rating modification factor to a client's premium as of the date the leased workers were first provided, if the insurer receives such factors from the rating organization within 90 days of the date the worker leasing notice is received by the insurer. Prior to the receipt of the experience rating modification factor, the insurer may apply a tentative factor to the client's premium in compliance with OAR 836-085-0210 and by giving written notice to the leasing company;

(c) An insurer may not apply an experience rating modification factor to a client's premium from the date leased workers were first provided if the factor is received from the rating organization more than 90 days after the insurer's receipt of the client's worker leasing notice, until a date at least 30 days after the insurer has provided notice to the leasing company; and

(d) Notwithstanding subsections (a), (b) and (c) of this section, any client experience rating modification factors received by the insurer for a client that results in a premium reduction to that client shall be applied as of the date leased workers were first provided by the leasing company to the client.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2) & 746.240

Hist.: ID 3-1988, f. & cert. ef. 1-20-88; ID 13-1989, f. 12-6-89, cert. ef. 1-1-90; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96

836-085-0217

Employer Failure to Cooperate; Appeal

(1) As provided in this rule, sections (2) and (3) of OAR 836-085-0215 do not apply if the rating organization is unable to calculate the modification factor for an insured employer because the employer has failed to cooperate in audits or because of other material fault attributable to the employer or an agent of the employer.

(2) An employer may appeal application of experience modification factors under section (1) of this rule by applying to the Administrator of the Insurance Division for a hearing not later than the 30th day after the insurer notifies the employer that the insure intends to apply the factors because of the employer's noncooperation or other material fault. The Administrator shall hold a hearing on the appeal as provided in ORS 737.505, and may affirm or deny the appeal.

(3) An appeal under section (2) of this rule shall stay the application of the experience modification factors under section (1) of this rule.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2) & 746.240

Hist.: ID 3-1988, f. & cert. ef. 1-20-88

836-085-0220

Statistical Reporting Requirements

(1) An insurer must submit experience rating exposure, premium and loss data to the rating organization in accordance with requirements for timely submission prescribed by OAR 836-042-0045.

(2) The rating organization shall notify the Administrator of the Insurance Division in writing of each instance of a late submission of data for an employer identifying the employer and the insurer submitting the data.

(3) The rating organization shall also notify the Administrator in writing of each instance of an insurer's failure to provide data within 30 days of a request for such data and identify the employer and insurer from whom the data was requested.

(4) Notification to the Administration shall be made at least once each calendar month.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2)

Hist.: ID 3-1988, f. & cert. ef. 1-20-88

836-085-0225

Unfair Trade Practices

(1) Retroactive application of experience rating modification factors in any manner other than provided for in OAR 836-085-0215 constitutes an unfair trade practice under ORS 746.240.

(2) Failure of an insurer or rating organization to comply with the statistical reporting requirements of OAR 836-085-0220 constitutes an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2) & 746.240

Hist.: ID 3-1988, f. & cert. ef. 1-20-88

836-085-0230

Penalties for Late Submission of Rating Data

(1) When the Director imposes a civil penalty for violation of OAR 836-042-0045, the civil penalty shall be not less than $100 for each failure by the insurer to submit the data on the date that the submission of data is due. The Director may increase the civil penalty by $100 with respect to each such failure for each 30-day period following the due date in which the insurer continues the failure to submit the data.

(2) With respect to each calendar month in which an insurer has failed to submit data, for all failures by the insurer to submit data during that month, including continuing failures, the Director shall not impose civil penalties under section (1) of this rule that exceed $10,000 in the aggregate.

(3) Failure by an insurer to submit data for an individual employer after imposition of civil penalty under section (1) of this rule may result in suspension of the insurer's certificate of authority.

Stat. Auth.: ORS Ch. 731 & 737

Stats. Implemented: ORS 737.322(2)

Hist.: ID 3-1988, f. & cert. ef. 1-20-88; ID 7-1989, f. & cert. ef. 7-28-89

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE DIVISION

DIVISION 200

DEPARTMENT REGULATORY PROGRAMS

Service Contracts

836-200-0000

Statutory Authority; Registration; Fees; Expiration; Renewal

(1) OAR 836-200-0000 to 836-200-0060 are adopted under the authority of ORS 646.267 and 646.285 for the purpose of implementing ORS 646.263 to 646.285.

(2) The fee for filing a registration as an obligor of service contracts is $200. The fee under this section (2) must be included with the filing.

(3) The fee for annual renewal of a registration as an obligor of service contracts is $50.

(4) A registration expires on July 1 unless it is renewed on or before that date. A registrant must renew the registration by submitting the renewal fee to the Director of the Department of Consumer and Business Services.

(5) A registrant shall immediately notify the Director of any change in the information submitted in the registration of the registrant.

(6) ORS 646.263 to 646.285 and OAR 836-200-0000 to 836-200-0060 apply to merchandise and not to real property.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 6-1995(Temp), f. & cert. ef. 9-12-95; ID 7-1996, f. & cert. ef. 5-28-96; ID 8-1997, f. & cert. ef. 7-10-97

836-200-0010

Assessments

(1) An obligor shall pay an annual assessment as required in ORS 646.281 in the amount of $75. The amount of the assessment is based on the expected costs of this registration program.

(2) Assessments under section (1) of this rule shall be imposed and collected annually unless the Director determines that additional amounts need to be assessed and collected in order to support the legislatively authorized budget of the Department with respect to its functions under ORS 646.263 to 646.285 or in order to support changes in the budget authorized by the Emergency Board. The additional amounts shall be assessed as provided in this rule.

(3) The Director shall assess a registrant only if the registrant is authorized to transact service contracts at the time of billing.

(4) A registrant must pay each assessment imposed under this rule not later than the 30th day after the date of the billing of the assessment by the Department. A registrant shall pay interest at nine percent per annum on any assessment that is not paid when due.

(5) In the event the Director determines that an assessment or a part thereof paid by a registrant is in excess of the amount legally due and payable to the Department, if the amount of the refund is less than $50, the Department shall pay the refund only upon receipt of a written request from the registrant. The written request must be received by the Department not later than three years from the date the assessment was paid to the Department.

Stat. Auth.: ORS 646.285

Stats. Implemented: ORS 646.285

Hist.: ID 7-1996, f. & cert. ef. 5-28-96; ID 8-1997, f. & cert. ef. 7-10-97

836-200-0020

Filing Procedures

(1) An applicant for registration must include proof of financial stability with the registration application. The proof must satisfy applicable requirements of OAR 836-200-0030 and 836-200-0040.

(2) An applicant for registration must file with the Director a copy of the service contract form or forms that the applicant intends to use as a registrant in Oregon.

(3) A registrant must file with the Director all amendments to its service contract form or forms used in Oregon that change any contra ct term or condition applicable to the contract's use in Oregon, and all new contract forms to be used in Oregon. A registrant need not file any amendment that changes a contract only in graphics or form, and not substantively.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 6-1995(Temp), f. & cert. ef. 9-12-95; ID 7-1996, f. & cert. ef. 5-28-96

836-200-0030

Form 10 K and Other Financial Stability Filings

(1) As provided in ORS 646.267, a registrant or applicant for registration may submit as proof of financial stability its own most recent Form 10-K that is filed with the Securities and Exchange Commission or, if the obligor's financial

statements are consolidated with those of its parent company, may file the most recent Form 10-K of its parent company.

(2) A registrant or applicant for registration that is incorporated in another country may submit as proof of financial stability its own most recent Form 20-F or Form 40-F that is filed with the Securities and Exchange Commissioner, or may file the most recent Form 20-F or Form 40-F of its parent company if the obligor's financial statements are consolidated with those of its parent company, if the Form 20-F or Form 40-F shows a net worth of the obligor or its parent of at least $100 million in United States funds.

(3) A registrant or applicant for registration that is incorporated in another country that is a signing party to the North American Free Trade Agreement may submit as proof of financial stability its own most recent filing in its domiciliary country that the Securities and Exchange Commission recognizes as equivalent to the Form 10-K. If the parent company of the registrant or applicant is incorporated in another country that is a signing party to the North American Free Trade Agreement, the registrant or applicant may file the most recent filing by its parent company in the domiciliary country that the Securities and Exchange Commission recognizes as equivalent to the Form 10-K. A filing described in this section (3) is acceptable as proof of financial stability only if the filing shows a net worth of the obligor or its parent of at least $100 million in United States funds.

(4) A registrant or applicant who submits the Form 10-K, Form 20-F or Form 40-F of its parent company, or submits a filing described in section (3) of this rule that is filed by its parent company must include with the filing a statement by the parent company to the effect that:

(a) The company is the parent of the registrant; and

(b) The parent company agrees to guarantee the obligations of the registrant relating to service contracts sold by the obligor in this state.

(5) A statement described in section (4) of this rule must be signed by a director or officer of the parent company who is authorized by the parent company to sign such an agreement.

(6) A statement described in section (4) of this rule, when filed as proof of financial stability, shall be considered to be signed by a person who was authorized by the parent company to sign the agreement.

(7) A statement described in section (4) of this rule may be revoked by the parent company only if:

(a) The registrant gives notice of the revocation not later than the 60th day before the effective date of the revocation;

(b) The parent company agrees that it will continue to be liable for the obligations of the registrant relating to service contracts sold by the obligor in this state that are outstanding as of the effective date of revocation, or the registrant submits other proof satisfactory to the Director that a successor person is likewise obligated; and

(c) The registrant files proof of financial stability that replaces or succeeds the proof of financial stability guaranteed by the parent company.

(8) If a registrant has submitted its Form 10-K or other proof of financial stability under this rule or has submitted the parent company's Form 10-K or other proof of financial stability of the parent under this rule, the registrant or its parent company must continue to be qualified to file the Form 10-K or other proof as long as the Form 10K or other submission is relied upon as proof of financial stability. A registrant must notify the Director if the net worth of the company that filed the Form 10-K or other proof of financial stability, whether the company is itself or the parent company, falls below $100 million or if the company is no longer publicly held.

(9) If a registrant goes out of business or if the registration of a registrant expires or is suspended or revoked, a parent company that is bound by a statement described in section (4) of this rule continues to be responsible for all obligations of the registrant that are still outstanding.

(10) For the purpose of payment under a guarantee described in this rule, an obligor fails to perform under the service contract when the obligor fails to perform as agreed in the service contract by a date that is not later than the 60th day after the date of the demand for performance or by a date specified in the service contract for performance, whichever date is earlier.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 6-1995(Temp), f. & cert. ef. 9-12-95; ID 7-1996, f. & cert. ef. 5-28-96

836-200-0040

Reimbursement Insurance Policy

(1) When an obligor or applicant for registration relies on a reimbursement insurance policy for purposes of the financial stability requirement in ORS 646.267, the obligor or applicant must submit a copy of the policy to the Director.

(2) A reimbursement insurance policy insuring service contracts issued, sold or offered for sale in this state shall conspicuously state that, upon failure of the obligor to perform under the contract, the insurer that issued the policy shall pay on behalf of the obligor any sums the obligor is legally obligated to pay or shall provide the service that the obligor is legally obligated to perform according to the obligor's contractual obligations under the service contracts issued by the obligor. The following is an example of wording that will be acceptable for the purpose of this section:

Upon failure of the obligor to perform under the contract, _____ (name of insurer issuing policy) shall pay on behalf of the obligor any sums the obligor is legally obligated to pay or shall provide the service that the obligor is legally obligated to perform according to the obligor's contractual obligation under the service contracts issued by the obligor, and _____ (insurer) will pay claims against the obligor for return of the unearned purchase price of the service contract.

(3) For the purpose of payment under a reimbursement insurance policy, an obligor fails to perform under the service contract when the obligor fails to perform as agreed in the service contract by a date that is not later than the 60th day after the date of the demand for performance or by a date specified in the service contract for performance, whichever date is earlier.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 6-1995(Temp), f. & cert. ef. 9-12-95; ID 7-1996, f. & cert. ef. 5-28-96

836-200-0050

Registration Requirements Not Exclusive

Compliance with the filing requirements of OAR 836-200-0000 to 836-200-0060 are additional to and not in lieu of filing and other requirements established by law for the purpose of doing business in this state, including but not limited to compliance with filing requirements of the Secretary of State applicable to assumed business names and applicable to the business structure of an applicant.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 6-1995(Temp), f. & cert. ef. 9-12-95; ID 7-1996, f. & cert. ef. 5-28-96

836-200-0055

Annual Report

For the purpose of enabling the Director to determine the assessment against each registrant according to the formula established in 836-200-0010, each registrant shall file a report for the preceding calendar year with the Director on or before March 1 of each year, or within such extension of time therefor as the Director may grant. The first report must be filed on or before March 1, 1997, for calendar year 1996. The report shall be in the form specified by the Director, shall contain the total number of service contracts produced in Oregon by the registrant during the preceding calendar year and shall be verified as follows:

(1) If the registrant is a corporation, by at least two principal officers of the registrant.

(2) If the registrant is a partnership, by two partners.

(3) If the registrant is neither a corporation nor a partnership, by its president and secretary.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 7-1996, f. & cert. ef. 5-28-96

836-200-0060

Service on Registrant

The Director may make service on a registrant at the address shown on the current registration of the registrant on file with the Director, in the manner provided in ORS 183.310 to 183.550.

Stat. Auth.: ORS 646.267 & 646.285

Stats. Implemented: ORS 646.263 - 646.285

Hist.: ID 6-1995(Temp), f. & cert. ef. 9-12-95; ID 7-1996, f. & cert. ef. 5-28-96

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