DIVISION 1

GENERAL DEFINITIONS

836-001-0001 Statutory Authority; Purpose
836-001-0005 Insurance Code Definitions Adopted

DIVISION 5

PROCEDURAL RULES

836-005-0105 Notice to Interested Persons of Rulemaking
836-005-0107 Model Rules of Procedure Governing Rulemaking
836-005-0112 Persons Represented by Authorized Representative
836-005-0400 Annual Complaint Report

DIVISION 6

TAXATION

836-006-0010 Payment of Transition and Retaliatory Taxes
836-006-0021 Allocation of Consolidated Excise Tax for Purpose of Offsetting Retaliatory Taxes

DIVISION 9

FEES AND CHARGES

836-009-0001 Purpose
836-009-0007 Fees
836-009-0008 Mailing List Fee
836-009-0011 Assessments Against Insurers
836-009-0015 Refunds

DIVISION 10

GENERAL PROVISION

Rates and Forms Filing

836-010-0000 Statutory Authority and Implementation
836-010-0011 Filing, Review of Rates and Forms
836-010-0021 Required Actuarial Data

Authorization of Insurers and General Requirements

836-010-0130 Statutory Authority; Purpose; Applicability
836-010-0135 Definitions
836-010-0140 Title Plant Standards

DIVISION 11

ANNUAL STATEMENTS AND REPORTS BY INSURERS

Annual Statements

836-011-0000 Annual Statement Blank and Instructions

Annual Audited Financial Reports

836-011-0100 Authority; Effective Date
836-011-0110 Definition of Independent Certified Public Accountant
836-011-0120 Filing and Extensions for Filing of Annual Audited Financial Reports
836-011-0130 Exemptions
836-011-0140 Contents of Annual Audited Financial Report
836-011-0150 Designation of Independent Certified Public Accountant
836-011-0160 Qualifications of Independent Certified Public Accountant
836-011-0170 Consolidated or Combined Audits
836-011-0180 Scope of Examination and Report of Independent Certified Public Accountant
836-011-0190 Notification of Adverse Financial Condition
836-011-0200 Report on Significant Deficiencies in Internal Controls
836-011-0210 Accountant's Letter of Qualifications
836-011-0220 Certified Public Accountant Workpapers
836-011-0230 Canadian and British Companies

Risk-Based Capital Reporting

836-011-0300 Statutory Authority; Statutes Implemented
836-011-0305 Definitions
836-011-0310 RBC Reports
836-011-0320 Company Action Level Event
836-011-0330 Regulatory Action Level Event
836-011-0340 Authorized Control Level Event
836-011-0350 Mandatory Control Level Event
836-011-0360 Hearings
836-011-0380 Supplemental Provisions; Exemption
836-011-0390 Foreign Insurers

Disclosure of Material Transactions

836-011-0430 Scope and Authority
836-011-0440 Report
836-011-0450 Acquisitions and Dispositions of Assets
836-011-0460 Nonrenewals, Cancellations or Revisions of Ceded Reinsurance Agreements

Risk-Based Capital Reporting for Health Care Service Contractors

836-011-0500 Application; Statutory Authority; Statutes Implemented
836-011-0505 Definitions
836-011-0510 RBC Reports
836-011-0515 Company Action Level Event
836-011-0520 Regulatory Action Level Event
836-011-0525 Authorized Control Level Event
836-011-0530 Mandatory Control Level Event
836-011-0535 Hearings
836-011-0540 Supplemental Provisions; Rules; Exemption
836-011-0545 Foreign Health Care Service Contractors

DIVISION 12

CREDIT FOR REINSURANCE

836-012-0000 Authority
836-012-0011 Credit for Reinsurance — Reinsurer Authorized in this State
836-012-0021 Credit for Reinsurance — Accredited Reinsurers
836-012-0031 Credit for Reinsurance — Reinsurer Domiciled and Licensed in Another State
836-012-0041 Credit for Reinsurance — Reinsurers Maintaining Trust Funds
836-012-0051 Credit for Reinsurance Required by Law
836-012-0060 Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer Not Meeting the Requirements of OAR 836-012-0011 to 836-012-0051
836-012-0070 Trust Agreements Qualified Under OAR 836-012-0060
836-012-0080 Letters of Credit Qualified Under OAR 836-012-0060
836-012-0090 Other Security
836-012-0100 Reinsurance Contract
836-012-0110 Contracts Affected

Life Reinsurance Agreements

836-012-0300 Authority; Statement of Purpose; Director's Authority
836-012-0310 Accounting Requirements
836-012-0320 Written Agreements

DIVISION 13

ANNUAL STATEMENT; DIRECTOR'S AUTHORITY

Director's Authority to Take Corrective Action

836-013-0100 Authority
836-013-0110 Standards
836-013-0120 Director's Authority

DIVISION 14

ALTERNATIVE INSURANCE ORGANIZATIONS

Legal Expense Organizations

836-014-0001 Purpose, Authority and Effective Date
836-014-0005 Applicability and Scope
836-014-0010 Required Capitalization
836-014-0015 Annual Financial Statement
836-014-0020 Deposits
836-014-0025 Bond
836-014-0030 Sales Representatives
836-014-0035 Registration of Legal Expense Organization
836-014-0040 Amendments to Registration
836-014-0042 Renewal of Legal Expense Organization Registration
836-014-0045 Unfair Trade Practice

Multiple Employer Welfare Arrangements

836-014-0100 Actuarial Certification; Guidelines

Life Settlements

836-014-0200 Statutory Authority and Implementation
836-014-0210 License Fees
836-014-0220 Life Settlement Provider License Requirements
836-014-0230 Renewal Requirements
836-014-0240 Filing Requirements, Life Settlement Contracts
836-014-0250 Contents of Life Settlement Contracts
836-014-0260 Rights and Duties of Parties to Life Settlement Contract
836-014-0265 Response by Insurer
836-014-0270 Standards for Evaluation of Reasonable Payments; Definition of "Terminal Illness or Condition"
836-014-0280 Disclosure Required
836-014-0290 Contacts by Life Settlement Provider or Broker
836-014-0300 Advertising Standards
836-014-0310 Reporting Requirements
836-014-0320 Requirements for Brokers
836-014-0330 Unfair Trade Practices
836-014-0400 Market Assistance Plan

DIVISION 20

ADVERTISEMENTS OF HEALTH INSURANCE

836-020-0200 Purpose and Authority
836-020-0205 Applicability
836-020-0210 Definitions
836-020-0215 Method of Disclosure of Required Information
836-020-0220 Form and Content of Advertisements
836-020-0225 Advertisements of Benefits Payable, Losses Covered, or Premiums Payable
836-020-0230 Necessity for Disclosing Policy Provisions Relating to Renewal, Cancellation, and Termination
836-020-0235 Testimonials or Endorsements by Third Parties
836-020-0240 Use of Statistics
836-020-0245 Identification of Plan or Number of Policies
836-020-0250 Disparaging Comparisons and Statements
836-020-0255 Licensed Jurisdictions and Status of Insurer
836-020-0260 Identity of Insurer and Policy
836-020-0265 Group or Quasi-Group Implication
836-020-0270 Introductory, Initial, or Special Offers
836-020-0275 Statements About an Insurer
836-020-0280 Enforcement Procedures
836-020-0285 Prior Approval
836-020-0290 Severability
836-020-0295 Effective Date

Disclosure of Health Insurance Coverages

836-020-0300 Statutory Authority
836-020-0305 Disclosure; Application for Coverage

Use of Coordination of Benefit Provisions in Group and Blanket Health Insurance

836-020-0770 Authority, Purpose and Effective Date of OAR 836-020-0770 to 836-020-0805
836-020-0775 Definitions
836-020-0780 Use of Model COB Contract Provision
836-020-0785 Rules for Coordination of Benefits
836-020-0791 Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim
836-020-0796 Notice to Covered Persons
836-020-0801 Miscellaneous Provisions
836-020-0806 Effective Date for Existing Contracts

DIVISION 24

DOMESTIC INSURERS; ORGANIZATION; CORPORATE PROCEDURES

Shares, Shareholders, and Members

836-024-0003 Statutory Authority; Purpose
836-024-0004 Application of OAR 836-024-0003 to 836-024-0055
836-024-0006 Definitions
836-024-0008 Solicitations to which OAR 836-024-0003 to 836-024-0055 Apply
836-024-0026 Information to Be Furnished to Security Holders
836-024-0031 Requirements as to Proxy
836-024-0033 Presentation of Information in Proxy Statement
836-024-0036 Material Required to Be Filed
836-024-0038 Mailing Communications for Security Holders
836-024-0039 Proposals of Security Holders
836-024-0041 False or Misleading Statements
836-024-0046 Prohibition of Certain Solicitations
836-024-0051 Special Provisions Applicable to Election Contests; Definition
836-024-0053 Filings Required in an Election Contest
836-024-0054 Counter Solicitations Prior to Furnishing Required Written Proxy Statement
836-024-0055 Filing Requirements for Preliminary Solicitation Material
836-024-0056 Schedule A
836-024-0061 Schedule B
836-024-0100 Statutory Authority; Purpose
836-024-0105 Definitions
836-024-0110 Securities "Held of Record" for Purpose of ORS 732.425
836-024-0115 Filing of Statements
836-024-0120 Ownership of More than 10 Percent of an Equity Security
836-024-0125 Disclaimer of Beneficial Ownership
836-024-0130 Exemptions from ORS 732.430 and 732.435
836-024-0135 Exemptions from ORS 732.420 to 732.455 of Securities Purchased or Sold by Odd-lot Dealers
836-024-0140 Certain Transactions Subject to ORS 732.430
836-024-0145 Ownership of Securities Held in Trust
836-024-0150 Exemption for Small Transactions
836-024-0155 Exemption from ORS 732.435 That Need not be Reported Under ORS 732.430
836-024-0160 Exemption from ORS 732.435 of Certain Transactions Effected in Connection with a Distribution

836-024-0165 Exemption from ORS 732.435 of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar Plans
836-024-0170 Exemption from ORS 732.435 of Certain Transactions in Which Securities are Received by Redeeming other Securities
836-024-0175 Exemption of long Term Profits Incident to Sales Within Six Months of the Exercise of an Option
836-024-0180 Exemption from ORS 732.435 of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidation
836-024-0185 Exemption from ORS 732.435 of Transactions Involving the Deposit or Withdrawal of Equity Securities Under a Voting Trust or Deposit Agreement
836-024-0190 Exemption from ORS 732.435 of Certain Transactions Involving the Conversion of Equity Securities
836-024-0200 Exemption from ORS 732.435 of Certain Transactions Involving the Sale of Subscription Rights
836-024-0205 Exemption of Certain Securities from ORS 732.440
836-024-0210 Exemption from ORS 732.440 of Certain Transactions Effected in Connection with a Distribution
836-024-0215 Exemption from ORS 732.440 of Sales of Securities to be Acquired
836-024-0220 Arbitrage Transactions under ORS 732.450

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
836-027-0005 Definitions

Registration

836-027-0010 Registration of Insurers — Statement Filing
836-027-0012 Summary of Registration — Statement Filing
836-027-0020 Alternative and Consolidated Registrations
836-027-0025 Disclaimers and Termination of Registration

Forms Generally

836-027-0030 Forms; General Requirements
836-027-0035 Forms; Incorporation by Reference, Summaries, and Omissions
836-027-0040 Forms; Information Unknown or Unavailable and Extension of Time to Furnish
836-027-0045 Forms; Additional Information and Exhibits
836-027-0050 Instructions; Amendments

Subsidiaries of Domestic Insurers

836-027-0070 Subsidiaries of Domestic Insurers

Acquisitions and Mergers

836-027-0100 Acquisition of Control — Statement Filing
836-027-0110 Amendments to Form A
836-027-0120 Acquisition of Certain Persons Considered to Be Insurers
836-027-0130 Information to Be Included in Statement Required by ORS 732.517 to 732.592

Internal Transactions and Extraordinary Dividends

836-027-0160 Transactions Subject to Prior Notice — Notice Filing
836-027-0170 Extraordinary Dividends and Other Distributions
836-027-0180 Adequacy of Surplus

Corporate Procedures Generally

836-027-0200 Custodial Arrangements

Securities Lending Transactions

836-027-0300 Statutory Authority; Purpose
836-027-0310 Definitions
836-027-0320 Authorization by Board of Directors
836-027-0330 Agreement with Borrower
836-027-0340 Agreement with Agent as Alternative to Written Agreement
836-027-0350 Limitation
836-027-0360 Type of Borrower, Investment of Collateral, Valuation and Reporting

DIVISION 28

PURCHASING GROUPS AND RISK RETENTION GROUPS

836-028-0005 Statutory Authority, Purpose
836-028-0008 Unfair Trade Practice
836-028-0010 Registration of Purchasing Groups: Forms
836-028-0013 Permitted Insurers
836-028-0016 Amendments to Registration by Purchasing Group
836-028-0020 Use of Insurance Producers by Purchasing Groups
836-028-0035 Registration of Foreign Risk Retention Groups; Forms
836-028-0040 Amendments to Registration by Foreign Retention Groups
836-028-0045 Financial Statement of Foreign Risk Retention Group; Audit

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
836-031-0210 Definitions, Application and Explanation of Technical Terms Used
836-031-0220 Principles Governing Reserves
836-031-0230 Claim Reserves
836-031-0240 Premium Reserves
836-031-0250 Contract Reserves
836-031-0260 Reinsurance
836-031-0270 Specific Standards for Morbidity
836-031-0280 Specific Standards for Interest
836-031-0290 Specific Standards for Mortality
836-031-0300 Reserves for Waiver of Premium

Accounting (ORS 733.010 to 733.230) Investments and Accounting Generally

836-031-0400 Allowed Assets
836-031-0410 Title Insurance Unearned Premium Reserve

Standard Valuation Law; Actuarial Opinions and Memoranda

836-031-0600 Purpose
836-031-0610 Authority
836-031-0620 Scope
836-031-0630 Definitions
836-031-0640 General Requirements
836-031-0650 Required Opinions
836-031-0660 Statement of Actuarial Opinion Not Including an Asset Adequacy Analysis
836-031-0670 Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

836-031-0680 Description of Actuarial Memorandum Including an Asset Adequacy Analysis
836-031-0690 Additional Considerations for Analysis

Valuation of Life Insurance Policies

836-031-0750 Purpose, Authority and Applicability
836-031-0755 Applicability
836-031-0760 Definitions
836-031-0765 General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves
836-031-0770 Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)
836-031-0775 Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies that Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period
836-031-0855 Recoupment of Assessments by Oregon Insurance Guaranty Association

DIVISION 33

INVESTMENTS (ORS 733.510 TO 733.780)

836-033-0105 Statutory Authority; Purpose
836-033-0110 "Amply Secured Obligations" Defined
836-033-0120 Purpose and Authority; Definition
836-033-0130 Investments in Medium Grade and Lower Grade Obligations

DIVISION 42

RATES AND RATEMAKING

836-042-0001 Statutory Authority; Purpose and Effective Date
836-042-0005 Definitions
836-042-0015 Workers' Compensation Filings — Procedural Rules for Insurers and Rating Organizations
836-042-0020 Insurers Must Demonstrate Statistical Reporting Ability
836-042-0025 Workers' Compensation Filings Standards for Unfair Discrimination
836-042-0030 Rating Organization Report of Investment Income
836-042-0035 Workers' Compensation Policy Forms Filings by Insurers
836-042-0040 Statutory Authority; Purpose and Effective Date
836-042-0043 Definition
836-042-0045 Uniform Workers' Compensation Statistical Plan
836-042-0050 Statutory Authority; Purpose and Applicability
836-042-0055 Definitions; Payroll Inclusions and Exclusions
836-042-0060 Conditions for Division of Payroll of Individual Employees

Workers' Compensation Large Deductible Provisions

836-042-0070 Statutory Authority and Purpose
836-042-0075 Definitions
836-042-0080 Rate Filing Requirements and Standards
836-042-0085 Statistical Data Maintenance and Reporting Requirements
836-042-0090 Trade Practices Found Injurious to the Insurance-Buying Public
836-042-0201 Statutory Authority; Purpose; Effective Date
836-042-0205 Definitions
836-042-0210 Rating Plans for Which Employers May Be Combined; Retrospective Rating Deposit Required; When Group Rating May Be Applied

Employer Rating Groups

836-042-0215 Consent to Group Rating Required Before Policy Issuance; Provision Required in Consent Form; Contents of Consent Form
836-042-0220 Filing Requirements and Procedural Rules
836-042-0225 Criteria for Grouping; Criteria for Substantially Similar Occupations Within Organization; Open Enrollment Required
836-042-0300 Statutory Authority; Purpose; Applicability; Effective Date
836-042-0302 Definitions
836-042-0304 Fictitious Arrangement Prohibited
836-042-0306 Premium Rates
836-042-0308 Statistics
836-042-0310 Producers
836-042-0312 Compulsory Participation Prohibited
836-042-0314 Tie-In Sales Prohibited
836-042-0316 Disclosure Required
836-042-0318 Underwriting Standards
836-042-0320 Cancellation and Non-Renewal
836-042-0322 Compulsory Facilities
836-042-0400 Statutory Authority; Purpose; Applicability; Effective Date
836-042-0405 Definitions
836-042-0410 Commercial Risks; Prohibition; Requirements; Filing
836-042-0415 Day Care Facilities; Prohibition; Requirements; Filing
836-042-0420 Anniversary Filings
836-042-0425 Statistics
836-042-0430 Disclosure Required for Day Care Facilities

Rates and Ratemaking

836-042-0501 Statutory Authority; Purpose; Applicability; Effective Date
836-042-0505 Definitions
836-042-0510 Rates, Rating Plans System — Prior Review
836-042-0512 Specified Commercial Liability Markets
836-042-0515 Commercial Liability Filings — Procedural Rules for Insurers and Rating Organizations
836-042-0520 Supporting Data

DIVISION 43

RATING AND RATING ORGANIZATIONS (WORKERS' COMPENSATION INSURANCE ASSIGNED RISK PLAN — ORS CHAPTER 737)

836-043-0001 Statutory Authority; Purpose; Applicability
836-043-0005 Definitions for the Workers' Compensation Insurance Plan
836-043-0009 Participation by Insurers and Insurance Producers
836-043-0017 Plan Administrator
836-043-0021 Servicing Carriers
836-043-0024 Right to Apply
836-043-0028 Application by Electronic Transmission or Telephone
836-043-0032 Nonelectronic Application
836-043-0036 Facsimile Transmission
836-043-0037 Operative Dates for Transmission Methods
836-043-0041 Application Review
836-043-0044 Binding Coverage
836-043-0046 Rates and Forms, Policy Term, Additional Coverages and Other Provisions
836-043-0048 Additional States' Coverage
836-043-0050 Interstate Assignments
836-043-0053 Premium Obligations
836-043-0056 Insurer Termination of Guaranty Contracts or Surety Bonds
836-043-0060 Assignment Formula
836-043-0062 Issuance and Continuation of Policy
836-043-0064 Renewal, Nonrenewal
836-043-0066 Reassignment

836-043-0068 Cancellation
836-043-0070 Dispute Resolution Procedure
836-043-0072 Voluntary Coverage
836-043-0076 Takeout Credit
836-043-0079 Notification of Outstanding Premium
836-043-0082 Policyholder Services
836-043-0086 Agent Designation and Compensation
836-043-0089 Confidentiality of Information
836-043-0091 Self-Funded Plan

Rating and Rating Organization Workers' Compensation Premium Audit Program System

836-043-0101 Statutory Authority; Purpose; Applicability
836-043-0105 Definitions
836-043-0110 Insurer Premium Audit Program
836-043-0115 Insurer Audit Procedure Guide
836-043-0120 Minimum Standards of Employer Education Program

Test Audit Program

836-043-0125 Purpose
836-043-0130 Selection of Risks for Test Audit
836-043-0135 Test Audits
836-043-0140 Test Auditor's Reports
836-043-0145 Disposition of Test Audits
836-043-0150 Summary of Test Audit Results
836-043-0155 Test Audit Standards
836-043-0165 Monitoring Audits Program System
836-043-0170 Premium Audit Hearings

Rating and Rating Organization Workers' Compensation Insurance Classification Notice

836-043-0175 Statutory Authority; Purpose; Applicability
836-043-0180 Definitions
836-043-0185 Insurer Classification Notice
836-043-0190 Insurer Reclassification Billings

Rates and Rating Organizations Workers' Compensation Rating System Review and Advisory Committee

836-043-0200 Statutory Authority; Purpose; Applicability
836-043-0210 Definitions
836-043-0220 Committee Participation
836-043-0230 Committee Operating Rules
836-043-0240 Committee Activities

Rating and Rating Organizations

836-043-0300 Qualifications for Workers' Compensation Rating Organizations
836-043-0310 Exchange of Data Among Workers' Compensation Rating Organizations
836-043-0320 Competive Selection Process; Designation of a Workers' Compensation Statistical Agent

DIVISION 50

GENERAL PROVISIONS

Assumption Reinsurance

836-050-0000 Purpose, Statutory Authority and Implementation
836-050-0010 Notice of Transfer
836-050-0020 Notice of Rejection
836-050-0105 Statutory Authority; Purpose; Applicability
836-050-0110 Uniform Claim Forms
836-050-0115 Permitted Modifications to Uniform Forms

Notice of Advance Payment for Death or Personal Injury or Destruction of Property on Running of Period of Limitation

836-050-0150 Advance Payments

Life and Health Insurance Benefit Provisions Relating to HIV Infection

836-050-0200 Purpose, Scope and Definitions
836-050-0205 Authority
836-050-0207 Unfair Trade Practices
836-050-0210 General Exclusions
836-050-0215 Pre-Existing Condition Exclusions; Health Insurance

Application Questions and Underwriting Practice Relating to HIV Infection

836-050-0230 Purpose, Scope and Definitions
836-050-0235 Rulemaking Authority
836-050-0237 Unfair Trade Practices
836-050-0240 General Principles
836-050-0245 Medical and Lifestyle Application Questions and Underwriting Standards
836-050-0250 Testing for HIV Infection
836-050-0255 Inquiries Regarding Past Test Results

Group Policyholders

836-050-0275 Credit Unions as Association; Group Life Insurance
836-050-0280 Credit Unions as Association; Group Health Insurance

DIVISION 51

LIFE, INDIVIDUAL AND GROUP; ANNUITIES

Life Disclosure Requirements

836-051-0005 Statutory Authority; Purpose; Applicability
836-051-0010 Definitions
836-051-0015 Disclosure Requirements
836-051-0020 General Requirements

Mortality Tables Authorized for Use in Determining Non-Forfeiture and Reserve Values

836-051-0101 Statutory Authority; Purpose; Applicability; and Effective Date
836-051-0106 Life Insurance Valuation and Nonforfeiture Standards
836-051-0110 Life Insurance Nonforfeiture Standards for Men and Women
836-051-0115 Smoker/Nonsmoker Mortality Tables

Annuity Mortality Tables

836-051-0200 Authority; Effective Date
836-051-0210 Purpose
836-051-0220 Definitions
836-051-0230 Individual Annuity or Pure Endowment Contracts
836-051-0240 Group Annuity or Pure Endowment Contracts
836-051-0250 Application of the 1994 GAR Table

Accelerated Benefits Provision for Life Products

836-051-0300 Statutory Authority; Effective Date; Applicability
836-051-0310 Acknowledgement of Concurrence for Payout from Assignee or Beneficiary
836-051-0320 Payment Options; Filing of Claims; Remaining Benefits
836-051-0330 Disclosure
836-051-0340 Exercise of the Accelerated Benefit
836-051-0350 Waiver of Premiums
836-051-0360 Discrimination
836-051-0370 Minimum Benefit Standards
836-051-0380 Actuarial Disclosure and Reserves

Life Insurance Illustrations

836-051-0500 Purpose; Authority

836-051-0510 Applicability and Scope
836-051-0520 Definitions
836-051-0530 Policies to Be Illustrated
836-051-0540 General Rules and Prohibitions
836-051-0550 Standards for Basic Illustrations
836-051-0560 Standards for Supplemental Illustrations
836-051-0570 Delivery of Illustration and Record Retention
836-051-0580 Annual Report; Notice to Policy Owners
836-051-0590 Annual Certifications
836-051-0600 Trade Practice Regulation

Authorization, Genetic Testing

836-051-0700 Authorization, Genetic Testing

DIVISION 52

INSURANCE POLICIES

Medicare Supplement Insurance

836-052-0103 Purpose
836-052-0107 Authority
836-052-0114 Applicability and Scope
836-052-0119 Definitions
836-052-0124 Policy Definitions and Terms
836-052-0129 Policy Provisions
836-052-0133 Benefit Standards for Policies or Certificates Issued for Delivery on or After July 1, 1992
836-052-0134 Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 1, 1992
836-052-0136 Standard Medicare Supplement Benefit Plans
836-052-0138 Open Enrollment
836-052-0139 Medicare Select Policies and Certificates
836-052-0140 Standards for Claims Payment
836-052-0142 Guaranteed Issue for Eligible Persons
836-052-0145 Loss Ratio Standards and Refund or Credit of Premium
836-052-0151 Filing and Approval of Policies and Certificates and Premium Rates
836-052-0156 Permitted Compensation Arrangements
836-052-0160 Required Disclosure Provisions
836-052-0165 Requirements for Application Forms, Replacement Coverage
836-052-0170 Filing Requirements for Advertising
836-052-0175 Standards for Marketing
836-052-0180 Appropriateness of Recommended Purchase and Excessive Insurance
836-052-0185 Reporting of Multiple Policies
836-052-0190 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies and Certificates
836-052-0194 Separability

Long Term Care Insurance
General Terms

836-052-0500 Statutory Authority; Applicability

Long Term Care Insurance Policy Terms

836-052-0516 Policy Definitions
836-052-0526 Policy Practices and Provisions
836-052-0536 Unintentional Lapse
836-052-0546 Required Policy Provisions
836-052-0556 Required Disclosure of Rating Practices to Consumers

Long Term Care Insurance Practices

836-052-0566 Initial Rate Filing Requirements
836-052-0576 Prohibition Against Post-Claims Underwriting, Applications

Long Term Care Insurance
Benefits and Service Standards

836-052-0586 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies
836-052-0596 Standards for Covered Services
836-052-0606 Use and Definition of "Home" or Similar Wording
836-052-0616 Requirement to Offer Inflation Protection
836-052-0626 Requirements for Application Forms and Replacement Coverage
836-052-0636 Reporting Requirements
836-052-0646 Benefits Provided Through Advancement of Life Insurance Proceeds
836-052-0656 Reserve Standards

Long Term Care Insurance
Loss Ratio, Rate Filings

836-052-0666 Loss Ratio
836-052-0676 Premium Rate Schedule Increases
836-052-0686 Filing Requirements for Out-of-State Group Policies

Long Term Care Insurance Sales

836-052-0696 Filing Requirements for Advertising
836-052-0700 Physician Credentialing, Health Care Service Contractors
836-052-0706 Standards for Marketing
836-052-0716 Disclosure Statement
836-052-0726 Suitability
836-052-0736 Prohibition Against Preexisting Conditions, Waiting Periods and Probationary Periods in Replacement Policies and Certificates

Long Term Care Insurance
Nonforfeiture Benefit; Benefit Triggers

836-052-0746 Nonforfeiture Benefit Requirement
836-052-0756 Standards for Benefit Triggers
836-052-0766 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

Long Term Care Insurance
Outline of Coverage and Shopper's Guide

836-052-0776 Standard Format Outline of Coverage
836-052-0786 Requirement to Deliver Shopper's Guide

Notice of Termination of Group Health Insurance

836-052-0800 Purpose; Applicability
836-052-0810 Replacement Upon Termination
836-052-0830 Notice by Replacing Insurer
836-052-0840 Termination of Coverage
836-052-0850 Multiple Employer Trusts
836-052-0860 Form of Notice to Group Policyholder

DIVISION 53

HEALTH BENEFIT PLANS

836-053-0001 Modification of a Health Benefit Plan
836-053-0003 Prohibition of Exclusion Period for Pregnancy
836-053-0005 Prescription Drug Identification Cards
836-053-0010 Purpose; Statutory Authority; Enforcement
836-053-0016 Categories of Small Employers
836-053-0021 Plans Offered to Oregon Small Employers
836-053-0026 Plans Offers to HIPAA Small Employers
836-053-0030 Marketing
836-053-0040 Underwriting
836-053-0050 Trade Practices
836-053-0060 Benefit Design
836-053-0065 Rating
836-053-0070 Multiple Employer Welfare Arrangements

Group Health Benefit Plans (Other than Small Employer Plans)

836-053-0210 Purpose; Statutory Authority; Enforcement
836-053-0220 Definitions
836-053-0230 Underwriting
836-053-0250 Benefit Design

Individual Health Benefit Plans

836-053-0410 Purpose; Statutory Authority; Enforcement
836-053-0430 Marketing
836-053-0440 Underwriting
836-053-0460 Benefit Design
836-053-0465 Rating

Oregon Standard Health Statement

836-053-0510 Oregon Standard Health Statement

Portability Health Benefit Plans

836-053-0700 Statutory Authority, Implementation; Enforcement
836-053-0710 Purpose
836-053-0750 Notification
836-053-0760 Portability Plans Benefit Matrix
836-053-0780 Rating
836-053-0785 Eligible Individuals
836-053-0790 Underwriting
836-053-0800 Trade Practices

Quality Assessment and Improvement

836-053-0900 Purpose; Statutory Authority
836-053-0910 Rate Filing
836-053-1000 Statutory Authority and Implementation
836-053-1010 Insurer Policies
836-053-1020 Drug Formularies
836-053-1030 Written Information to Enrollees
836-053-1040 Information Available Upon Request
836-053-1060 Definitions
836-053-1070 Reporting Grievance; Format and Contents
836-053-1080 Tracking Grievances
836-053-1090 Assistance in Filing Grievances
836-053-1100 Time Requirements for Grievance Review
836-053-1110 Notice of Complaint Filing with Director
836-053-1130 Annual Summary, Utilization Review
836-053-1140 Appeal, Utilization Determination Review
836-053-1170 Annual Summary, Quality Assessment Activities
836-053-1190 Annual Summary, Uniform Indicators of Network Adequacy
836-053-1200 Prior Authorization Requirements

Independent Review

836-053-1300 Purpose and Scope; Application
836-053-1305 Definitions; Authority to Act for Enrollee
836-053-1310 Contracting Requirements
836-053-1315 Performance Criteria
836-053-1317 Professional Qualifications
836-053-1320 Conflict of Interest
836-053-1325 Procedures for Conducting Independent Reviews
836-053-1330 Criteria and Considerations for Independent Review Determinations
836-053-1335 Procedures for Complaint Investigation
836-053-1337 Preliminary Review by Insurer
836-053-1340 Timelines and Notice for Dispute That is Not Expedited
836-053-1342 Timelines and Notice for Expedited Decision-Making
836-053-1345 Quality Assurance Mechanisms
836-053-1350 Ongoing Requirements for Independent Review Organizations
836-053-1355 Synopses
836-053-1360 Independent Review Reporting
836-053-1365 Fees for Independent Reviews

Annual Reporting Requirements

836-053-1400 Format and instructions for Report Required by Ch. 765, Oregon Laws 2005
836-053-1404 Definitions; noncontracting providers; co-morbidity disorders
836-053-1405 General Requirements for Coverage of Mental or Nervous Conditions and Chemical Dependency

DIVISION 54

INSURANCE POLICIES

Motor Vehicle Liability Insurance

836-054-0000 Election of Lower Limits for Uninsured Motorist Coverage

Property and Casualty Professional Negligence

836-054-0050 Statutory Authority; and Purpose
836-054-0055 Definitions
836-054-0060 Professional Liability Reports from Insurers
836-054-0065 Report Content — Professional Liability Claim Information

Workers' Compensation Large Deductible Provisions

836-054-0201 Statutory Authority and Purpose
836-054-0205 Definitions
836-054-0210 Required Content of Large Deductible Provisions

Mortgage Insurance

836-054-0300 Loan to Value

DIVISION 58

MOTOR VEHICLE LIABILITY INSURANCE

836-058-0010 Permitted Reasons to Exclude Named Person
836-058-0020 Exclusion from Excess Coverage

DIVISION 60

INSURANCE POLICIES (ORS Chapter 743)

Credit Life and Credit Health Insurance

836-060-0000 Statutory Authority; Purpose; Effective Date
836-060-0005 Definitions
836-060-0011 Rights and Treatment of Debtors
836-060-0016 Policy Forms and Related Material
836-060-0021 Determination of Reasonableness of Benefits in Relation to Premium Charge
836-060-0026 Credit Life Insurance Rates
836-060-0027 Credit Life Reserves
836-060-0031 Credit Health Insurance Rates
836-060-0036 Refund Formulas
836-060-0041 Experience Reports
836-060-0043 Use of Rates — Direct Business Only
836-060-0046 Supervision of Credit Insurance Operations
836-060-0055 Prohibited Transactions
836-060-0060 Disclosure

DIVISION 62

VENDOR'S SINGLE INTEREST POLICIES AND MOTOR VEHICLE PHYSICAL DAMAGE ONLY POLICIES

836-062-0001 Statutory Authority; Effective Date
836-062-0005 Motor Vehicle Physical Damage Only Policies; Required Notice
836-062-0010 Vendor Single Interest Policies; Required Notice

DIVISION 71

INSURANCE LICENSING

Insurance Producers, Adjusters and Insurance Consultants

836-071-0101 Adjuster and Insurance Consultant License Application; Required Information
836-071-0105 Additional Application Information
836-071-0108 Limited Class Insurance Licenses
836-071-0110 Fingerprints
836-071-0112 Social Security Numbers; Insurance Producer Applications
836-071-0115 Satisfaction of Qualifications for Classes of Insurance
836-071-0117 Managing General Agents; Amount of Claims Adjustment or Payment for Purposes of Statutory Definition
836-071-0120 Examination Procedure
836-071-0125 Period for Completion of License Application
836-071-0127 Examination Scores
836-071-0130 Adjuster or Insurance Consultant License Renewal
836-071-0135 Renewal of Expired Adjuster or Insurance Consultant License
836-071-0140 License Amendment
836-071-0145 Amended License Issuance
836-071-0148 Extended License Expiration Date, Agents Called into Active Military Duty
836-071-0150 Errors and Omissions Insurance; Insurance Consultants; Managing General Agents
836-071-0160 Errors and Omissions Insurance; Reinsurance Intermediary Managers

Training and Examinations

836-071-0180 Insurance Producer Pre-Examination Requirements
836-071-0185 Qualification of Agents Selling Variable Life Insurance, Including Annuities
836-071-0190 Registration of a School
836-071-0195 Revocation of Registration of a School; Reinstatement

Continuing Education

836-071-0210 Statutory Authority; Purpose
836-071-0215 Continuing Education Requirements for Insurance Producers; Hours; Credit for Experience and Coursework
836-071-0220 Continuing Education; Documentation
836-071-0225 Continuing Education; Standard for Granting Credit Hours
836-071-0230 Continuing Education; Course Qualification Guidelines
836-071-0235 Provider Registration
836-071-0240 Course Registration
836-071-0242 Provider Trade Practices
836-071-0245 Revocation of Provider Registration
836-071-0247 Requirements for Granting Credit; Attendance Records
836-071-0250 Credit for Unregistered Courses

Fees and Disclosure; Incidental Charges

836-071-0260 Fees Charged by Insurance Producers
836-071-0263 Fees Charged by Insurance Consultants or Insurance Producers
836-071-0267 Incidental Charges for Customer Services; Personal, Commercial Lines

Insurance Producer Service Fees

836-071-0269 Purpose and Authority
836-071-0272 Scope of OAR 836-071-0269 to 836-071-0277; Definitions
836-071-0274 Service Fees Prohibited on Personal Lines
836-071-0277 Service Fees Allowed on Commercial Lines; Conditions

Regulation Generally

836-071-0280 Permitted and Prohibited Activities of Insurance Personnel Exempt from Insurance Producer License Requirement
836-071-0285 Agent Review of Applications
836-071-0287 Transaction of Group Life, Health Insurance by Insurance Producer without Appointment
836-071-0291 Certificate of Deposit in Lieu of Trust Account
836-071-0295 Transaction of Insurance by Individual Insurance Producer for Appointed Firm or CorporateInsurance Producer
836-071-0297 Permitted Transaction of Insurance by Unappointed Insurance Producer
836-071-0300 Requirement of Contract with or Employment of Licensee
836-071-0310 Referral Fee from Oregon Medical Insurance Pool
836-071-0315 Managing General Agents; Dollar Amounts Governing Settlement Authority Procedures Under Contract with Insurer
836-071-0320 Managing General Agents; Designation of Associations of Actuaries
836-071-0321 Terms for OAR 836-071-0323 to 836-071-0346
836-071-0323 License Applicants and Licensees with Prior Convictions
836-071-0326 Application by Person under OAR 836-071-0323
836-071-0328 Unlicensed Individuals with Prior Convictions Who are Engaged or Participate in Business of Insurance
836-071-0331 Director's Procedures, Application for Consent
836-071-0336 Factors to be Considered by the Director
836-071-0341 Issuance of Written Consent
836-071-0346 Denial of Consent
836-071-0351 Subsequent Conviction of Person Previously Granted Written Consent

Limited License, Rental Companies

836-071-0355 Limited License Application, Rental Companies; Required Information
836-071-0360 License Renewal
836-071-0370 List of Employees Selling Coverage; Continuing Education
836-071-0380 Course of Training for Training Program and for Continuing Education
836-071-0390 Statewide Filing Officer
836-071-0400 Applicable Insurance Code Statutes

Surplus Lines

836-071-0500 Licensing and Filing Requirements

DIVISION 74

INSURANCE DIVISION TRUST ACCOUNTS

836-074-0005 Statutory Authority; Effective Date
836-074-0010 Definitions
836-074-0015 Director's Enforcement Authority
836-074-0017 Exemptions
836-074-0020 Premium Funds Trust Account
836-074-0025 Deposit and Payment of Funds
836-074-0030 Advancing Return Premiums
836-074-0035 Other Permissible Funds
836-074-0040 Interest on Trust Funds
836-074-0045 Accounting Records; Inspection
836-074-0047 Examinations and Audits
836-074-0048 Other Trust Account Requirements
836-074-0050 Single Account for Affiliated Persons

DIVISION 75

THIRD PARTY ADMINISTRATORS

836-075-0000 Third Party Administrators; License Application; Required Information
836-075-0010 Completion of Application
836-075-0020 Amendment of License Application Information
836-075-0030 Third Party Administrator License Renewal
836-075-0040 Annual Report Requirements
836-075-0050 Exemptions from Third Party Administrator License Requirements
836-075-0060 ERISA Exemption Registration
836-075-0070 Errors and Omissions Insurance; Third Party Administrators

DIVISION 80

TRADE PRACTICES

Replacement of Life Insurance and Annuities

836-080-0001 Statutory Authority; Purpose; Applicability
836-080-0005 Definitions
836-080-0014 Duties of Agent
836-080-0022 Duties of Insurers that Use Agents Insurance Producers
836-080-0029 Duties of Replacing Insurers that Use Agents
836-080-0034 Duties of the Existing Insurer
836-080-0039 Duties of Insurers with Respect to Direct Response Solicitations
836-080-0043 Violations and Penalties

Unfair Discrimination Based on Sex or Marital Status

836-080-0050 Authority; Purpose and Scope
836-080-0055 Unfair Discrimination Identified

Payment of Health Insurance Claims (Sampling Method)

836-080-0080 Definition, Claims Handling Services; Claims Procedures and Information
836-080-0085 Annual Report; Sampling

Suitability

836-080-0090 Suitability in the Sale of Life Insurance and Annuities

Trade Practices (ORS Chapter 746)

General (ORS 746.005 to 746.270)

836-080-0105 Statutory Authority; Purpose; Effective Date
836-080-0110 Applicability
836-080-0115 Definitions
836-080-0120 Statement as to Participation Required Upon Request Before Delivery of Policy; Provision Required in Participating Policy; Contents of Provision
836-080-0125 Prohibited Representations Regarding Participation Rights
836-080-0130 Dividend Statement Permitted; Required to Be Written; Prohibited and Permitted Advice
836-080-0135 Dividend Rights Accrue Upon Declaration of Dividends; Contents of Dividend Declaration Resolution
836-080-0140 Unfair Discrimination in Allocation of Dividends Prohibited; Criteria for Allocation; Prima Facie Evidence of Unfair Discrimination
836-080-0145 Unfair Forfeiture of Dividend for Failure to Renew Prohibited
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
836-080-0155 False or Deceptive Publications by Insurer Prohibited
836-080-0205 Statutory Authority; Purpose; Applicability
836-080-0210 Definitions
836-080-0215 Claim Files
836-080-0220 Misrepresentation and Other Prohibited Claim Practices
836-080-0225 Required Claim Communication Practices
836-080-0230 Standard for Prompt Claim Investigation
836-080-0235 Standards for Prompt and Fair Settlements — Generally
836-080-0240 Standards for Prompt and Fair Settlements — Automobile Insurance
836-080-0250 Workers' Compensation Insurance Unfair Claim Settlement Practices Standards
836-080-0305 Statutory Authority; Purpose; Applicability
836-080-0310 Definitions
836-080-0315 Providing Things of Value to Intermediaries Generally Prohibited
836-080-0320 Miscellaneous Things of Value
836-080-0325 Business Development Activities
836-080-0335 Gifts
836-080-0337 Real Property Information
836-080-0340 Assistance in Qualifying a Subdivisions
836-080-0345 Automatic Change in Monetary Limits
836-080-0355 Title Insurer Responsible for Violations by Agent
836-080-0360 Use by Title Company of an Intermediary's Office
836-080-0365 Filing Escrow Rates Required
836-080-0370 Instruction of Title Company Employees About Rules Required

Use of Insurance Scores and Credit History

836-080-0425 Applicability; Definitions
836-080-0430 Disclosure of Use of Credit History or Insurance Scores
836-080-0435 Policies Governing Credit Histories and Insurance Scores
836-080-0436 Absence of or Inability to Determine Credit History; Relation to Risk to Insurer
836-080-0438 Definition of Adverse Underwriting Decision; Notice
836-080-0440 Unfair Insurance Trade Practice

Privacy of Personal Information (ORS 746.600 to 746.690)

836-080-0501 Authority; Rule of Construction; Applicability
836-080-0506 Definitions and Examples
836-080-0511 Application of Notice Requirements
836-080-0516 Initial Notice to Consumers
836-080-0519 Information To Be Included In Privacy Notices
836-080-0523 Annual Notice
836-080-0526 Information to be Included in Annual Notice
836-080-0531 Revised Privacy Notices
836-080-0536 Delivery
836-080-0541 Opt In Notice; Form of Opt Out Notice to Consumers and Opt Out Methods for Purpose of ORS 746.665(1)(k)
836-080-0546 Limits on Sharing Account Number Information for Marketing Purposes
836-080-0551 Authorization Request Delivery

Privacy of Health Insurance-Related Information

Generally

836-080-0600 Authority; Rule of Construction; Applicability
836-080-0610 Definitions and Examples

Notice of Information Practices

836-080-0615 Personal Information Notice
836-080-0620 Notice of Personal Financial Information Practices
836-080-0625 Alternative Procedures
836-080-0630 Application of Notice Requirements

836-080-0635 Initial Notice to Consumers
836-080-0640 Information to Be Included in Initial Privacy Notice
836-080-0645 Annual Notice
836-080-0650 Information to Be Included in Annual Notice
836-080-0655 Revised Privacy Notices
836-080-0660 Delivery

Disclosure of Personal, Privileged Information

836-080-0665 Authorization
836-080-0670 Authorization Exemptions
836-080-0675 Disclosure Without Authorization
836-080-0680 Opt in Notice; Form of Opt Out Notice to Consumers and Opt Out Methods for Purpose of OAR 836-080-0675
836-080-0685 Limits on Sharing Account Number Information for Marketing Purposes
836-080-0690 Authorization Request Delivery
836-080-0695 Access to Recorded Personal Information
836-080-0700 Correction, Amendment or Deletion of Recorded Personal Information

DIVISION 81

TRADE PRACTICES — GENERAL PROVISIONS

836-081-0005 Statutory Authority; Purpose; Definitions
836-081-0010 Unfair Discrimination — Insurance Other Than Life or Health Insurance

Unfair Discrimination on the Basis of Blindness or Partial Blindness

836-081-0020 Statutory Authority; Purpose; Applicability
836-081-0030 Unfair Discrimination Acts or Practices

Standards for Safeguarding Customer Information

836-081-0101 Purpose, Policy, Authority and Effective Date
836-081-0106 Definitions
836-081-0111 Information Security Program
836-081-0116 Objectives of Information Security Program
836-081-0121 Examples of Methods of Development and Implementation
836-081-0126 Unfair Insurance Trade Practice

DIVISION 82

DISCONTINUANCE AND REPLACEMENT OF GROUP COVERAGE

836-082-0050 Statutory Authority
836-082-0055 Continuance of Group Health Insurance Coverage in Situations Involving Replacement

DIVISION 85

PRACTICES INJURIOUS TO PUBLIC OR FREE COMPETITION

Midterm Cancellation, Midterm Premium Increases, and Nonrenewal Notice

836-085-0001 Statutory Authority; Purpose; Applicability
836-085-0005 Definitions
836-085-0010 Midterm Cancellation
836-085-0011 Hearing on Cancellation
836-085-0015 Longterm Cancellation
836-085-0025 Renewal with Altered Terms
836-085-0035 Cancellation or Nonrenewal Notice
836-085-0040 Cancellation for Nonpayment of Premium
836-085-0045 Unfair Trade Practices
836-085-0050 Proof of Notice
836-085-0055 Cancellation of Commercial Package Policies

Practices Injurious to Public or Free Competition

836-085-0201 Statutory Authority; Purpose; Applicability
836-085-0205 Definitions
836-085-0210 Adjustment for Experience of Employer; Calculation of Tentative Modification Factors
836-085-0215 Insurer Implementation of Employer Experience Rating Modifications
836-085-0217 Employer Failure to Cooperate; Appeal
836-085-0225 Unfair Trade Practices
836-085-0230 Penalties for Late Submission of Rating Data

DIVISION 200

DEPARTMENT REGULATORY PROGRAMS

Service Contracts

836-200-0000 Statutory Authority; Registration; Fees; Expiration; Renewal
836-200-0010 Assessments
836-200-0020 Filing Procedures
836-200-0030 Form 10K and Other Financial Stability Filings
836-200-0040 Reimbursement Insurance Policy
836-200-0050 Registration Requirements Not Exclusive
836-200-0055 Annual Report
836-200-0060 Service on Registrant
836-200-0100 Notice, Collision Damage Waivers

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 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 731
Stats. Implemented: ORS 731.052 et seq. & 731.244
Hist.: IC 65, f. & ef. 4-20-76

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 Director of the Department of Consumer and Business Services will give prior notice of the proposed adoption, amendment, or repeal of an administrative rule by the Insurance Division:

(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 Director's mailing list established by the Insurance Division 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 Association of Insurance and Financial Advisors;
(d) National Association of Independent Insurers;
(e) American Insurance Association;
(f) Alliance of American Insurers;
(g) American Council of Life Insurers;
(h) America's Health Insurance Plans;
(i) Professional Insurance Agents of Oregon/Idaho;
(j) Oregon Association of Health Underwriters;
(k) Reinsurance Association of America;
(L) Insurance Information Institute;
(m) National Council on Compensation Insurance; and
(n) 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; ID 19-2006, f. & cert. ef. 9-26-06

836-005-0107
Model Rules of Procedure Governing Rulemaking

The Model Rules of Procedure, OAR 137-001-0005 to 137-005-0070, in effect on January 1, 2006, as promulgated by the Attorney General of the State of Oregon under the Administrative Procedures Act, are adopted as the rules of procedure for the Insurance Division.

[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 - 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; ID 7-1998, f. & cert. ef. 4-15-98; ID 10-2000, f. & cert. ef. 11-3-00; ID 3-2002, f. & cert. ef. 1-24-02; ID 3-2004, f. & cert. ef. 5-7-04; ID 8-2006, f. & cert. ef. 4-27-06

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 821
Stats. Implemented: ORS 183.457(1)(d) & 183.457(2)(b)
Hist.: IC 6-1988, f. & cert. ef. 3-30-88

836-005-0400
Annual Complaint Report

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 that were closed by the Department of Consumer and Business Services during the reporting period. The report shall be based on the records of the Department of Consumer and Business Services. The report shall be structured as a cross tabulation of complaints closed during the reporting period, by complaint type and disposition, against each insurer with respect to whom one or more complaints were closed during the period for which the report is made.

Stat. Auth.: ORS 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; ID 19-2006, f. & cert. ef. 9-26-06

DIVISION 6

TAXATION

836-006-0010
Payment of Transition and Retaliatory Taxes

(1) An insurer shall pay to the Director on April 1 of each year the 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, 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 & Ch. 786(2), OL 1995
Hist.: ID 13-1997, f. & cert. ef. 10-14-97; ID 19-2006, f. & cert. ef. 9-26-06

836-006-0021
Allocation of Consolidated Excise Tax for Purpose of Offsetting Retaliatory Taxes

(1) When the excise tax owing by a consolidated group pursuant to ORS 317.710 and 317.715 is determined, the share of the excise tax attributable to the member domestic insurer shall be established as provided in this rule for the purpose of allocating shares of the tax to member foreign insurers in order to calculate retaliatory taxes owing under ORS 731.854.

(2) The consolidated group excise tax shall be allocated to the domestic insurer in the proportion that the domestic insurer's Oregon

direct premiums written, wages and commissions, and real estate income bear to the total Oregon direct premiums written, wages and commissions, and real estate income for the consolidated group.

Stat. Auth.: ORS 731.244 & 731.854
Stats. Implemented: ORS 731.854 & 731.859
Hist.: ID 15-1998, f. & cert. ef. 9-25-98

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 $2,500. 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 $1,500;

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

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

(a) Examination fees:

(A) Insurance producer, property and casualty insurance or life and health insurance — $80;

(B) Insurance producer, property insurance only, casualty insurance only, personal lines insurance only, life insurance only or health insurance only — $70;

(C) Surplus lines licensee — $70;

(D) Adjuster, general lines insurance or life and health insurance — $80;

(E) Adjuster, health insurance or any single other line designated by rule — $70;

(F) Consultant, life and health insurance or general lines insurance — $80;

(G) Consultant, life insurance only, health insurance only or any other single line designated by rule — $70.

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

(A) Insurance producer, property and casualty insurance or life and health insurance — $80;

(B) Insurance producer, property insurance only, casualty insurance only, personal lines insurance only, life insurance only or health insurance only — $70;

(C) Surplus lines licensee — $70;

(D) Adjuster, general lines insurance or life and health insurance — $80;

(E) Adjuster, health insurance or any single other line designated by rule — $70;

(F) Consultant, life and health insurance or general lines insurance — $80;

(G) Consultant, life insurance only, health insurance only or any other single line designated by rule — $70.

(c) For purposes of the fees charged under subsections (a) and (b) of this section:

(A) Surety is included in the casualty insurance line and marine and transportation insurance may be included in the property insurance line or the casualty insurance line; and

(B) The personal lines line is a subcategory of the casualty insurance line. Consequently, a person who holds a license that is endorsed to transact casualty insurance need not obtain a separate endorsement to transact personal lines insurance.

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

(a) Resident insurance producer — $30;

(b) Nonresident insurance producer — $30;

(c) Adjuster — $30;

(d) Insurance consultant — $30.

(4) The following fees apply to issuance of licenses for insurance producers, adjusters and insurance consultants:

(a) Resident insurance producer — $45;

(b) Nonresident insurance producer — $45;

(c) Adjuster — $45;

(d) Insurance consultant — $45.

(5) The examination fee under section (2) of this rule must be paid to the examination vendor. The application fee under section (3) of this rule and the license issuance fee under section (4) of this rule must be paid at the same time. There is no refund of the application and examination fees. Refund of the license issuance fee is governed by section (14) of this rule.

(6) The fees established in this section apply to the renewal of licenses for insurance producers, adjusters and insurance consultants. A license shall expire on the last day of the month in which the second anniversary of the initial issuance date occurs, and on the second anniversary following each renewal thereafter. The fees are as follows:

(a) Resident insurance producer — $45;

(b) Nonresident insurance producer — $45;

(c) Adjuster — $45;

(d) Insurance consultant — $45.

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

(8) 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.

(9) 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.

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

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

(12) The fee for filing a statement by an acquiring party under ORS 732.521 for the purpose of acquiring a controlling interest in an insurer (a "Form A" filing as prescribed in OAR 836-027-0100) is $50 per hour of Division staff time spent on reviewing the statement, with a minimum fee of $5,000.

(13) 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.

(14) Fees paid as required under this rule are not refundable except as provided in this section. 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. A fee paid for a license under section (4) of this rule is refundable if the license applicant fails the examination or if the license is otherwise not issued to the applicant.

(15) The amendments to section (2)(a), (b) and (d) of this rule that were filed in ID 15-2002 with the Secretary of State on June 26, 2002 to become effective on July 1, 2002, are re-adopted with the operative date of July 1, 2002, and those same amendments to section (2)(a) and (b) of this rule are repealed effective July 1, 2003.

Stat. Auth.: ORS 293.445, 731.244, 731.804 & 744.037
Stats. Implemented: ORS 731.804, 744.001, 744.002, 744.004, 744.007, 744.066, 744.069, 744.075, 744.528, 744.531, 744.535, 744.619 & 744.621
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; ID 16-1997, f. 11-25-97, cert. ef. 1-1-98; ID 6-1999, f. 12-13-99, cert. ef. 1-1-00; ID 14-2000, f. 12-27-00, cert. ef. 1-1-01; ID 13-2001, f. 11-16-01, cert. ef. 1-1-02; ID 15-2002, f. 6-26-02, cert. ef. 7-1-02; ID 4-2003(Temp), f. 6-30-03, cert. ef. 7-1-03 thru 12-19-03; ID 8-2003, f. 12-12-03, cert. ef. 12-19-03; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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) Billings of annual assessments shall be issued not later than October 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 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; ID 6-2006, f. & cert. ef. 4-14-06

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 representative 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 293 & 731
Stats. Implemented: ORS 293.445(4)
Hist.: ID 8-1989, f. & cert. ef. 8-11-89

DIVISION 10

GENERAL PROVISIONS

Rates and Forms Filing

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 May 1, 2002.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.296, 737.205, 737.207, 742.001, 743.015 & 743.018
Hist.: ID 9-1994, f. 7-1-94, cert. ef. 7-15-94; ID 20-1997(Temp), f. 12-29-97, cert. ef. 12-30-97 thru 6-11-98; ID 11-1998, f. & cert. ef. 8-10-98; ID 11-2002(Temp), f. & cert. ef. 4-18-02 thru 10-11-02; ID 20-2002, f. 10-11-02, cert. ef. 10-12-02

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, multiple employer welfare arrangements as governed by ORS 750.301 to 750.431 and fraternal benefit societies as governed by ORS Chapter 748. This rule does not apply to:

(a) Purchasing group insurance filings; or

(b) Negotiated forms as described in ORS 742.003, but only if each of the negotiated forms is issued only to one policyholder, the insurer has determined that the forms comply with benefits and coverages mandated by statute and the forms have a company-assigned form number.

(2) An insurer must follow the applicable standards set forth on the Oregon Insurance Division's website, http://www.oregoninsurance.org/doc/rateform.htm, when making rate and form filings, except that if the insurer files electronically on SERFF (System for Electronic Rates and Forms Filing), the insurer must comply with the Oregon standards set forth in SERFF.

(3) An insurer must submit a completed certificate of compliance 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 certificate of compliance in **Exhibit 1** to this rule. The certificate of compliance must certify compliance with the applicable filing require-

ments and product standards set forth on the Oregon Insurance Division's website, http://www.oregoninsurance.org/docs/serff/filing_requirements.htm, or on the SERFF system for Oregon, if filed electronically. The certificate must be accompanied by the applicable product standards form. A certificate of compliance must be completed and signed by:

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

(b) Signed by the filer who is specifically designated by the insurer to prepare and make the filing.

(4) An insurer filing changes to a form or forms that were previously approved must highlight or otherwise visually call attention to the changes in new or revised forms and must submit a letter explaining the changes.

(5) A filing received for prior approval by the Department that does not contain a certificate of compliance and does not comply with the standards referenced in this rule is incomplete and will be returned to the insurer as disapproved.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 731.244 & 731.296

Stats. Implemented: ORS 731.296, 737.205, 737.207, 742.001, 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; ID 20-1997(Temp), f. 12-29-97, cert. ef. 12-30-97 thru 6-11-98; ID 11-1998, f. & cert. ef. 8-10-98; Administrative correction 6-25-99; ID 6-2000, f. & cert. ef. 7-19-00; ID 3-2001, f. 3-19-01, cert. ef. 5-1-01; ID 11-2002(Temp), f. & cert. ef. 4-18-02 thru 10-11-02; ID 20-2002, f. 10-11-02, cert. ef. 10-12-02

836-010-0021
Required Actuarial Data

(1) An insurer shall file with the Director, on or before March 15 of each year, geographic average rates for small employer, portability and individual health benefit plans for a rating period. The supporting actuarial data must be submitted with the certificate of compliance. The geographic average rates must demonstrate compliance with the applicable provisions of:

(a) ORS 743.737, governing small employer premium rates;

(b) ORS 743.760, governing portability premiums rates; and

(c) ORS 743.767, governing individual premium rates.

(2) Except as provided in this section, supporting actuarial data shall accompany every filing of property or casualty insurance rates submitted on a file and use basis under ORS 737.205 and prior approved rates under ORS 737.207. 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 section 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; and

(f) Purchasing group insurance filings.

(3) A rate filing for commercial liability insurance received by the Department that is subject to ORS 737.207 and does not comply with the requirement of section (2) of this rule is in noncompliance with the requirements and standards of ORS Chapter 737.

Stat. Auth.: ORS 731.244

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

Hist.: ID 9-1994, f. 7-1-94, cert. ef. 7-15-94; ID 20-1997(Temp), f. 12-29-97, cert. ef. 12-30-97 thru 6-11-98; ID 11-1998, f. & cert. ef. 8-10-98; Administrative correction, 6-25-99; ID 12-2000 f. 11-14-00, cert. ef. 1-1-01; ID 13-2000(Temp), f. & cert. ef. 12-21-00 thru 6-9-01; Administrative correction 11-20-01; ID 11-2002(Temp), f. & cert. ef. 4-18-02 thru 10-11-02; ID 20-2002, f. 10-11-02, cert. ef. 10-12-02

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 836-010-0145 applies to all authorized title insurers.

Stat. Auth.: ORS 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 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 731
Stats. Implemented: ORS 731.438
Hist.: IC 1-1978, f. 3-27-78, ef. 4-1-78

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:

(a) For the 2005 reporting year on the annual statement blank approved for the 2005 reporting year by the National Association of Insurance Commissioners, for the type or types of insurance transacted by the insurer.

(b) For the 2006 reporting year on the annual statement blank approved for the 2006 reporting year by the National Association of Insurance Commissioners, 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 under section (1) of this rule as follows:

(a) For the 2005 reporting year, according to the applicable instructions published for that year by the National Association of Insurance Commissioners, for completing the blank, as required by ORS 731.574.

(b) For the 2006 reporting year, according to the applicable instructions published for that year by the National Association of Insurance Commissioners, for completing the blank, as required by ORS 731.574.

(3) Every authorized insurer, including every health care service contractor, shall file each annual statement supplement as follows:

(a) For the 2005 reporting year, as required by the applicable instructions published for that year by the National Association of Insurance Commissioners, and shall complete the supplement according to those instructions.

(b) For the 2006 reporting year, as required by the applicable instructions published for that year by the National Association of Insurance Commissioners, and shall complete the supplement according to those instructions.

(4) This rule is adopted under the authority of ORS 731.244, 731.574 and 733.210 for the purpose of implementing ORS 731.574 and 733.210.

Stat. Auth.: ORS 731.244, 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; ID 16-1998, f. & cert. ef. 11-10-98; ID 5-1999, f. & cert. ef. 11-18-99; ID 1-2001, f. & cert. ef. 2-7-01; ID 4-2002, f. & cert. ef. 1-30-02; ID 6-2003, f. & cert. ef. 12-3-03; ID 1-2006, f. & cert. ef. 1-23-06

Annual Audited 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. The purpose of OAR 836-011-0100 to 836-011-0230 is to improve the Director's surveillance of the financial condition of insurers by requiring an annual examination by independent certified public accountants of the financial statements reporting the financial position and the results of operations of insurers.

(2) 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; ID 22-2002, f. & cert. ef. 11-27-02

836-011-0110
Definition of Independent Certified Public Accountant

As used in OAR 836-011-0100 to 836-011-0230:

(1) "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.

(2) "Audited financial report" means a report that includes the items specified in OAR 836-011-0140.

Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(c)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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 include sufficient detail to permit the Director to make an informed decision.

(4) The requirements under section (1) of this rule are 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; ID 22-2002, f. & cert. ef. 11-27-02

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. Not later than the 10th day after denial of an insurer's written request for an exemption under this section, the insurer may request in writing a hearing on its application for an exemption.

Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(h)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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 be those required by the appropriate National Association of Insurance Commissioners (NAIC) Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, 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.

(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; ID 22-2002, f. & cert. ef. 11-27-02

836-011-0150
Designation of Independent Certified Public Accountant

(1) Each insurer required by OAR 836-011-0120 to file an annual audited financial report, within 60 days after becoming subject to the requirement, must register with the Director in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in OAR 836-011-0120 and 836-011-0150. This section establishes the initial registration requirement for an insurer when the insurer first becomes subject to the requirement. Except as provided in section (3) of this rule, an insurer that has already registered the name and address of the independent certified public accountant or accounting firm under this section need not register its certified public accountant with the Director.

(2) 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. The insurer shall file a copy of the letter with the Director.

(3) 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, not later than the 10th business day after the date of the notice of dismissal or resignation, 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.

Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(c)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

836-011-0160
Qualifications of Independent Certified Public Accountant

(1) The Director shall not recognize any person as a qualified independent certified public accountant for the purposes of OAR 836-011-0100 to 836-011-0230 if the person:

(a) 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 or, if the insurer is a Canadian or British insurer, the person is not a chartered accountant; or

(b) With respect to the audit of the insurer, has either directly or indirectly entered into an agreement of indemnity or a release from liability, the intent or effect of which is to shift or limit in any manner the potential liability of the person for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing or other misrepresentations made by the insurer or its representatives.

(2) Except as otherwise provided in this rule, the Director shall recognize an independent certified public accountant as qualified as long as the certified public accountant conforms 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) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. In the event of a delinquency proceeding commenced against the insurer under ORS 734.130, however, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(4) No partner or other person responsible for rendering a report may act in that capacity for more than seven consecutive years. Following a period of service, the partner or other person is disqualified from acting in that or a similar capacity for the same insurer or its insurance subsidiaries or affiliates 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.

(5) The Director shall not recognize an individual as an independent certified public accountant, or accept an annual audited financial report required by OAR 836-011-0100 to 836-011-0230 that is prepared in whole or part by an individual, if the individual:

(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 demonstrated a pattern or practice of failing 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 2-2002(Temp), f. & cert. ef. 1-15-01 thru 7-5-02; ID 17-2002, f. & cert. ef. 7-11-02; ID 22-2002, f. & cert. ef. 11-27-02

836-011-0170
Consolidated or Combined 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 may be 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; ID 22-2002, f. & cert. ef. 11-27-02

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 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(d) - 731.488(2)(e)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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 business 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 Public Accountants**.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(f)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

836-011-0200
Report on Significant Deficiencies in Internal Controls

(1) In addition to the annual audited financial statements, each insurer shall furnish the Director with a written report prepared by the accountant describing significant deficiencies in the insurer's internal control structure noted by the accountant during the audit. 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) requires an accountant to communicate significant deficiencies, known as "reportable conditions," noted during a financial statement audit to the appropriate parties within an entity. A report shall not be issued if the accountant does not identify significant deficiencies. If significant deficiencies are noted, the insurer shall file the written report annually with the Director not later than the 60th day after the filing of the annual audited financial statements.

(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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(g)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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 will rely on the information contained in the report and opinion in the monitoring and regulation of the financial position of insurers.

(d) That the accountant consents to the requirements of OAR 836-011-220 and that the accountant agrees to make the workpapers described in OAR 836-011-0220 available for review by the Director, or the Director's designee or appointed agent.

(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) - 731.488(2)(c)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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 work papers 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 Consumer and Business Services, 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; and

(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 and examiners, the insurer and independent certified public accountant shall allow the Director and examiners 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(i)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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 conforms to those requirements.

Stat. Auth.: ORS 731.244 & 731.488
Stats. Implemented: ORS 731.488(2)(b) - 731.488(2)(c)
Hist.: ID 4-1992, f. & cert. ef. 3-26-92; ID 22-2002, f. & cert. ef. 11-27-02

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

(1) "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

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

Risk-Based Capital Reporting for Health Care Service Contractors

836-011-0500
Application; Statutory Authority; Statutes Implemented

(1) OAR 836-011-0500 to 836-011-0550 apply to health care service contractors.

(2) OAR 836-011-0500 to 836-011-0550 are adopted pursuant to the authority of ORS 731.244 and 750.045 for the purpose of implementing ORS 731.574, 733.210 and 750.045.

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0505
Definitions

As used in OAR 836-011-0500 to 836-011-0550:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the Director in accordance with OAR 836-011-0510(4).

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

(3) "Domestic health care service contractor" means a health care service contractor domiciled in this state.

(4) "Foreign health care service contractor" means a health care service contractor that is authorized to transact business in this state as a health care service contractor but is not domiciled in this state.

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

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

(7) "RBC level" means a health care service contractor'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 health care service contractor, 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;

(d) "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC.

(8) "RBC plan" means a comprehensive financial plan containing the elements specified in OAR 836-011-0515(2). If the Director rejects the RBC plan and it is revised by the health care service contractor with or without the Director's recommendation, the plan shall be called the "revised RBC plan."

(9) "RBC report" means the report required in OAR 836-011-0510.

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

(a) A health care service contractor's statutory capital and surplus (i.e. net worth) 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 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0510
RBC Reports

(1) A domestic health care service contractor 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, a domestic health care service contractor 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 health care service contractor is authorized to do business, if the insurance commissioner has notified the health care service contractor of its request in writing, in which case the health care service contractor 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 health care service contractor's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) 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.

(3) An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in OAR 836-011-0500 to 836-011-0550 and the formulas, schedules and instructions referenced in OAR 836-011-0500 to 836-011-0550 is desirable in the business of a health care service contractor. Accordingly, health care service contractors should seek to maintain capital above the RBC levels required by OAR 836-011-0500 to 836-011-0550. Additional capital is used and useful in the insurance business and helps to secure a health care service contractor against various risks inherent in, or affecting, the business of a health care service contractor and not accounted for or only partially measured by the risk-based capital requirements contained in OAR 836-011-0500 to 836-011-0550.

(4) If a domestic health care service contractor files an RBC report that in the judgment of the Director is inaccurate, then the Director shall adjust the RBC report to correct the inaccuracy and shall notify the health care service contractor of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0515
Company Action Level Event

(1) "Company Action Level Event" means any of the following events:

(a) The filing of an RBC report by a health care service contractor that indicates that the health care service contractor's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(b) Notification by the Director to the health care service contractor of an adjusted RBC report that indicates an event in subsection (a) of this subsection, if the health care service contractor does not challenge the adjusted RBC report under OAR 836-011-0535; or

(c) If, pursuant to OAR 836-011-0535, a health care service contractor challenges an adjusted RBC report that indicates the event in subsection (a) of this section, the notification by the Director to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge.

(2) In the event of a Company Action Level Event, the health care service contractor shall prepare and submit to the Director an RBC plan that shall:

(a) Identify the conditions that contribute to the Company Action Level Event;

(b) Contain proposals of corrective actions that the health care service contractor intends to take and that would be expected to result in the elimination of the Company Action Level Event;

(c) Provide projections of the health care service contractor's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the health care service contractor's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the health care service contractor'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 RBC plan shall be submitted:

(a) Within 45 days of the Company Action Level Event; or

(b) If the health care service contractor challenges an adjusted RBC report pursuant to OAR 836-011-0535, within 45 days after notification to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge.

(4) Within 60 days after the submission by a health care service contractor of an RBC plan to the Director, the Director shall notify the health care service contractor whether the RBC plan shall be implemented or is, in the judgment of the Director, unsatisfactory. If the Director determines the RBC plan is unsatisfactory, the notification to the health care service contractor 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 health care service contractor 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) Within 45 days after the notification from the Director; or

(b) If the health care service contractor challenges the notification from the Director under OAR 836-011-0535, within 45 days after a notification to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge.

(5) In the event of a notification by the Director to a health care service contractor that the health care service contractor's RBC plan or revised RBC plan is unsatisfactory, the Director may at the Director's discretion, subject to the health care service contractor's right to a hearing under OAR 836-011-0535, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(6) Every domestic health care service contractor 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 health care service contractor is authorized to do business if:

(a) The state has an RBC provision substantially similar to ORS 731.752; and

(b) The insurance commissioner of that state has notified the health care service contractor of its request for the filing in writing, in which case the health care service contractor shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) Fifteen days after the receipt of 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 sections (3) and (4) of this rule.

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0520
Regulatory Action Level Event

(1) "Regulatory Action Level Event" means, with respect to a health care service contractor, any of the following events:

(a) The filing of an RBC report by the health care service contractor that indicates that the health care service contractor'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 a health care service contractor of an adjusted RBC report that indicates the event in subsection (a) of

this section, if the health care service contractor does not challenge the adjusted RBC report under OAR 836-011-0535;

(c) If, pursuant to OAR 836-011-0535, the health care service contractor challenges an adjusted RBC report that indicates the event in subsection (a) of this section, the notification by the Director to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge;

(d) The failure of the health care service contractor to file an RBC report by the filing date, unless the health care service contractor has provided an explanation for the failure that is satisfactory to the Director and has cured the failure within ten days after the filing date;

(e) The failure of the health care service contractor to submit an RBC plan to the Director within the time period set forth in OAR 836-011-0515;

(f) Notification by the Director to the health care service contractor that:

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

(B) Notification constitutes a Regulatory Action Level Event with respect to the health care service contractor, if the health care service contractor has not challenged the determination under OAR 836-011-0535;

(g) If, pursuant to OAR 836-011-0535, the health care service contractor challenges a determination by the Director under subsection (f) of this section, the notification by the Director to the health care service contractor that the Director has, after a hearing, rejected the challenge;

(h) Notification by the Director to the health care service contractor that the health care service contractor 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 health care service contractor 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, if the health care service contractor has not challenged the determination under OAR 836-011-0535; or

(i) If, pursuant to OAR 836-011-0535, the health care service contractor challenges a determination by the Director under subsection (h) of this section, the notification by the Director to the health care service contractor 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 health care service contractor to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as the Director deems necessary of the assets, liabilities and operations of the health care service contractor including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the Director shall determine are required (a "corrective order").

(3) In determining corrective actions, the Director may take into account factors the Director deems relevant with respect to the health care service contractor based upon the Director's examination or analysis of the assets, liabilities and operations of the health care service contractor, 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) Within 45 days after the occurrence of the Regulatory Action Level Event;

(b) If the health care service contractor challenges an adjusted RBC report pursuant to OAR 836-011-0535 and the challenge is not frivolous in the judgment of the Director within 45 days after the notification to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge; or

(c) If the health care service contractor challenges a revised RBC plan pursuant to OAR 836-011-0535 and the challenge is not frivolous in the judgment of the Director, within 45 days after the notification to the health care service contractor that the care service contractor has, after a hearing, rejected the health care service contractor's challenge.

(4) The Director may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Director to review the health care service contractor's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the health care service contractor and formulate the corrective order with respect to the health care service contractor. The fees, costs and expenses relating to consultants shall be borne by the affected health care service contractor or such other party as directed by the Director.

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0525
Authorized Control Level Event

(1) "Authorized Control Level Event" means any of the following events:

(a) The filing of an RBC report by the health care service contractor that indicates that the health care service contractor's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(b) The notification by the Director to the health care service contractor of an adjusted RBC report that indicates the event in subsection (a) of this section, if the health care service contractor does not challenge the adjusted RBC report under OAR 836-011-0535;

(c) If, pursuant to OAR 836-011-0535, the health care service contractor challenges an adjusted RBC report that indicates the event in subsection (a) of this section, notification by the Director to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge;

(d) The failure of the health care service contractor to respond, in a manner satisfactory to the Director, to a corrective order (if the health care service contractor has not challenged the corrective order under OAR 836-011-0535); or

(e) If the health care service contractor has challenged a corrective order under OAR 836-011-0535 and the Director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health care service contractor to respond, in a manner satisfactory to the Director, to the corrective order subsequent to rejection or modification by the Director.

(2) In the event of an Authorized Control Level Event with respect to a health care service contractor, the Director shall:

(a) Take such actions as are required under OAR 836-011-0520 regarding a health care service contractor with respect to which an Regulatory Action Level Event has occurred; or

(b) If the Director deems it to be in the best interests of the policyholders and creditors of the health care service contractor and of the public, take such actions as are necessary to cause the health care service contractor to be placed under regulatory control under ORS 734.059 to 734.440. In the event the Director takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Director to take action under ORS 734.059 to 734.440, and the Director shall have the rights, powers and duties with respect to the health care service contractor as are set forth in ORS 734.059 to 744.440. In the event the Director takes actions under this subsection pursuant to an adjusted RBC report, the health care service contractor shall be entitled to such protections as are afforded to health care service contractors under the provisions of ORS 734.059 to 734.440.

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0530
Mandatory Control Level Event

(1) "Mandatory Control Level Event" means any of the following events:

(a) The filing of an RBC report that indicates that the health care service contractor's total adjusted capital is less than its Mandatory Control Level RBC;

(b) Notification by the Director to the health care service contractor of an adjusted RBC report that indicates the event in subsection (a) of this section, if the health care service contractor does not challenge the adjusted RBC report under OAR 836-011-0535; or

(c) If, pursuant to OAR 836-011-0535, the health care service contractor challenges an adjusted RBC report that indicates the event in subsection (a) of this section, notification by the Director to the health care service contractor that the Director has, after a hearing, rejected the health care service contractor's challenge.

(2) In the event of a Mandatory Control Level Event, the Director shall take such actions as are necessary to place the health care service contractor under regulatory control under ORS 734.059 to 734.440. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Director to take action under ORS 734.059 to 734.440, and the Director shall have the rights, powers and duties with respect to the health care service contractor as are set forth in ORS 734.059 to 734.440. If the Director takes actions pursuant to an adjusted RBC report, the health care service contractor shall be entitled to the protections of ORS 734.059 to 734.440. Notwithstanding the provisions of this rule, the Director may forego action for up to 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 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0535
Hearings

Upon the occurrence of any of the following events, a health care service contractor 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 health care service contractor 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 health care service contractor'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 health care service contractor's request. The events to which the opportunity for a hearing under this rule relates are as follows:

(1) Notification to a health care service contractor by the Director of an adjusted RBC report;

(2) Notification to a health care service contractor by the Director that:

(a) The health care service contractor's RBC plan or revised RBC plan is unsatisfactory; and

(b) Notification constitutes a Regulatory Action Level Event with respect to the health care service contractor;

(3) Notification to a health care service contractor by the Director that the health care service contractor 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 health care service contractor to eliminate the Company Action Level Event with respect to the health care service contractor in accordance with its RBC plan or revised RBC plan; or

(4) Notification to a health care service contractor by the Director of a corrective order with respect to the health care service contractor.

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0540
Supplemental Provisions; Rules; Exemption

(1) OAR 836-011-0500 to 836-011-0550 are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the Director under such laws, including, but not limited to, ORS 734.059 to 734.440 and OAR 836-011-0100 to 836-011-0120.

(2) The Director may exempt from the application of OAR 836-011-0500 to 836-011-0550 a domestic health care service contractor that:

(a) Writes direct business only in this state;

(b) Assumes no reinsurance in excess of five percent of direct premium written; and

(c) Writes direct annual premiums for comprehensive medical business of $2 million or less; or

(d) Is a limited health care service contractor that covers less than 500 lives.

Stat. Auth.: ORS 731.244 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

836-011-0545
Foreign Health Care Service Contractors

(1) A foreign health care service contractor 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 the later of:

(a) The date an RBC report would be required to be filed by a domestic health care service contractor under OAR 836-011-0500 to 836-011-0550; or

(b) The 15th day after the request is received by the foreign health care service contractor.

(2) A foreign health care service contractor 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 a foreign health care service contractor as determined under the RBC statute or other law applicable in the state of domicile of the health care service contractor (or, if no RBC statute or other law is in force in that state, under the provisions of OAR 836-011-0500 to 836-011-0550), if the insurance commissioner of the state of domicile of the foreign health care service contractor fails to require the foreign health care service contractor to file an RBC plan in the manner specified under that state's RBC statute or other law (or, if no RBC statute or other law is in force in that state, under OAR 836-011-0515), the Director may require the foreign health care service contractor to file an RBC plan with the Director. In such event, the failure of the foreign health care service contractor to file an RBC plan with the Director shall be grounds to order the health care service contractor 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 a foreign health care service contractor, if no domiciliary receiver has been appointed with respect to the foreign health care service contractor under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the Director may apply for an order under ORS 734.190 with respect to the liquidation of property of foreign health care service contractors 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 & 750.045
Stats. Implemented: ORS 731.574, 733.210 & 750.045
Hist.: ID 22-2002, f. & cert. ef. 11-27-02

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 and appropriate in the public interest 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: Exhibits referenced are available from the agency.]
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; ID 22-2002, f. & cert. ef. 11-27-02

Registration of Insurance Holding Company Systems

836-012-0011
Credit for Reinsurance — Reinsurer Authorized in this State

Pursuant to ORS 731.509(3), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that

was authorized in this state as of any date on which statutory financial statement credit for reinsurance is claimed.

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; ID 22-2002, f. & cert. ef. 11-27-02

836-012-0021
Credit for Reinsurance — Accredited Reinsurers

(1) Pursuant to ORS 731.509(4) 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 any date on which statutory financial statement credit for reinsurance is claimed. 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 certificate of authority or other acceptable 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:

(A) 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

(B) 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. Credit shall not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the Director.

[ED. NOTE: Exhibits referenced are available from the agency.]
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; ID 22-2002, f. & cert. ef. 11-27-02

836-012-0031
Credit for Reinsurance — Reinsurer Domiciled and Licensed in Another State

(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 any date on which statutory financial statement credit for reinsurance is claimed:

(a) Is domiciled 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 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 836-012-0000) 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: Exhibits referenced are available from the agency.]
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; ID 22-2002, f. & cert. ef. 11-27-02

836-012-0041
Credit for Reinsurance — Reinsurers Maintaining Trust Funds

(1) Pursuant to ORS 731.509(6), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, 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 domiciled 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 shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States domiciled insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000.

(b)(A) The trust fund for a group that includes incorporated and individual unincorporated underwriters shall consist of:

(i) For reinsurance ceded, under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, funds in trust in an amount not less than the group's several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any member of the group;

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of OAR 836-012-0000 to 836-012-0110, funds in trust in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and

(iii) In addition to the trusts described in subparagraphs (i) and (ii) of this paragraph, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.

(B) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the Director:

(i) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or

(ii) If a certification is unavailable, a financial statement prepared by independent public accountants, of each underwriter member of the group.

(c)(A) 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:

(i) Consist of funds in trust in an amount not less than the assuming insurers' several liabilities attributable to business ceded by United States domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;

(ii) 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; and

(iii) 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.

(B) Within 90 days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the Director an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared

by independent public accountants, of each underwriter member of the group.

(3)(a) Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. 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 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; and

(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 shall not expire prior to the next following December 31.

(b)(A) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

(B) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

(C) If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

(D) The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

(4) For purposes of this rule, the term "liabilities" means the assuming insurer's gross liabilities attributable to reinsurance ceded by U. S. domiciled insurers that are not otherwise secured by acceptable means, and, shall include:

(a) For business ceded by domestic insurers authorized to write accident and health insurance and property and casualty insurance:

(A) Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;

(B) Reserves for losses reported and outstanding;

(C) Reserves for losses incurred but not reported;

(D) Reserves for allocated loss expenses; and

(E) Unearned premiums.

(b) For business ceded by domestic insurers authorized to write life, health and annuity insurance:

(A) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

(B) Aggregate reserves for accident and health policies.

(C) Deposit funds and other liabilities without life or disability contingencies; and

(D) Liabilities for policy and contract claims.

(5) Assets deposited in trusts established pursuant to ORS 731.509 and this rule shall be valued according to their fair market value and shall consist only of cash in U. S. dollars, certificates of deposit issued by a U. S. financial institution as defined in ORS 731.510(2)(c), clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution as defined in ORS 731.510(2)(c), and investments of the type specified in this section, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent of total investments. No more than 20 percent of the total of the investments in the trust may be foreign investments authorized under subsections (a)(E), (c), (f)(B) or (g) of this section, and no more than ten percent of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U. S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of ORS 731.509 shall be invested only as follows:

(a) Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:

(A) The United States or by any agency or instrumentality of the United States;

(B) A state of the United States;

(C) A territory, possession or other governmental unit of the United States;

(D) An agency or instrumentality of a governmental unit referred to in paragraphs (B) and (C) of this subsection if the obligations are by law (statutory of otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this subsection if payable solely out of special assessments on properties benefited by local improvements; or

(E) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(b) Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U. S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U. S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

(A) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;

(B) Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or

(C) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC.

(c) Obligations issued, assumed or guaranteed by a solvent non-U. S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(d) An investment made pursuant to the provisions of subsections (a), (b) or (c) of this section shall be subject to the following additional limitations:

(A) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent of the assets of the trust;

(B) An investment in any one mortgage-related security shall not exceed five percent of the assets of the trust;

(C) The aggregate total investment in mortgage-related securities shall not exceed 25 percent of the assets of the trust; and

(D) Preferred or guaranteed shares issued or guaranteed by a solvent U. S. institution are permissible investments if all of the institution's obligations are eligible as investments under paragraph (A) or (C) of subsection (b) of this section, but shall not exceed two percent of the assets of the trust.

(e) As used in this rule:

(A) "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:

(i) Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(I) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

(II) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Sections 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Section 1703; or

(ii) Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of sub-subparagraphs (i)(I) and (i)(II) of this paragraph.

(B) "Promissory note," when used in connection with a manufactured home, also includes a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

(f) Equity interests are subject to the following provisions:

(A) Investments in common shares or partnership interests of a solvent U. S. institution are permissible if:

(i) Its obligations and preferred shares, if any, are eligible as investments under this section; and

(ii) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a to 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the National Association of Securities Dealers, Inc. A trust shall not invest in equity interests under this paragraph an amount exceeding one percent of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company.

(B) Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:

(i) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

(ii) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;

(iii) An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent of the assets of the trust. The cost of an investment in equity interests made pursuant to this subsection, when added to the aggregate cost of other investments in equity interests then held pursuant to this subsection, shall not exceed ten percent of the assets in the trust;

(g) Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(h) Investment companies are subject to the following provisions:

(A) Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. § 802, are permissible investments if the investment company:

(i) Invests at least 90 percent of its assets in the types of securities that qualify as an investment under subsection (a), (b) or (c) of this section or invests in securities that are determined by the commissioner to be substantively similar to the types of securities set forth in subsection (a), (b) or (c) of this section; or

(ii) Invests at least 90 percent of its assets in the types of equity interests that qualify as an investment under subsection (f)(A) of this section.

(B) Investments made by a trust in investment companies under this subsection shall not exceed the following limitations:

(i) An investment in an investment company qualifying under paragraph (A)(i) of this subsection shall not exceed ten percent of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed 25 percent of the assets in the trust; and

(ii) Investments in an investment company qualifying under paragraph (A)(ii) of this subsection shall not exceed five percent of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to subsection (f)(A) of this section.

(i) Letters of credit are subject to the following provisions:

(A) In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement, as duly approved by the Director, to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(B) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where the draw would be required shall be considered to be negligence or willful misconduct, or both.

(6) A specific security provided to a ceding insurer by an assuming insurer pursuant to OAR 836-012-0060 shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this section.

[ED. NOTE: Exhibits referenced are available from the agency.]

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; ID 22-2002, f. & cert. ef. 11-27-02

836-012-0051

Credit for Reinsurance Required by Law

Pursuant to ORS 731.509(7), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of ORS 731.509(3), (4), (5) or (6), but only with respect to the insurance of risks located in jurisdictions where the 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; ID 22-2002, f. & cert. ef. 11-27-02

836-012-0060

Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer Not Meeting the Requirements of OAR 836-012-0011 to 836-012-0051

(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 insur-

er as security for the payment of obligations under the reinsurance contract. The 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, or in trust for, 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; or

(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 section (1) of this rule shall be allowed only when the requirements of OAR 836-012-0100 and the applicable provisions 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; ID 22-2002, f. & cert. ef. 11-27-02

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 or unlicensed 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 shall 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 shall create a trust account into which assets must be deposited.

(c) All assets in the trust account shall be held by the trustee at the trustee's office in the United States.

(d) The trust agreement shall 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 of 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 domiciled.

(i) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying commission to or reimbursing the expenses of the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement, as duly approved by the Director, to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(j) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances in which such a draw would be required shall be deemed to be negligence or willful misconduct, or both.

(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, the trust agreement may 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, only 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), apart from its general assets, in trust for such uses and purposes specified in paragraphs (A) and (B) of this subsection as may remain executory after such withdrawal and for any period after the termination date.

(l) Notwithstanding other provisions of OAR 836-012-0000 to 836-012-0110, when a trust agreement is established to meet the requirements of OAR 836-012-0060 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, if it is customary to provide a trust agreement for a specific purpose, the trust agreement may 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, only for the following purposes:

(A) To pay or reimburse the ceding insurer for:

(i) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and

(ii) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement.

(B) To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

(C) When the ceding insurer has received notification of termination of the trust and when 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 assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U. S. financial institution apart from its general assets, in trust for the uses and purposes specified in paragraphs (A) and (B) of this subsection as may remain executory after withdrawal and for any period after the termination date.

(m) 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.

(n) Notwithstanding any other provisions in the trust instrument, if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight or other designated receiver all of the assets of the trust fund. The assets shall be applied in accordance with the priority statutes and laws of the state in which the trust is domiciled applicable to the assets of insurance companies in liquidation. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy claims of the U. S. beneficiaries of the trust, the assets or any part of them shall be returned to the trustee for distribution in accordance with 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 the beneficiary and grantor receive 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 the trustee and the beneficiary receive 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 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 in United States dollars; certificates of deposit issued by a United States bank and payable in United States dollars; and investments permitted by the Insurance Code or any combination thereof, except that investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent of total investments. 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 pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(II) 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; and

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(ii) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

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

(A) Give the assuming insurer the right to seek the ceding insurer's approval, which the ceding insurer shall not unnecessarily or arbitrarily withhold, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer. 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) of this rule; 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) of this rule.

(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)(b)(B);

(ii) Court or 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, 2003, will continue to be acceptable until January 1, 2003, 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; ID 22-2002, f. & cert. ef. 11-27-02

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, 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" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

(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" that 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), or any successor publication, 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), or any successor publication, the letter of credit shall specifically address and provide 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 17 of Publication 500, or any successor publication, 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 expiration 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 pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(II) The assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(ii) When the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and when the assuming insurer's entire obligations under the specific reinsurance remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amount in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in subparagraph (i) of this paragraph as may remain after withdrawal and for any period after the termination date.

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

(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) of this section; or

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

[Publications: Publications referenced are available from the agency.]
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; ID 22-2002, f. & cert. ef. 11-27-02

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, OL 1993 (Enrolled HB 2119)
Stats. Implemented: ORS 731.508(1), 731.508(3), 731.509 & 731.511
Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 22-2002, f. & cert. ef. 11-27-02

836-012-0100
Reinsurance Contract

Credit shall not be granted, nor an asset or reduction from liability allowed, 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(8), 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; ID 22-2002, f. & cert. ef. 11-27-02

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 term care insurance and long term disability insurance	+ 0 + 0 0 0
Health Insurance — long-term care insurance and long term disability insurance	+ 0 + + + 0
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 dump-in premiums allowed	0 + + + + +

(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:

$$\text{Rate} = 2\,(I + CG) \,/\, X + Y - I - CG$$

When: I — is the net investment income;

CG — is capital gains less capital losses;

X — is the current year cash and invested assets plus investment 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

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, OL 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 ORS 731.385 regarding a foreign insurer may be limited to the extent provided by statute.

Stat. Auth.: ORS 731.385
Stats. Implemented: ORS 731.385
Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 19-2006, f. & cert. ef. 9-26-06

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 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 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 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 by the Director, 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: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 731 & 750
Stats. Implemented: ORS 750.645(1)(a)
Hist.: ID 4-1990, f. & cert. ef. 1-24-90; ID 19-2006, f. & cert. ef. 9-26-06

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 731 & 750
Stats. Implemented: ORS 750.685(2) - 750.685(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 by the Director.

Stat. Auth.: ORS 731 & 750
Stats. Implemented: ORS 750.685(2) - 750.685(3)
Hist.: ID 4-1990, f. & cert. ef. 1-24-90; ID 19-2006, f. & cert. ef. 9-26-06

836-014-0030
Sales Representatives

Every legal expense organization shall submit to the Director, on the form prescribed by the Director, 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.

Stat. Auth.: ORS 731 & 750
Stats. Implemented: ORS 750.645(2)
Hist.: ID 4-1990, f. & cert. ef. 1-24-90; ID 19-2006, f. & cert. ef. 9-26-06

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 prescribed by the Director.

(2) A statement designating a registered agent and a registered office. The statement must be on the form prescribed by the Director. 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 by the Director in OAR 836-014-0030.

(4) A Financial Statement. The statement must follow the form prescribed by the Director in OAR 836-014-0015 and comply with 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.

Stat. Auth.: ORS 731 & 750
Stats. Implemented: ORS 750.515, 750.535 & 750.545
Hist.: ID 4-1990, f. & cert. ef. 1-24-90; ID 19-2006, f. & cert. ef. 9-26-06

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 prescribed by the Director.

Stat. Auth.: ORS 731 & 750
Stats. Implemented: ORS 750.535 & 750.575
Hist.: ID 4-1990, f. & cert. ef. 1-24-90; ID 19-2006, f. & cert. ef. 9-26-06

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 prescribed by the Director. If mailed, the renewal application must be postmarked by the United States Postal Service not later than the expiration date of the registration.

Stat. Auth.: ORS 731 & 750

Stats. Implemented: ORS 750.515 & 750.565(2)
Hist.: ID 4-1990, f. & cert. ef. 1-24-90; ID 19-2006, f. & cert. ef. 9-26-06

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 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 the corresponding 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, 744.331, 744.348, 744.358 and 746.240 for the purpose of implementing ORS 744.326, 744.328, 744.331, 744.341, 744.348 and 744.358.

(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, 744.331, 744.348, 744.358.
Stats. Implemented: ORS 744.326, 744.328, 744.331, 744.341, 744.348, 744.358
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

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, 744.331, 744.358
Stats. Implemented: ORS 744.326, 744.328
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

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 ORS 744.319 to 744.358.

Stat. Auth.: ORS 731.244, 744.358
Stats. Implemented: ORS 744.328
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; ID 15-2006, f. & cert. ef. 7-27-06

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.: ORS 744.331
Stats. Implemented: ORS 744.331
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

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 ORS 744.341.

(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 ORS 744.348 and 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.: ORS 744.358
Stats. Implemented: ORS 744.326, 744.341
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

836-014-0250
Contents of Life Settlement Contracts

(1) In addition to the requirements of ORS 744.341, 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 ORS 744.341. The rescission provision must appear on the first page of the contract. The rescission period specified in ORS 744.341 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.: ORS 744.358
Stats. Implemented: ORS 744.341
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97; ID 15-2006, f. & cert. ef. 7-27-06

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 ORS 744.356 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.: ORS 744.358
Stats. Implemented: ORS 744.341, 744.356
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97; ID 15-2006, f. & cert. ef. 7-27-06

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, 744.358
Stats. Implemented: ORS 744.358
Hist.: ID 14-1997, f. & cert. ef. 10-17-97; ID 15-2006, f. & cert. ef. 7-27-06

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.: ORS 744.358
Stats. Implemented: ORS 744.358
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97; ID 15-2006, f. & cert. ef. 7-27-06

836-014-0280
Disclosure Required

(1) A life settlement provider shall disclose the information specified in ORS 744.348 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.: ORS 744.358
Stats. Implemented: ORS 744.348
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97; ID 15-2006, f. & cert. ef. 7-27-06

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.: ORS 744.358
Stats. Implemented: ORS 744.358
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 14-1997, f. & cert. ef. 10-17-97; ID 15-2006, f. & cert. ef. 7-27-06

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.: ORS 744.358
Stats. Implemented: ORS 744.358
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

836-014-0310
Reporting Requirements

The report required by ORS 744.343 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.: ORS 744.342, 744.358
Stats. Implemented: ORS 744.342
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

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.: ORS 744.358
Stats. Implemented: ORS 744.358
Hist.: ID 3-1996, f. & cert. ef. 2-26-96; ID 15-2006, f. & cert. ef. 7-27-06

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

836-014-0400
Market Assistance Plan

(1) Insurers that are authorized to write commercial general liability insurance relating to construction contractors and are writing that coverage shall form a market assistance plan to assist businesses and service providers unable to purchase the coverage in adequate amounts from either the admitted or nonadmitted market. For the purpose of this rule, commercial general liability insurance is a class of commercial liability insurance.

(2) Except as provided in section (3) of this rule, the market assistance plan established under this rule shall operate under the plan of operation prepared pursuant to ORS 735.210(2) and approved by the Director on July 26, 2004.

(3) At the request of the Director, for the purpose of implementing the purpose of the market assistance plan under section (1) of this rule, the insurers that formed the market assistance plan may modify the plan and the plan of operation described in section (2) of this rule, subject to approval of the modification by the Director.

Stat. Auth.: ORS 731.244 & 735.210
Stats. Implemented: ORS 735.210
Hist.: ID 8-2004(Temp), f. & cert. ef. 10-12-04 thru 3-20-05; ID 1-2005, f. 3-1-05, cert. ef. 3-21-05

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 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 insurance producers 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 731, 743 & 746
Stats. Implemented: ORS 742.009 & 746.075
Hist.: IC 53, f. 3-5-73, ef. 3-15-73; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 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 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 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 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 settlements 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 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 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 noncomparable 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 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 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 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 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 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 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 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 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 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 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 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

836-020-0305
Disclosure; Application for Coverage

(1) When an insurance producer or representative of an insurer accepts an application for individual health insurance coverage other than coverage described in section (2) of this rule, the insurance producer 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 insurance producer 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 insurance producer or representative of an insurer accepts an application for individual accidental death and dismemberment insurance, accident only insurance or hospital indemnity insurance, the insurance producer 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 insurance producer, representative or insurer must deliver an outline that has first been approved by the Director under section (5) of this rule.

(3) When an insurance producer 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 insurance producer 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 insurance producer 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 insurance producer 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 insurance producer 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: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

Use of Coordination of Benefits Provisions in Group and Blanket Health Insurance

836-020-0770
Authority, Purpose and Effective Date of OAR 836-020-0770 to 836-020-0805

(1) OAR 836-020-0770 to 836-020-0805 are adopted by the Director of the Department of Consumer and Business Services pursuant to the authority of ORS 731.244 and 743.552, for the purpose of implementing ORS 743.549 and 743.552.

(2) The purpose of OAR 836-020-0770 to 836-020-0805 is to:

(a) Establish a uniform order of benefit determination under which plans pay claims;

(b) Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, as provided in OAR 836-020-0770 to 836-020-0805, do not have to pay their benefits first; and

(c) Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

(3) Insurers must make their plans compliant with OAR 836-020-0770 to 836-020-0805 not later than July 1, 2007. Until the date on which an insurer makes a plan of the insurer compliant, the plan shall continue to be subject to the prior rules, OAR 836-020-0700 to 836-020-0765. In the event a question of order of benefit determination arises between a plan operating under OAR 836-020-0770 to 836-020-0805 and a plan operating under the prior rules, OAR 836-020-0700 to 836-020-0765, the order of benefit determination shall be governed by the prior rules.

Stat. Auth: ORS 731.244, 743.552

Stats. Implemented: 743.549, 743.552

Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0775
Definitions

As used in OAR 836-020-0770 to 836-020-0805:

(1) "Allowable expense," except as otherwise provided in this rule or as otherwise used in a statute, is defined and its use is governed by the following:

(a) The term means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

(b) If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

(c) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(d) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

(e) The following are examples of expenses that are not allowable expenses:

(A) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(B) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(C) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(D) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(e) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which COB applies.

(f) When a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid.

(g) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

(A) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

(B) Because the covered person has a lower benefit for the reason that the covered person did not use a preferred provider.

(2) "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

(3) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(a) Services, including supplies;

(b) Payment for all or a portion of the expenses incurred;

(c) A combination of subsections (a) and (b) of this section; or

(d) An indemnification.

(4) "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(5) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.

(6) "Coordination of benefits" or "COB" means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(7) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(8) "Group-type contract:"

(a) Means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage; and.

(b) Does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(9) "High-deductible health plan" has the meaning given the term under section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10) "Hospital indemnity benefits:"

(a) Means benefits not related to expenses incurred; and

(b) "Hospital indemnity benefits" 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.

(11) "Plan" is defined and its use is governed by the following:

(a) The term means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(b) If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection. The definition of "plan" in the model COB provision in **Appendix A** (Exhibit 1 to OAR 836-020-0780) is an example.

(c) "Plan" includes:

(A) Group insurance contracts and subscriber contracts;

(B) Uninsured arrangements of group or group-type coverage;

(C) Group coverage through closed panel plans;

(D) Group-type contracts;

(E) The medical care components of group long-term care contracts, such as skilled nursing care; and

(F) Medicare or other governmental benefits, as permitted by law, except as provided in subsection (d)(H) of this section. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(d) "Plan" does not include:

(A) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(B) Accident only coverage;

(C) Specified disease or specified accident coverage;

(D) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(E) Benefits provided in group long-term care insurance policies for non-medical services, including for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(F) Medicare supplement policies;

(G) A state plan under Medicaid; or

(H) A governmental plan, that by law provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

(12) "Primary plan" means a plan 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:

(a) The plan has no order of benefit determination rules or its rules differ from those permitted by OAR 836-020-0770 to 836-020-0805; or

(b) All plans that cover the person use the order of benefit determination rules required by OAR 836-020-0770 to 836-020-0805, and under those rules the plan determines its benefits first.

(13) "Secondary plan" means a plan that is not a primary plan.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth: ORS 731.244, 743.552

Stats. Implemented: 743.549, 743.552

Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0780

Use of Model COB Contract Provision

(1) **Appendix A** (Exhibit 1 to this rule) contains a model COB provision for use in contracts. The use of this model COB provision is subject to OAR 836-020-0785(1), (2) and (3).

(2) **Appendix B** (Exhibit 2 to this rule) is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two or more plans will pay for or provide benefits.

(3) The COB provision contained in Appendix A and the plain language explanation in **Appendix B** do not have to use the specific words and format shown in **Appendix A** or **Appendix B**. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

(4) A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(a) Another plan exists and the covered person did not enroll in that plan;

(b) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

(5) A plan may not contain a provision that its benefits are "always excess" or "always secondary" except in accordance with the rules permitted by OAR 836-020-0770 to 836-020-0805.

(6) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use OAR 836-020-0790 to determine the amount it should pay for the benefit.

(7) A plan may not use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have, that does not meet the definition of plan in OAR 836-020-0775.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth: ORS 731.244, 743.552

Stats. Implemented: 743.549, 743.552

Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0785

Rules for Coordination of Benefits

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(1)(a) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

(b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(c) When multiple contracts providing coordinated coverage are treated as a single plan under OAR 836-020-0770 to 836-020-0805, this rule applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with OAR 836-020-0770 to 836-020-0805.

(d) If a person is covered by more than one secondary plan, the order of benefit determination rules of OAR 836-020-0770 to 836-020-0805 decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of OAR 836-020-0770 to 836-020-0805, has its benefits determined before those of that secondary plan.

(2)(a) Except as provided in subsection (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with OAR 836-020-0770 to 836-020-0805 is always the primary plan unless the provisions of both plans, regardless of the provisions of this subsection, state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group and 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. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of OAR 836-020-0770 to 836-020-0805, it is secondary to that other plan.

(4) Order of benefit determination: Each plan must determine its order of benefits using the first of the following rules that applies:

(a) Rule regarding non-dependent or dependent:

(A) Subject to paragraph (B) of this subsection, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(B)(i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(C) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(b) Rule regarding dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(B) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This subparagraph does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (A) of this subsection determines the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of paragraph (A) of this subsection determines the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph (A) or (B) of this subsection as if those individuals were parents of the child.

(c) Rule regarding active employee or retired or laid-off employee:

(A) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(B) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

(C) This rule does not apply if the rule in subsection (a) of this section can determine the order of benefits.

(d) Rule regarding COBRA or state continuation coverage:

(A) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(B) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(C) This rule does not apply if the rule in subsection (a) of this section can determine the order of benefits

(e) Rule regarding longer or shorter length of coverage:

(A) If the preceding rules in this section do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(B) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

(C) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

(D) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, 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 the person's coverage under the present plan has been in force.

(f) If none of the preceding rules of this section determines the order of benefits, the allowable expenses shall be shared equally between the plans.

Stat. Auth: ORS 731.244, 743.552
Stats. Implemented: 743.549, 743.552
Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0791
Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

(1) In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan.

(2) The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim.

(3) In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Stat. Auth: ORS 731.244, 743.552
Stats. Implemented: 743.549, 743.552
Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0796
Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

Stat. Auth: ORS 731.244, 743.552
Stats. Implemented: 743.549, 743.552
Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0801
Miscellaneous Provisions

(1) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of 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 section may be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

(2)(a) A plan with order of benefit determination rules that comply with OAR 836-020-0770 to 836-020-0805 (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

(A) If the complying plan is the primary plan, it shall pay or provide its benefits first;

(B) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

(C) If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

(b) If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth in subsection (c) of this section, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

(c) The complying plan may not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

(3) COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(4) If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Stat. Auth: ORS 731.244, 743.552
Stats. Implemented: 743.549, 743.552
Hist.: ID 14-2006, f. & cert. ef. 7-20-06

836-020-0806
Effective Date for Existing Contracts

(1) A contract that provides health care benefits and that was issued before the effective date of OAR 836-020-0770 to 836-020-0805 must comply with 836-020-0770 to 836-020-0805 by:

(a) The later of:

(A) The next anniversary date or renewal date of the contract; or

(B) 12 months following the effective date of OAR 836-020-0770 to 836-020-0805; or

(b) The expiration of any applicable collectively bargained contract pursuant to which it was written.

(2) For the transition period between the adoption of OAR 836-020-0770 to 836-020-0805 and the timeframe for which plans are to be in compliance pursuant to section (1) of this rule, a plan that is subject to the prior COB requirements is not a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under OAR 836-020-0700 to 836-020-0765 as those rules applied on the date preceding the effective date of OAR 836-020-0770 to 836-020-0805 and the new COB requirements under OAR 836-020-0770 to 836-020-0805, the prior COB requirements apply.

Stat. Auth: ORS 731.244, 743.552
Stats. Implemented: 743.549, 743.552
Hist.: ID 14-2006, f. & cert. ef. 7-20-06

DIVISION 24

DOMESTIC INSURERS; ORGANIZATION; CORPORATE PROCEDURES

Shares, Shareholders, and Members

836-024-0003
Statutory Authority; Purpose

OAR 836-024-0003 to 836-024-0055 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 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0004
Application of OAR 836-024-0003 to 836-024-0055

(1) A domestic stock insurer that has a class of equity securities held of record by 300 or more persons, or any director, officer or employee of that insurer, or any other person, may not solicit or permit the use of the name of a holder of any of the equity securities to solicit, by mail or otherwise, any proxy, consent or authorization in respect to any class of equity securities contrary to any provision of OAR 836-024-0003 to 836-024-0055 or Schedules A and B. OAR 836-024-0003 to 836-024-0055 do not apply, however, to:

(a) A domestic stock insurer if 95 percent or more of its equity securities is owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by fewer than 500 persons; or

(b) A domestic stock insurer, with respect to a class of securities, if the insurer files with the federal Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities and Exchange Act of 1934, as amended, and its applicable regulations, with respect to that class of securities.

(2) If proxies, consents or authorizations relating to a class of equity securities of a domestic stock insurer subject to section (1) of this rule are not solicited by or on behalf of the management of the insurer from the holders of record of the securities according to OAR 836-024-0003 to 836-024-0055 and its schedules, the insurer shall:

(a) File with the Director a written information statement containing the information specified in Schedule C; and

(b) Transmit the written information statement referred to in subsection (a) of this section to every security holder who is entitled to vote on a matter to be acted upon at any meeting of the security holders, and from whom a proxy is not solicited.

(3) **Exhibits A**, **B** and **C** are incorporated into this rule as **Exhibits 1**, **2** and **3**.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 731.244, 732.415

Stats. Implemented: ORS 732.415(4)

Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0006

Definitions

As used in OAR 836-024-0003 to 836-024-0055, unless the context otherwise requires:

(1) An "affiliate" of, or a person affiliated with, a specified person is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) "Associate," when used to indicate a relationship with any person, means:

(a) A corporation or organization of which the person is an officer or partner or is, directly or indirectly, the beneficial owner of ten percent or more of any class of equity securities, but does not include the issuer or a majority-owned subsidiary of the issuer;

(b) A trust or other estate in which the person has a substantial beneficial interest or as to which the person served as trustee or in a similar fiduciary capacity; and

(c) A relative or spouse of that person, or any relative of the spouse, who has the same home as the person or who is a director or officer of the issuer or any of its parents or subsidiaries.

(3) "Beneficial owner" includes a person who, directly or indirectly, through a contract, arrangement, understanding, relationship or otherwise, has or shares:

(a) Voting power, including the power to vote, or the power to direct voting of, a security; or

(b) Investment power that includes the power to dispose of, or to direct the disposition of, the new security.

(4) "Control," and including the terms "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by ORS 732.568 that control does not exist in fact. The Director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(5) "Issuer" means the issuer of the securities regarding which a proxy is solicited.

(6) "Last fiscal year" of the issuer means the last fiscal year of the issuer ending prior to the date of the meeting for which proxies are to be solicited.

(7) "Officer" means the president, secretary, treasurer, any vice president in charge of a principal business function, such as sales, administration or finance, and any other person who performs similar policy-making functions for the issuer.

(8) A "parent" of a specified person is an affiliate controlling the person directly or indirectly through one or more intermediaries.

(9) A "person" includes a government or a political subdivision thereof, and applies to a trust only when the interest or interests of the beneficiary or beneficiaries are evidenced by a security.

(10) "Proxy statement" means the statement required by OAR 836-024-0026, regardless of whether the statement is contained in a single document.

(11) "Schedule A" means the schedule incorporated in **Exhibit 1**, OAR 836-024-0004.

(12) "Schedule B" means the schedule incorporated in **Exhibit 2**, OAR 836-024-0004.

(13) "Schedule C" means the schedule incorporated in **Exhibit 3**, OAR 836-024-0004.

(14) "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.

(15) "Solicit" and "Solicitation" do not apply to the security holder, the performance by the issuer of acts required by OAR 836-024-0038 or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 731 & 732

Stats. Implemented: ORS 732.415(4)

Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0008

Solicitations to which OAR 836-024-0003 to 836-024-0055 Apply

OAR 836-024-0041 applies to every solicitation that is subject to 836-024-0004. 836-024-0006 to 836-024-0039 and 836-024-0046 apply to every solicitation that is subject to 836-024-0004 except the following:

(1) A solicitation not made on behalf of the issuer, when the total number of persons solicited is not more than ten.

(2) A solicitation by a person regarding securities carried in the name of the person or in the name of the person's nominee other than as voting trustee, or held in the person's custody, if the person does all of the following:

(a) Receives no commission or remuneration for the solicitation, directly or indirectly, other than reimbursement of reasonable expenses.

(b) Furnishes promptly to the solicited person a copy of all soliciting material relating to the same subject matter or meeting that is received from all persons. The persons who furnish the soliciting material shall furnish copies of that soliciting material for distribution to the solicited persons and shall, upon request, pay the reasonable expenses incurred in forwarding the material.

(c) Does no more than:

(A) Impartially instruct the solicited person to forward a proxy to the person, if any, to whom the solicited person desires to give a proxy; or

(B) Impartially request instructions from the solicited person regarding the authority to be conferred by the proxy and state that a proxy will be given if no instructions are received by a certain date.

(3) A solicitation by a person relating to securities of which the person is the beneficial owner.

(4) A solicitation through a newspaper advertisement that informs security holders of a source from which they may obtain copies of a proxy statement, form of proxy and any other soliciting material, and does no more than:

(a) Name the issuer;

(b) State the reason for the advertisement; and

(c) Identify the proposal or proposals to be acted upon by security holders.

(5) Any solicitation that the Director finds for good cause should be exempted from all or part of OAR 836-024-0003 to 836-024-0055.

Stat. Auth.: ORS 731.244, 732.415

Stats. Implemented: ORS 732.415(4)

Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0026

Information to Be Furnished to Security Holders

(1) A solicitation subject to OAR 836-024-0003 to 836-024-0055 may 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 issuer 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 to security holders that is subject to the following:

(a) The report must contain financial statements for the last two fiscal years, in comparative columnar form and prepared on a consistent basis, that in the opinion of the management will adequately reflect the financial position of the issuer at the end of each year and the results of its operations for each year. Consolidated financial statements of the issuer and its subsidiaries must be included in the report if they are necessary to reflect the financial position and results of

operations of the issuer and its subsidiaries, but in that case the individual statements of the issuer may be omitted. The Director may permit the omission of financial statements for the earlier of the two fiscal years, upon the request of the issuer, upon a showing of good cause.

(b) The financial statements for the last two fiscal years required by subsection (a) of this section must be prepared in a manner acceptable to the Director.

(c) The report must include a summary of the issuer's operations, or the operations of the issuer and its subsidiaries consolidated, or both as appropriate, in comparative columnar form, for each of the last five fiscal years of the issuer (or the life of the issuer and its predecessors, if less than five years).

(d) The report must contain a brief description of the business or businesses done by the issuer and its subsidiaries during the most recent fiscal year that, in the opinion of management, will indicate the general nature and scope of the business of the issuer and its subsidiaries.

(e) The report must identify each of the issuer's directors and officers and must indicate the principal occupation or employment of each person and the name and principal business of any organization by which the person is so employed.

(f) The report must identify the principal market in which securities of any class entitled to vote at the meeting are traded, stating the range of bid and asked quotations for each quarterly period during the issuer's two most recent fiscal years, and must set forth each dividend paid during the two-year period.

(g) Subject to the requirements of this section:

(A) The report may be in any form that management considers to be suitable; and

(B) The information required by subsections (c) to (f) of this section may be presented in an appendix or other separate section of the report, but only if the attention of security holders is called to the presentation.

(h) Solicitations made on behalf of the management before the financial statements are available are not subject to this section if solicitation is being made at the time in opposition to the management and if the management's proxy statement includes an undertaking in bold face type to furnish the annual report, at least 20 days before the date of the meeting, to all persons being solicited.

(3) Two copies of each report sent to the security holders pursuant to this rule shall be mailed to the Director 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 Director pursuant to OAR 836-024-0036(1), whichever date is later.

(4) If the issuer knows that consents or authorizations, or securities of any class entitled to vote at a meeting with respect to which the issuer intends to solicit proxies, are held of record by a broker, dealer, bank or voting trustee, or their nominees, the issuer shall inquire of the record holder at least ten days prior to the record date for the meeting of security holders whether other persons are the beneficial owners of the securities. If other persons are beneficial owners, the issuer shall also inquire of the record holder the number of copies of the proxy and other soliciting material and, in the case of an annual meeting at which directors are to be elected, the number of copies of the annual report to security holders, needed for supplying these materials to beneficial owners.

(5) The issuer shall supply the record holder in a timely manner with the additional copies of the annual report determined to be needed in section (4) of this rule, and assembled in a form and at a place reasonably requested by the record holder, in order to address and send one copy to each beneficial owner of the securities and shall pay the record holder's reasonable mailing expenses upon request.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0031
Requirements as to Proxy

(1) The form of proxy shall:

(a) Indicate in bold-face type whether the proxy is solicited on behalf of the issuer's board of directors, and if not, by whom it is solicited;

(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 issuer or by security holders.

(2) The form of proxy need not refer to proposals as to which discretionary authority is conferred pursuant to section (5) of this rule.

(3) A proxy must provide means for the person solicited to specify by ballot a choice between approval or disapproval of, or abstention with respect to, 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 represented by the proxy in each case.

(4) A form of proxy that provides both for elections to office and for action on other specified matters must clearly provide means, by a box or otherwise, 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 that does not withhold authority to vote for elections to office shall be considered a grant of such authority, if the form of proxy so states in boldface type.

(5) A proxy may confer discretionary authority to vote with respect to any of the following matters:

(a) Matters that, within a reasonable time before the solicitation, the persons making the solicitation do not know are to be presented at the meeting, if a specific statement to that effect is made in the proxy statement or form of proxy;

(b) Approval of the minutes of the prior meeting if the approval does not amount to ratification of the action taken at that meeting;

(c) The election of any person to any office for which a bona fide nominee is named in the proxy statement and the nominee is unable to serve or for good cause will not serve;

(d) Any proposal omitted from the proxy statement and the form of proxy pursuant to OAR 836-024-0039 and 836-024-0041; and

(e) Matters incident to the conduct of the meeting.

(6) A proxy may not confer authority to vote in either of the following instances:

(a) For the election of any person to any office for which a bona fide nominee is not named in the proxy statement. A person is not a bona fide nominee and may not be named as such unless the person has consented to being named in the proxy statement and to serve if elected.

(b) 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.

(7) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions:

(a) That the securities represented by the proxy will be voted; and

(b) That when the person solicited has specified a choice, by means of ballot provided pursuant to section (3) of this rule, with respect to any matter to be acted upon, the vote will be in accordance with specifications so made.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0033
Presentation of Information in Proxy Statement

(1) The information included in the proxy statement shall be clearly presented. The statements made must be divided into groups according to subject matter. The various groups of statements must be preceded by appropriate headings.

(2) All proxy statements shall disclose, under an appropriate caption, the date by which proposals of security holders intended to be presented at the next annual meeting must be received by the issuer for inclusion in the issuer's proxy statement and form of proxy relating to that meeting. The date must be calculated according to OAR 836-024-0039(2). If the date of the next annual meeting is subsequently advanced by more than 30 calendar days or delayed by more than 90 calendar days from the date of the annual meeting to which the proxy statement relates, the issuer in a timely manner shall inform security holders of the change and the date by which proposals of security holders must be received, by any means reasonably calculated to inform the security holders.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.:ID 16-2006, f. & cert. ef. 8-7-06

836-024-0036
Material Required to Be Filed

(1) Two preliminary copies of the proxy statement and form of proxy, and any other soliciting material to be furnished to security holders with the proxy, or the information pursuant to Schedule C, shall be filed with the Director at least ten days prior to the date final copies of the material are first sent or given to security holders, or a shorter period prior to that date that the Director authorizes 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 after the proxy statements shall be filed with the Director 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, or a shorter period prior to that date that the Director authorizes upon a showing of good cause.

(3) Two definitive copies of the proxy statement, form of proxy and all other soliciting material, or the information statement, in the form in which the material is furnished to security holders, shall be filed with, or mailed for filing to, the Director not later than the date the material is first sent or given to a security holder.

(4) 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 rule.

(5) 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 Director prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Director 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.

(6) If a proxy statement, form of proxy or other material filed pursuant to this rule is amended or revised, one of the copies of the amendment or revision shall be marked to clearly show the changes.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0038
Mailing Communications for Security Holders

(1) If the management of the issuer has made or intends to make any solicitation subject to OAR 836-024-0003 to 836-024-0055, the issuer shall perform any act described in this rule that is requested in writing with respect to the same subject matter or meeting by any security holder who is, or by security holders who are, entitled to vote at least one percent of the votes entitled to be voted on the matter. The requesting security holder or security holders shall pay the reasonable expenses incurred by the issuer in performing the act or acts requested.

(2) The issuer shall mail or otherwise furnish to a security holder, as promptly as practicable after the receipt of the request:

(a) A statement of the approximate number of record owners and, to the extent known to the issuer, the approximate number of beneficial owners of any class of securities, any of whom have been or are to be solicited on behalf of the management, or any group of whom that is designated by the security holder; and

(b) An estimate of the cost of mailing a specified proxy statement, form of proxy or other communication to the owners.

(3) The issuer shall mail copies of any proxy statement, form of proxy or other communication furnished by the security holder to the security owners specified in section (2) of this rule and designated by the security holder. The issuer shall mail the material furnished by the security holder with reasonable promptness after receiving the material to be mailed, envelopes or other containers therefor, and postage or payment for postage. The issuer need not, however, mail any material before the first day that solicitation is made on behalf of the issuer. The issuer is not responsible for the proxy statement, form of proxy or other communication.

(4) Instead of performing the acts specified in section (3) of this rule, the issuer may furnish promptly to a security holder a reasonably current list of the names and addresses of the record owners and, to the extent known to the issuer, the beneficial owners designated by the security holder and a schedule of the handling and mailing costs if the schedule has been supplied to the issuer.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.:ID 16-2006, f. & cert. ef. 8-7-06

836-024-0039
Proposals of Security Holders

(1) As used in this rule, "proponent" means a holder or holders of an issuer's securities.

(2) An issuer shall set forth a proposal for action in its proxy statement if the proponent notifies the issuer as provided in this section and if the proponent is entitled at the time of the notice to vote at least one percent of the votes entitled to be voted on the proposal. The proponent must notify the issuer in writing not less than 90 days before the issuer's annual meeting of the proponent's intention to present a proposal for action at an upcoming meeting of the issuer's security holders. The issuer shall identify the proposal in the issuer's form of proxy and provide for specifying approval or disapproval of the proposal. The proxy statement shall also include the name and address of the proponent.

(3) If the issuer opposes a proposal received from a proponent, the issuer shall also include in its proxy statement, at the request of the proponent, a statement of the proponent not exceeding 200 words in support of the proposal.

(4) The issuer may omit a proposal and any supporting statement from its proxy statement and form of proxy under any of the following circumstances:

(a) The proponent has submitted more than one proposal in connection with a particular meeting.

(b) The proposal is more than 300 words in length.

(c) The proposal or the supporting statement is contrary to any provision of OAR 836-024-0003 to 836-024-0055.

(d) The proposal relates to the enforcement of a personal claim or the redress of a personal grievance against the issuer, its management or any other person.

(e) The proposal deals with a matter not significantly related to the issuer's business, a matter beyond the issuer's power to effectuate, a matter relating to the conduct of the ordinary business operations of the issuer or an election to office.

(f) The proposal is counter to a proposal to be submitted by the issuer at the meeting, the proposal has been rendered moot or the proposal relates to specific amounts of cash or stock dividends.

(g) The proposal is substantially duplicative of a proposal that was previously submitted to the issuer by another proponent and will be included in the management's proxy material for the meeting.

(h) Substantially the same proposal has previously been submitted to security holders in the issuer's proxy statement and form of proxy relating to any annual or special meeting of security holders held within the preceding five years and received less than five percent of the total number of votes cast at the time of the proposal's most recent submission.

(5) If the issuer intends to omit a proposal from its proxy statement or forms of proxy or both, the issuer shall notify the proponent in writing of its intention at least ten days before the issuer's preliminary proxy material is filed pursuant to OAR 836-024-0036.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.:ID 16-2006, f. & cert. ef. 8-7-06

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 836-024-0055 may 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 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 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0046
Prohibition of Certain Solicitations

A person making a solicitation may 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 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0051
Special Provisions Applicable to Election Contests; Definition

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 regarding the election or removal of directors at an annual or special meeting of security holders. As used in OAR 836-024-0051 to 836-024-0055, unless the context requires otherwise:

(1) "Participant" and "participant in a solicitation" include:

(a) The issuer;

(b) A director of the issuer, 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.

(2) "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 duties in the course of such employment;

(d) A person regularly employed as an officer or employee of the issuer 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 employee is not otherwise a participant.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0053
Filings Required in an Election Contest

(1) A solicitation may not be made by a person other than the issuer unless 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 is filed with the Director by or on behalf of each participant in the solicitation. The statement and material must be filed with the Director at least five business days prior to the solicitation or a shorter period authorized by the Director upon a showing of good cause.

(2) Within five business days after a solicitation subject to this rule is made by the issuer, or within a longer period that the Director authorizes on a showing of good cause, a statement in duplicate containing the information specified by Schedule B shall be filed with the Director by or on behalf of each participant in the solicitation, other than the issuer, and by or on behalf of each management nominee for director.

(3) If a solicitation on behalf of the issuer or another person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this rule in opposition, a statement in duplicate containing the information specified in Schedule B shall be filed with the Director, by or on behalf of each participant in the prior solicitation, other than the issuer, as soon as it is reasonably practicable after the commencement of the solicitation in opposition.

(4) If, subsequent to the filing of the statements required by sections (1) to (3) of this rule, additional persons become participants in a solicitation subject to this rule, a statement in duplicate containing the information specified by Schedule B shall be filed with the Director by or on behalf of each such person within three business days after the person becomes a participant, or within a longer period that the Director 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 Director.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0054
Counter Solicitations Prior to Furnishing Required Written Proxy Statement

Notwithstanding the provisions of OAR 836-024-0026(1), a solicitation subject to OAR 836-024-0051 to 836-024-0055 may be made prior to furnishing security holders with 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. This section does not apply, however, if a proxy statement 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 of the information, 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 to security holders at the earliest practicable date.

Stat. Auth.: ORS 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

836-024-0055
Filing Requirements for Preliminary Solicitation Material

(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 Director in preliminary form at least five business days prior to the date definitive copies of the material are first sent or given to the persons unless on a showing of good cause the Director 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 solicitation subject to OAR 836-024-0051 to 836-024-0055, or to a participant in a solicitation, other than the solicitation by the management, shall be filed with the Director as proxy material subject to OAR 836-024-0051 to 836-024-0055. The annual report portion to which this section applies must be filed with the Director, 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 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76; ID 16-2006, f. & cert. ef. 8-7-06

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 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 731 & 732
Stats. Implemented: ORS 732.415(4)
Hist.: IC 68, f. & ef. 6-22-76

836-024-0100
Statutory authority; purpose

(1) OAR 836-024-0100 to 836-024-0220 are adopted under the authority of ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450 and 732.455, for the purpose of implementing ORS 732.420 to 732.455.

(2) OAR 836-024-0100 to 836-024-0220 apply to domestic stock insurers.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0105
Definitions

As used in OAR 836-024-0100 to 836-024-0220:

(1) "Class" means all securities of an insurer that are of substantially similar character and in which the holders enjoy substantially similar rights and privileges.

(2) "Equity security" as defined in ORS 732.420 also includes any voting trust certificate or certificate of deposit for an equity security.

(3) "Officer" means a president, vice president, treasurer, actuary, secretary, controller and any other person who performs functions for the insurer corresponding to functions performed by those officers.

Stat. Auth.: ORS 731.244, 732.420, 732.455
Stats. Implemented: ORS 732.420, 732.425, 732.430, 732.435, 732.440
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0110
Securities "Held of Record" for Purpose of ORS 732.425

(1) To determine for the purpose of ORS 732.425 whether the equity securities of an insurer are held of record by 100 or more persons, securities are considered to be "held of record" by each person who is identified as the owner of the securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

(a) If the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as an owner on the records if the records had been maintained in accordance with accepted practice shall be included as a holder of record.

(b) Securities identified as held of record by a corporation, a partnership, a trust (regardless of whether the trustees are named) or other organization shall be included as held of record by one person.

(c) Securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or other fiduciary with respect to a single trust, estate or account shall be included as held of record by one person.

(d) Securities held by two or more persons as co-owners shall be included as held by one person.

(e) Each outstanding unrecorded or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if the securities were recorded, they would be held of record under this rule by a lesser number of persons.

(f) Securities recorded in substantially similar names may be included as held of record by one person when the insurer has reason to believe that, because of the address or other indication, the names represent the same person.

(2) Section (1) of this rule does not apply in either of the following circumstances. Instead:

(a) Securities that, to the knowledge of the insurer, are held subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in the securities, except that the insurer may rely in good faith on information received in response to its request from a nonaffiliated issuer of the certificates or evidences of interest.

(b) If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent ORS 732.420 to 732.455, the insurer shall consider the beneficial owners of the securities to be the record owners.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0115
Filing of Statements

(1) A person who is required by ORS 732.430 to file a statement of beneficial ownership of equity securities shall file the initial statement on Form 3, which is prescribed in **Exhibit 1** to this rule. A person who is required by ORS 732.430 to file a statement of change in beneficial ownership shall file the statement of change on Form 4, which is prescribed in **Exhibit 2** to this rule.

(2) A director or officer who is required to file a statement of change on Form 4 shall include in the first statement of change the information required by Form 4 with respect to all changes in the beneficial ownership of equity securities of the insurer that occurred within six months prior to the date of the changes that required the filing of the statement, when a change occurs in the director's or officer's beneficial ownership of equity securities:

(a) Within six months after the director or officer became a director or officer of the insurer; or

(b) Within six months after a statement relating to the equity securities of the insurer has been filed with the Director, pursuant to ORS 732.430.

(3) A person who has ceased to be a director or officer of an insurer that has equity securities for which a statement is filed under ORS 732.430, or who is a director or officer of an insurer when the insurer ceased to have any equity securities for which a statement is filed under ORS 732.430, shall file a statement on Form 4 with respect to any change in the person's beneficial ownership of equity securities of the insurer if the change occurs:

(a) On or after the date on which the person ceased to be a director or officer or the date on which the insurer ceased to have any such equity securities, as the case may be; and

(b) Within six months after any change in the beneficial ownership of the securities prior to the date in subsection (a) of this section.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0120
Ownership of more than 10 percent of an equity security

(1) When it is to be determined for the purpose of ORS 732.430 whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, the class of the equity security consists of the total amount of the class outstanding, except for any securities of the class held by or for the account of the insurer or subsidiary of the insurer. To determine the percentage ownership of voting trust certificates or certificates of deposit for equity securities, however, the class of voting trust certificates or certificates of deposit consists of the amount of voting trust certificates or certificates of deposit issuable with respect to the total amount of outstanding equity securities of the class that may be deposited under the voting trust agreement or deposit agreement in question, regardless of whether all of the outstanding securities have been so deposited. For the purpose of this rule, a person acting in good faith may rely on the information contained in the latest Annual Statement filed with the Director of the Department of Consumer and Business Services with respect to the amount of securities of a class outstanding or in the case of voting trust certificates or certificates of deposit the amount issuable.

(2) When it is to be determined for the purpose of ORS 732.430 whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of equity securities, the person is considered to be the beneficial owner of securities of any class that the person has a right to acquire through the exercise of presently exercisable options, warrants or rights or through the conversion of presently convertible securities. A security that is subject to such an option, warrant, right or conversion privilege held by a person is considered to be outstanding for the purpose of computing, in accordance with section (1) of this rule, the percentage of outstanding securities of the class owned by the person. The security, however, is not considered to be outstanding for the purpose of computing the percentage of the class owned by another person.

(3) Section (2) of this rule does not relieve any person of a duty to comply with ORS 732.430 with respect to any equity securities consisting of options, warrants, rights or convertible securities that are otherwise subject as a class under ORS 732.430.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0125
Disclaimer of Beneficial Ownership

A person who files a statement may declare expressly in the statement that the filing may not be construed as an admission that the person is the beneficial owner for the purpose of ORS 732.420 to 732.455 of any equity securities covered by the statement.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0130
Exemptions from ORS 732.430 and 732.435

(1) Securities held by the following persons are exempt from ORS 732.430 and 732.435 for 12 months following the date of the person's appointment and qualification:

(a) An executor or administrator of the estate of a decedent;

(b) A guardian or committee for an incompetent; and

(c) A receiver, trustee in bankruptcy, assignor for the benefit of creditors, conservator, liquidating agent or other similar person authorized by law to administer the estate or assets of other persons.

(2) After the 12-month period following the appointment of a person to whom section (1) of this rule applies:

(a) The person shall file a statement under ORS 732.430 with respect to the securities held by the estates that the person administers; and

(b) The person is liable for profits realized from trading in the securities pursuant to ORS 732.435 only when the estate being administered is a beneficial owner of more than ten percent of any class of equity security of an insurer subject to ORS 732.430 and 732.435.

(3) Securities reacquired by or for the account of an insurer and held by it for its account are exempt from ORS 732.430 and 732.435 while they are held by the insurer.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0135
Exemptions from ORS 732.420 to 732.455 of Securities Purchased or Sold by Odd-lot Dealers

Securities purchased or sold by an odd-lot dealer are exempt from ORS 732.420 to 732.455 with respect to participation by the odd-lot dealer when the securities are purchased or sold:

(1) In odd lots that are reasonably necessary to carry on odd-lot transactions; or

(2) In round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0140
Certain Transactions Subject to ORS 732.430

Acquisition or disposition of the privilege of a transferable option, put, call, spread or straddle is a change in the beneficial ownership of the security to which the privilege relates. A person who acquires or disposes of such a privilege shall file a statement relating to the acquisition or disposition. This rule does not exempt a person, however, from filing the statements required when the option, put, call, spread or straddle is exercised.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0145
Ownership of Securities Held in Trust

(1) Beneficial ownership of a security for the purpose of ORS 732.430 includes any of the following:

(a) Ownership of securities as a trustee when either the trustee or members of the immediate family of the trustee have a vested interest in the income or corpus of the trust;

(b) Ownership of a vested beneficial interest in a trust; and

(c) Ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(2) Except as provided in section (4) of this rule, the following are exempt from the filing requirement in ORS 732.430:

(a) A person who has beneficial ownership of securities solely as a settlor or beneficiary of a trust, when less than 20 percent in market value of the securities having a readily ascertainable market value held by the trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities for which reports would otherwise be required.

(b) A person who has an obligation that would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, when the ownership, acquisition or disposition of the securities by the trust is made without prior approval by the settlor or beneficiary.

(3) An exemption under section (2) of this rule is not acquired or lost solely because of changes in the value of the trust assets during a fiscal year or during any time that there is no transaction by the trust in the securities otherwise subject to the reporting requirements of ORS 732.430.

(4) If ten percent of a class of an equity security of an insurer is held in trust, the trust and its trustee are considered to be a person that must file reports required by ORS 732.430.

(5) A trust is not required to file more than one report of holdings or of a transaction in securities held by a trust, regardless of the number of officers, directors or 10 percent stockholders that are trustees, settlors or beneficiaries of a trust, if the filed report discloses the name of all trustees, settlers and beneficiaries who are officers, directors or ten percent stockholders. A person having an interest only as a beneficiary of a trust is not required to file a report as long as the person relies in good faith upon an understanding that the trustee of the trust will file whatever reports might otherwise be required of the beneficiary.

(6) As used in this rule, the "immediate family" of a trustee means:

(a) A son or daughter of the trustee, or a descendant of either;

(b) A stepson or stepdaughter of the trustee;

(c) The father or mother of the trustee, or an ancestor of either;

(d) A stepfather or stepmother of the trustee; or

(e) A spouse of the trustee.

(7) For the purpose of determining whether any of the relations described in section (6) of this rule exists, a legally adopted child of a person is considered to be a child of the person by blood.

(8) For the purpose of determining under ORS 732.430 whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, the interest of that person in the remainder of a trust shall be excluded from the computation.

(9) A person is not required to file a report under ORS 732.430 with respect to the person's indirect interest in portfolio securities held by either of the following, regardless of whether the person is otherwise subject to the requirement of filing reports under ORS 732.430:

(a) A pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan.

(b) A business trust with more than 25 beneficiaries.

(10) This rule does not impose any duties or liabilities relating to the reporting of a transaction or holding prior to the effective date of the transaction or holding.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0150
Exemption for Small Transactions

(1) An acquisition of securities is exempt from ORS 732.430 when the person effecting the acquisition:

(a) Does not effect any disposition of securities of the same class, other than by gift, within six months of the acquisition; and

(b) Does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six-month period during which the acquisition occurs.

(2) An acquisition or disposition of securities by way of gift, when the total amount of the gifts does not exceed $3,000 in market

value for any six-month period, is exempt from ORS 732.430 and may be excluded from the computations under section (1)(b) of this rule.

(3) A person effecting a transaction exempted by section (1) or (2) of this rule shall include in the first report filed after the transaction a statement showing acquisitions and dispositions of the person for each six-month period or portion thereof that has elapsed since the last filing.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0155
Exemption from ORS 732.435 That Need not be Reported Under ORS 732.430

A transaction that has been or is exempted from the requirements of ORS 732.430 is also exempted from ORS 732.435 to the extent that the transaction would otherwise be subject to ORS 732.435.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0160
Exemption from ORS 732.435 of Certain Transactions Effected in Connection with a Distribution

(1) If the following conditions apply, a transaction of purchase and sale, or sale and purchase, of a security that is effected in connection with the distribution of a substantial block of securities is exempt from ORS 732.435 because the transaction is not included within the purpose of ORS 732.435:

(a) The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of business, in distribution of the block of securities;

(b) The security involved in the transaction is:

(A) A part of a block of securities and is acquired by the person effecting the transaction, with a view to its distribution, from the insurer or other person on whose behalf the securities are distributed or from a person who participates in good faith in the distribution of the block of securities; or

(B) A security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over-allotment or other short position created in connection with the distribution; and

(c) Other persons who are not subject to ORS 732.435 participate in the distribution of the block of securities on terms at least as favorable as those on which the person is participating and to an extent at least equal to the aggregate participation of all persons exempted from ORS 732.435 by this rule. The performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing the functions, however, does not preclude an exemption that would otherwise apply under this rule.

(2) Exemption of a transaction under this rule with respect to participation in the transaction by one person does not render the transaction exempt with respect to participation by any other person unless the other person also meets the conditions of this rule.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0165
Exemption from ORS 732.435 of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar plans

When a director or officer of an insurer issuing stock or a stock option acquires shares of the insurer's stock pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, other than stock acquired upon the exercise of an option, warrant or right, or acquires a qualified or restricted stock option through an employee stock purchase plan, the acquisition is exempt from ORS 732.435 if the plan meets the following conditions:

(1) The plan has been approved, directly or indirectly, by the affirmative votes of the holders of a majority of the securities of the insurer present, or represented, and entitled to vote at a meeting held according to Oregon law or by the written consent of the holders of a majority of the securities of the insurer entitled to vote. For the purpose of this section, "insurer" includes a predecessor corporation if the plan or obligations to participate in the plan were assumed by the insurer in connection with the succession. If, however, the vote or written consent was not solicited substantially in accordance with OAR 836-024-0003 to 836-024-0055 at the time of the vote or written consent, the following shall apply:

(a) The insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan that would be required by OAR 836-024-0003 to 836-024-0055 at the time the information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of the date on which ORS 732.420 to 732.455 first applies to the insurer, or the date of the acquisition of an equity security for which an exemption is claimed.

(b) The written information required in subsection (a) of this section may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of the written information must be filed with or mailed for filing to the Director of the Department of Consumer and Business Services not later than the date on which it is first sent or given to security holders of the insurer.

(2) If a person is authorized to exercise discretion in the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or in the determination of the number or maximum number of shares of stock that may be allocated to a director or officer or that may be covered by qualified, restricted or employee stock purchase plan stock options granted to the director or officer, the discretion may be exercised only as follows:

(a) With respect to the participation of directors:

(A) By the board of directors of the insurer, but a majority of the members of the board and a majority of the directors acting in the matter must be disinterested persons;

(B) By, or only in accordance with the recommendations of, a committee of three or more persons who have full authority to act in the matter, but only if all of the members of the committee are disinterested persons; or

(C) Otherwise in accordance with the plan, if the plan:

(i) Specifies the number or maximum number of shares of stock that directors may acquire or that may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which the stock may be acquired or the options may be acquired and exercised; or

(ii) Sets forth, by formula or otherwise, effective and determinable limitations with respect to acquisition or purchase based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages of shares outstanding from time to time, or similar factors.

(b) With respect to the participation of officers who are not directors:

(A) By the board of directors of the insurer or a committee of three or more directors; or

(B) By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, but only if all of the members of the committee are disinterested persons.

(c) For the purpose of this section, a director or committee member is a disinterested person only if the person, at the time discretion is exercised, is not eligible and has not at any time within one year prior to the exercise of discretion been eligible for selection as a person:

(A) To whom stock may be allocated; or

(B) To whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(d) This section does not apply with respect to any option granted, or other equity security acquired, prior to the date that ORS 732.430, 732.435 and 732.440 first become applicable with respect to any class of equity securities of any insurer.

(3) As to each participant or as to all participants, the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock that may be allocated, or that may be subject to qualified, restricted or employee stock purchase plan stock options granted pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date, and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earning of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors that will result in an effective and determinable limitation. The limitations may be subject to any provision for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

(4) All terms used in this rule have the same meaning as the terms have in ORS 732.420 to 732.455 and in OAR 836-024-0105. In addition, the following definitions apply to this rule:

(a) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

(b) The definitions of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in sections 422 and 423 of the Internal Revenue Code of 1954, as amended, apply to those terms as they are used in this rule. For the purpose of this rule, however, an option that meets all of the conditions of sections 422 and 423 of the Internal Revenue Code of 1954, as amended, other than the date of issuance, shall be considered to be a "restricted stock option."

(c) The term "exercise of an option, warrant or right" does not include:

(A) The making of any election to receive under any plan an award of compensation in the forma of stock or credits for stock, except that an election must be made prior to the making of the award and the election must be irrevocable until at least six months after termination of employment;

(B) The subsequent crediting of the stock;

(C) The making of any election as to a time for delivery of the stock after termination of employment, but only if the election is made at least six months prior to delivery.

(D) The fulfillment of any condition to the absolute right to receive stock; or

(E) The acceptance of certificates for shares of stock.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0170
Exemption from ORS 732.435 of Certain Transactions in Which Securities are Received by Redeeming other Securities

An acquisition of an equity security, other than a convertible security or right to purchase a security, by a director or officer of the insurer issuing the security, is exempt from ORS 732.435 if all of the following conditions are met:

(1) The equity security is acquired by way of redemption of another security of an insurer, substantially all of whose assets other than cash or government bonds consist of securities of the insurer issuing the equity security, and the equity security:

(a) Represented substantially and in practical effect a stated or readily ascertainable amount of equity security;

(b) Had a value that was substantially determined by the value of the equity security; and

(c) Conferred upon the holder the right to receive the equity security without the payment of any consideration other than the security redeemed.

(2) The director or officer did not acquire any security of the same class as the security redeemed within six months prior to the redemption or does not acquire any such security within six months after the redemption.

(3) The insurer issuing the equity security acquired has recognized the applicability of section (1) of this rule by appropriate corporate action.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0175
Exemption of long Term Profits Incident to Sales Within Six Months of the Exercise of an Option

(1) As provided in section (2) of this rule, the Director exempts as not comprehended within the purposes of ORS 732.435 any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security in which the purchase is made pursuant to the exercise of an option or similar right that was:

(a) Acquired more than six months before its exercise; or

(b) Acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

(2) Regarding any transaction described in section (1) of this rule, the profits inuring to the insurer may not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in this rule may be considered to enlarge the amount of profit that would inure to the insurer in the absence of this rule.

(3) The Director exempts as not comprehended within the purposes of ORS 732.435 the disposition of a security purchased in a transaction specified in section (1) of this rule pursuant to a plan or agreement described in this section when the terms of the plan or agreement are binding upon all stockholders of the insurer, except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings. This section applies to a plan or agreement:

(a) For merger or consolidation or reclassification of the insurer's securities; or

(b) For the exchange of the insurer's securities for the securities of another person that has acquired its assets, or that is in control, as defined in section 368(c) of the Internal Revenue Code of 1954, of a person that has acquired its assets.

(4) The exemptions under this rule do not apply to any transaction made unlawful by ORS 732.440 or rules adopted under that statute.

(5) The person claiming an exemption under this section bears the burden of establishing market price of the security.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0180
Exemption from ORS 732.435 of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidation

(1) The Director exempts as not comprehended within the purposes of ORS 732.435 the following transactions:

(a) The acquisition of a security of an insurer pursuant to a merger or consolidation in exchange for a security of a company that, prior to the merger or consolidation:

(A) Owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company; or

(B) Held more than 85 percent of the combined assets of the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by reference to their most available financial statements for a 12-month period prior to the merger or consolidation.

(b) The disposition of a security of an insurer, pursuant to a merger or consolidation of an insurer that, prior to the merger or consolidation:

(A) Owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company; or

(B) Held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation as determined by reference to their most recent available financial statements for a 12-month period prior to the merger or consolidation.

(2) A merger for the purpose of this rule includes the sale or purchase of substantially all the assets of one insurer by another in exchange for stock that is then distributed to the security holders of the insurer that sold its assets.

(3) Notwithstanding sections (1) and (2) of this rule, except for a purchase or sale exempted by this rule, the exemption under this rule is unavailable to a officer, director or stockholder to the extent of the

purchase and sale if the officer, director or stockholder purchases a security in a company involved in the merger or consolidation or sells a security in another company involved in the merger or consolidation within a period of less than six months during which the merger or consolidation took place.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0185
Exemption from ORS 732.435 of Transactions Involving the Deposit or Withdrawal of Equity Securities Under a Voting Trust or Deposit Agreement

(1) If substantially all of the assets held under a voting trust or deposit agreement immediately after the deposit of a security under the voting trust or deposit agreement or immediately prior to the withdrawal of a security under the voting trust or deposit agreement consisted of equity securities of the same class as the security deposited or withdrawn, the following transactions are exempt from ORS 732.435:

(a) The acquisition or disposition of an equity security involved in the deposit of the security under the voting trust or deposit agreement, and the acquisition or disposition of the certificate representing the equity security; and

(b) The acquisition or disposition of an equity security involved in the withdrawal of an equity security from the voting trust or deposit agreement, and the acquisition or disposition of the certificate representing the equity security.

(2) Unless a purchase or sale of an equity security described in this section is included in a transaction involved in a deposit or withdrawal that is exempt either under section (1) of this rule or under another provision of OAR 836-024-0100 to 836-024-0220 that implements ORS 732.435, the exemption in section (1) of this rule does not apply to the extent that the purchase or sale has occurred within a period of less than six months before or after a transaction described in section (1) of this rule, including the date of the transaction itself. This section applies to the following:

(a) A purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class; or

(b) A sale of an equity security of the class deposited and a purchase of any certificate representing an equity security of the class.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0190
Exemption from ORS 732.435 of Certain Transactions Involving the Conversion of Equity Securities

(1) An acquisition or disposition of an equity security involved in the conversion of an equity security is exempt from ORS 732.435 if the converted equity security, either immediately or after a stated period of time, is convertible by its terms or pursuant to the terms of the insurer's articles of incorporation or other governing instrument into another equity security of the same insurer.

(2) Unless an acquisition or disposition described in section (1) of this rule is included in a transaction involved in the conversion or in a transaction exempted by any other provision of OAR 836-024-0100 to 836-024-0220 that implements ORS 732.435, the exemption established in subsection (1) of this rule does not apply if either of the following has occurred within a period of less than six months before or after the conversion, including the date of the conversion. This section applies to the following:

(a) A purchase of any equity security of the class convertible, including any acquisition of or change in a conversion privilege and a sale of any equity security of the class issuable upon conversion; or

(b) A sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion.

(3) For the purpose of this rule:

(a) An equity security is not considered to be acquired or disposed of upon conversion of an equity security if the terms of the converted equity security require the payment or entail the receipt of cash or other property in connection with the conversion, other than equity securities involved in the conversion, equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

(b) An equity security is considered to be convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of the security or the governing instruments.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0200
Exemption from ORS 732.435 of Certain Transactions Involving the Sale of Subscription Rights

(1) Any sale of a subscription right to acquire any subject security of the same insurer is exempt from ORS 732.435, as provided in this rule, as not comprehended within the purpose of that statute, if:

(a) The subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(b) The subscription right by its terms expires within 45 days after issuance of the subscription;

(c) The subscription right by its terms is issued on a pro rata basis to all holders of the beneficiary security of the insurer; and

(d) A registration statement under the securities Act of 1933 is in effect as to each subject security, or the applicable terms of any exemption from registration have been met with respect to each subject security.

(2) As used in this rule:

(a) "Beneficiary security" means a security registered pursuant to section 12 of the federal Securities Exchange Act, to the holders of which a subscription right is granted.

(b) "Subject security" means a security that is the subject of a subscription right.

(c) "Subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security.

(3) If a person purchases subscription rights for cash or other consideration, then a sale by the person of subscription rights otherwise exempted by this rule is not exempted to the extent of the purchases within the six-month period preceding or following the sale.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0205
Exemption of Certain Securities from ORS 732.440

A security is exempt from ORS 732.440 to the extent necessary to render lawful under that statute the broker's execution of an order for an account in which the broker has no direct or indirect interest.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0210
Exemption from ORS 732.440 of Certain Transactions Effected in Connection with a Distribution

A security is exempt from the operation of ORS 732.440 to the extent necessary to render lawful under that section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, if the following conditions are met:

(1) The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on the dealer's behalf intends in good faith to offset the sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

(2) Other persons to whom ORS 732.440 does not apply participate in the distribution of the block of securities on terms at least as favorable as those under which the dealer is participating and to an extent at least equal to the aggregate participation of persons exempted from ORS 732.440 by this rule. The performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing the functions does not preclude an exemption that would otherwise be available under this rule.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0215
Exemption from ORS 732.440 of Sales of Securities to be Acquired

(1) When a person is entitled, as an incident to ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired is exempt from ORS 732.440 if:

(a) The sale is made subject to the same conditions as those attaching to the right of acquisition;

(b) The person exercises reasonable diligence to deliver the security to the purchaser promptly after the person's right of acquisition matures; and

(c) The person reports the sale on the appropriate form for reporting transactions by persons subject to ORS 732.430.

(2) This rule does not exempt transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by the seller pursuant to the right of acquisition.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

836-024-0220
Arbitrage Transactions under ORS 732.450

A director or officer of an insurer may not effect any foreign or domestic arbitrage transaction in any equity security of the insurer unless the director or officer includes the transaction in the statements required by ORS 732.430 and accounts to the insurer for the profits arising from the transaction as provided by ORS 732.435. ORS 732.440 does not apply to such an arbitrage transaction. ORS 732.420 to 743.455 do not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than a director or officer of the insurer.

Stat. Auth: ORS 731.244, 732.420, 732.430, 732.435, 732.445, 732.450, 732.455
Stats. Implemented: ORS 732.420 - 732.455
Hist.: ID 16-2006, f. & cert. ef. 8-7-06

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: Exhibits referenced are available from the agency.]
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: Exhibits referenced are available from the agency.]
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: Exhibits referenced are available from the agency.]
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: Forms referenced are available from the agency.]
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 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 of the Department of Consumer and Business Services by personal delivery or mail. 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: Forms referenced are available from the agency.]
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; ID 19-2006, f. & cert. ef. 9-26-06

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 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 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 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 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: Exhibits referenced are available from the agency.]
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: Exhibits referenced are available from the agency.]
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

Corporate Procedures Generally

836-027-0200
Custodial Arrangements

(1) This rule is adopted pursuant to the rulemaking authority in ORS 731.244 and 732.245 for the purpose of implementing ORS 732.245.

(2) As used in this rule:

(a) "Agent" means:

(A) A national bank;

(B) A state bank; or

(C) A trust company with an account in a clearing corporation or a member of the Federal Reserve System.

(b) "Bank" has the meaning given that term in ORS 706.008;

(c) "Clearing corporation" means a corporation as defined in Article 8 of the Uniform Commercial Code (published by the American Law Institute and the National Conference of Commissioners on Uniform State Laws, 2003), that is organized for the purpose of effecting transactions in securities by computerized book-entry, except those securities issued under the laws of a foreign country;

(d) "Custodian" means a bank or trust company licensed by the United States or by any state thereof and regularly examined by its licensing authority;

(e) "National bank" has the meaning given that term in ORS 706.008;

(f) "Securities" has the meaning given "security" in ORS 59.015;

(g) "Securities depository" means a company that provides securities clearance or settlement services for member banks and other member institutions and that is regulated by the Securities and Exchange Commission, a Federal Reserve Bank and the appropriate banking authorities in its state of domicile;

(h) "State bank" has the meaning given that term in ORS 706.008; and

(i) "Trust company" means a trust company as that term is defined in ORS 706.008 or a company that is authorized under the laws of a state other than Oregon to transact trust business, and includes the trust department of a bank.

(3) A domestic insurer may enter into a custodial or safekeeping arrangement with a custodian for the purpose of holding securities owned by the insurer, either in or outside this state, as provided in this section and section (4) of this rule. Such an arrangement must be made by written agreement between the domestic insurer and the custodian, must meet the requirements and standards of section (4) of this rule and must provide that the securities be held by the custodian or its agent.

(4) A custodial or safekeeping arrangement to which section (3) of this rule applies must account for and safeguard the securities of the domestic insurer, must facilitate examination of the insurer and the records of the insurer's custody account maintained by the custodian and must be in accordance with the following standards established in the Examiners Handbook, published by the National Association of Insurance Commissioners:

(a) The custodian must agree to indemnify the insurer for any loss of the insurer's securities as a result of the negligence or dishonesty of the officers or employees of the custodian, or burglary, robbery, holdup, theft or mysterious disappearance, including loss by damage or destruction;

(b) The custodian must agree that, in the event of a loss of the insurer's securities for which the custodian is obligated to indemnify the insurer, the custodian shall promptly replace the securities or the value of any loss of rights or privileges resulting from the loss of the securities;

(c) The insurer's securities or a certified listing of the insurer's securities through a securities depository or a Federal Reserve book entry system shall be subject to inquiry and examination by the Director of the Department of Consumer and Business Services, either at the custodian's premises or elsewhere, as provided by ORS 731.296 and 731.308;

(d) The national bank, state bank or trust company as custodian shall not be liable for any failure to take any action required to be taken under this rule in the event and to the extent that the taking of such action is prevented or delayed by war (whether declared or not and including a war in progress), revolution, insurrection, riot, civil commotion, act of God, accident, fire, explosions, stoppage of labor, strikes or other differences with employees, laws, regulations, orders or other acts of any governmental authority, or any other cause whatever beyond its reasonable control;

(e) In the event that the custodian gains entry in a clearing corporation through an agent, there shall be a written agreement between the custodian and the agent that the agent shall be subjected to the same liability for loss of securities as the custodian. If the agent is governed by laws that differ from laws regulating the custodian, the Director may accept a standard of liability applicable to the agent that is different from the standard liability;

(f) The custodian must agree to provide written notification to the Director, within three business days of receipt by the custodian of the insurer's written notice of termination or withdrawal, if the custodial agreement has been terminated or if 100 percent of the account assets in any one custody account have been withdrawn;

(g) The custodian must agree that during regular business hours, and upon reasonable notice, an officer or employee of the insurer, an independent accountant selected by the insurer or a representative of an appropriate regulatory body, or any combination thereof, shall be entitled to examine, on the premises of the custodian, its records relating to securities, if the custodian is given written instructions to that effect from an authorized officer of the insurer;

(h) The custodian and its agents, upon reasonable request, must agree to send all reports that they receive from a clearing corporation or the Federal Reserve book-entry system that the clearing corporation or the Federal Reserve permits to be redistributed and reports prepared by the custodian's outside auditors, to the insurer on the custodian's or agent's respective systems of internal control;

(i) To the extent that certain information maintained by the custodian is relied upon by the insurer in preparation of its annual statement and supporting schedules, the custodian must agree to maintain records sufficient to determine and verify such information;

(j) The custodian must agree to provide, upon written request from a regulator or an authorized officer of the insurer, the appropriate affidavits, with respect to the insurer's securities held by the custodian;

(k) The custodian must agree to secure and maintain insurance protection in an adequate amount; and

(l) The custodian that is a foreign bank, or a U.S. custodian's foreign agent, or a foreign clearing corporation must agree to only hold foreign securities or securities required by the foreign country in order for the insurer to do business in that country. A U.S. custodian must hold all other securities.

(5) A domestic insurer may enter into a custodial or safekeeping arrangement directly with a securities depository for the purpose of holding securities owned by the insurer, either in or outside this state, as provided in this section. Such an arrangement must be made by written agreement between the domestic insurer and the securities depository and must provide that the securities be held by the securities depository.

(6) A domestic insurer must obtain the approval of the Director for any material change to a custodial or safekeeping arrangement established under ORS 732.245. A change is material for purposes of this section:

(a) When the arrangement is with a custodian, if the purpose or effect of the change is to revise or omit any standard set forth in section (4) of this rule;

(b) When the arrangement is with a securities depository, if the purpose or effect of the change is to reduce the safety of the securities.

Stat. Auth.: ORS 731.244 & 732.245
Stats. Implemented: ORS 732.245
Hist.: ID 18-1998, f. & cert. ef. 11-20-98; ID 3-2006, f. & cert. ef. 2-13-06

Securities Lending Transactions

836-027-0300
Statutory Authority; Purpose

(1) OAR 836-027-0300 to 836-027-0360 are adopted pursuant to the authority of ORS 731.244 and 733.510 for the purpose of implementing ORS 733.510.

(2) OAR 836-027-0300 to 836-027-0360 establish requirements and limitations relating to securities lending transactions by domestic insurers.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510
Hist.: ID 4-2000, f. & cert. ef. 5-11-00

836-027-0310
Definitions

As used in OAR 836-027-0300 to 836-027-0360:

(1) "Acceptable collateral" means, as to securities lending transactions, cash, cash equivalents, letters of credit, direct obligations of, or securities that are fully guaranteed as to principal and interest by the government of the United States or any agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation. "Acceptable collateral" also means, with respect to lending foreign securities, sovereign debt rated 1 by the Securities Valuation Office of the National Association of Insurance Commissioners or any successor office established by the National Association of Insurance Commissioners.

(2) "Equivalent securities" means, in a securities lending transaction, securities that are identical to the loaned securities in all features including the amount of the loaned securities, except as to certificate number if held in physical form. In addition, for purposes of this definition, when a different security is exchanged for a loaned security by recapitalization, merger, consolidation or other corporate action, the different security is considered to be the loaned security.

(3) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510
Hist.: ID 4-2000, f. & cert. ef. 5-11-00

836-027-0320
Authorization by Board of Directors

Before a domestic insurer enters into a securities lending transaction, the board of directors of the domestic insurer must adopt a written plan that specifies the guidelines and objectives to be followed with respect to securities lending transactions, including the following:

(1) An assessment that securities lending transactions, including the guidelines relating thereto, are appropriate for the business conducted by the insurer and are consistent with ORS 733.510(4).

(2) An assessment of the insurer's technical investment and administrative capabilities and expertise to engage in securities lending transactions.

(3) A description of how cash received will be invested or used for general corporate purposes of the insurer.

(4) Operational procedures to manage securities lending transactions and borrower default risk and the use of acceptable collateral in a manner that reflects the liquidity needs of securities lending transactions.

(5) The extent to which the domestic insurer may engage in securities lending transactions.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510
Hist.: ID 4-2000, f. & cert. ef. 5-11-00

836-027-0330
Agreement with Borrower

Except as provided in OAR 836-027-0340, a domestic insurer shall enter into a written agreement with each borrower in a securities lending transaction. The written agreement between the insurer and the borrower must contain the following provisions:

(1) All loans must terminate not more than one year from the date of origination or upon the earlier demand of the insurer. The insurer must have the right to terminate the loan in a maximum of the normal settlement time for the loaned security.

(2) At the termination of the loan, the borrower must be obligated to return equivalent securities.

(3) The insurer must be entitled to receive from the borrower all distributions made by the issuer of the loaned securities during the duration of the loan, including cash dividends, stock dividends, stock splits and interest distributions of any kind declared, granted or made by the issuer, or any affiliate thereof, and rights to purchase or subscribe for additional securities.

(4) At the inception of the loan, the borrower must provide acceptable collateral. If the acceptable collateral is in the form of cash or cash equivalents, it must be in an amount specified in this section. If the acceptable collateral is in the form of a letter of credit, it must be an irrevocable letter of credit drawn on a bank acceptable to the insurer and in an amount specified in this section. If the acceptable collateral is in the form of direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation or in the form of sovereign debt rated 1 by the Securities Valuation Office of the National Association of Insurance Commissioners or any successor office established by the National Association of Insurance Commissioners, such securities must have a market value in an amount specified in this section. For purposes of this section:

(a) Except as provided in subsection (b) of this section, the amount or market value of the collateral must be determined as of the transaction date and must be at least equal to 102 percent of the market value of the loaned securities at that date; and

(b) In the event that foreign securities are loaned and the denomination of the currency of the collateral is other than the denomination of the currency of the loaned foreign securities, the amount or market value of the collateral must be at least equal to 105 percent of the market value of the loaned securities at that date.

(5) If the amount or market value of the collateral provided by the borrower at any time is less than the applicable amount or market value specified in section (4) of this rule, the borrower must immediately provide additional collateral as follows:

(a) If the amount or market value of the collateral to which section (4)(a) of this rule applies should become less than 100 percent of the market value of the loaned securities at the close of any business day, the borrower must immediately provide additional collateral to increase the amount or market value of the collateral up to an amount

at least equal to 102 percent of the market value of the loaned securities;

(b) If the amount or market value of the collateral to which section (4)(b) of this rule applies should become less than 102 percent of the market value of the loaned securities at the close of any business day, the borrower must immediately provide additional collateral to increase the amount or market value of the collateral up to an amount at least equal to 105 percent of the market value of the loaned securities; and

(c) In any transaction in which the borrower and the insurer agree on a designated percentage that is greater than the applicable amount or market value specified in section (4) of this rule, if the amount or market value of the collateral provided by the borrower should become an amount less than such designated percentage of the market value of the loaned securities at the close of any business day, the borrower must immediately provide additional collateral to increase the amount or market value of the collateral up to an amount at least equal to the designated percentage of the market value of the loaned securities.

(6) If the collateral is an irrevocable letter of credit, a replacement letter of credit replacing the existing letter of credit must be in the possession of the insurer a minimum of the normal settlement time for the security loaned plus four business days before the expiration date of the existing letter of credit. If a replacement letter of credit is not in the possession of the insurer by the required time, the insurer must perfect its rights under the existing letter of credit. The release of a letter of credit by the insurer before its expiration date must be conditioned upon the actual return of the loaned securities to the insurer.

(7) The insurer must have and exercise the right to use the collateral to purchase securities of the same issue in the principal market where the securities are traded should the borrower fail to return the loaned securities as required or requested. The agreement between the insurer and the borrower must detail how to handle excess collateral, or a deficiency, after such purchase.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510
Hist.: ID 4-2000, f. & cert. ef. 5-11-00

836-027-0340
Agreement with Agent as Alternative to Written Agreement

As an alternative to a written agreement between a domestic insurer and the borrower described in OAR 836-027-0330, the insurer may enter into an agreement with an agent acting on behalf of the insurer, if the agent is a qualified business entity and if the agreement:

(1) Requires the agent to enter into separate agreements with each borrower that are consistent with the requirements of OAR 836-027-0330; and

(2) Prohibits securities lending transactions pursuant to the agreement with the agent or its affiliates.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510

836-027-0350
Limitation

A domestic insurer shall not enter into a securities lending transaction if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities then loaned to any one borrower would exceed five percent of its admitted assets; or

(2) The aggregate amount of all securities then loaned to all borrowers would exceed 40 percent of its admitted assets.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510
Hist.: ID 4-2000, f. & cert. ef. 5-11-00

836-027-0360
Type of Borrower, Investment of Collateral, Valuation and Reporting

In a securities lending transaction, a domestic insurer shall comply with the following requirements:

(1) The borrower must be a registered securities broker or a bank or trust company or registered as a primary dealer of government securities with the Federal Reserve System. For purposes of this rule:

(a) "Bank or trust company" means any bank or trust company that is organized under the laws of the United States or any state thereof and is regularly examined pursuant to such laws; and

(b) "Registered securities broker" means a securities broker registered under the federal Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.).

(2) For so long as a securities lending transaction remains outstanding, the insurer, its agent or custodian shall maintain, as to acceptable collateral received in the transaction, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the Director:

(a) Possession of the acceptable collateral;

(b) A perfected security interest in the acceptable collateral; or

(c) In the case of a jurisdiction outside the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(3) If the insurer has investment discretion concerning the collateral, the collateral may be invested only in assets with a maturity date no later than one year from date of purchase, and that, if held directly by the insurer, would qualified as admitted assets pursuant to ORS Chapter 733.

(4) Each securities lending transaction and investment of the collateral must comply with ORS 733.730 and 733.740.

(5) The valuation procedures as prescribed in the "Valuations of Securities" manual of the National Association of Insurance Commissioners shall be used to value loaned securities in any financial statements filed by the insurer with the Director.

(6) In any financial statements filed by the insurer with the Director, the securities lending transaction shall be reported as designated by the Director in accordance with Statement of Statutory Accounting Principles No. 18. An insurer shall file with its annual statement a supporting schedule that reports such transactions as required by the annual statement filing instructions.

(7) In situations in which the securities are held outside the State of Oregon, the securities must be held by a bank or trust company in accordance with OAR 836-027-0200.

(8) The insurer shall maintain within this state original copies of all agreements to lend securities and any attachments, amendments or exhibits thereto. A current inventory of all loaned securities containing the identity of and location of all collateral shall be maintained within the State of Oregon. In addition, adequate records shall be maintained within the State of Oregon to verify the insurer's activities in loaned securities and the possession of the necessary collateral.

Stat. Auth.: ORS 731.244 & 733.510
Stats. Implemented: ORS 733.510
Hist.: ID 4-2000, f. & cert. ef. 5-11-00

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 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 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 prescribed by the Director.

(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 prescribed by the Director.

Stat. Auth.: ORS 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; ID 19-2006, f. & cert. ef. 9-26-06

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 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 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 Insurance Producers by Purchasing Groups

A purchasing group shall employ an insurance producer to procure insurance for its members in Oregon. Such an insurance producer:

(1) Must hold a current insurance producer'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 731, 735 & 746
Stats. Implemented: ORS 735.350
Hist.: ID 19-1988, f. & cert. ef. 12-6-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 prescribed by the Director.

(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 prescribed by the Director.

Stat. Auth.: ORS 731, 735 & 746
Stats. Implemented: ORS 735.315
Hist.: IC 7-1988, f. & cert. ef. 4-14-88; ID 19-2006, f. & cert. ef. 9-26-06

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 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 731, 735 & 746
Stats. Implemented: ORS 735.315(2)(a) - 735.315(c)
Hist.: IC 7-1988, f. & cert. ef. 4-14-88

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 generally:

(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 **1987 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.

[ED. NOTE: Tables referenced are available from the agency.]
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

836-031-0410
Title Insurance Unearned Premium Reserve

(1) For the purpose of implementing ORS 733.090(2), the amount of the unearned premium reserve shall be determined as follows for each foreign or alien title insurer relating to policies insuring titles to real property in this state and for each domestic title insurer relating to all of its policies insuring titles to real property:

(a) Three percent of all gross premiums on title insurance policies issued by it during the preceding 15 years and prior to January 1, 2002; plus

(b) A percentage of all gross premiums on title insurance policies issued by it during the current calendar year as determined from section (2) of this rule; less

(c) Percentage portions of reserve additions for each calendar year following January 1, 2002 and preceding the current calendar year, as specified by the Director.

(2) The percentage of premium for reserve additions in subsection (b) of section (1) of this rule shall be as follows:

(a) Three percent for calendar year 2002.

(b) Four percent for calendar year 2003.

(c) Five percent for calendar year 2004.

(d) Six percent for calendar year 2005.

(e) Six and one-half percent for calendar year 2006.

(f) Seven percent for calendar year 2007 and for each calendar year thereafter.

(3) The portion of the unearned premium reserve of a foreign insurer relating to its policies insuring real property located elsewhere shall be not less than the amounts prescribed or permitted by the laws of the insurer's domicile.

(4) This rule applies to all reporting periods beginning on and after January 1, 2002.

Stat. Auth.: ORS 731.244 & 733.090
Stats. Implemented: ORS 733.090
Hist.: ID 13-2002, f. & cert. ef. 5-14-02; ID 7-2005, f. & cert. ef. 4-21-05

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.

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; ID 19-2006, f. & cert. ef. 9-26-06

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: Publications referenced are available from the agency.]
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.

[ED. NOTE: Exhibits referenced are available from the agency.]

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

_____

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 theCompany, Accounting Firm or the Security Analyst."

[ED. NOTE: Tables referenced are available from the agency.]

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

Valuation of Life Insurance Policies

836-031-0750
Purpose, Authority and Applicability

(1) The purpose of OAR 836-031-0750 to 836-031-0775 is to provide:

(a) Tables of select mortality factors and rules for their use;

(b) A minimum standard for the valuation of plans with nonlevel premiums or benefits; and

(c) A minimum standard for the valuation of plans with secondary guarantees.

(2) The method for calculating basic reserves defined in OAR 836-031-0750 to 836-031-0775 constitutes the Commissioners' Reserve Valuation Method for policies to which OAR 836-031-0750 to 836-031-0775 apply.

(3) OAR 836-031-0750 to 836-031-0775 are adopted under the rulemaking authority of ORS 731.244 for the purpose of implementing ORS 733.030.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.030, 733.210 & 733.300 - 733.322
Hist.: ID 7-1999, f. 12-29-99, cert. ef. 1-1-00

836-031-0755
Applicability

OAR 836-031-0750 to 836-031-0775 apply to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000, subject to OAR 836-051-0106 and the following exceptions and conditions:

(1) The following exceptions apply:

(a) OAR 836-031-0750 to 836-031-0775 do not apply to any individual life insurance policy issued on or after January 1, 2000, if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this regulation, that guarantees the premium rates of the new policy. OAR 836-031-0750 to 836-031-0775 also do not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(b) OAR 836-031-0750 to 836-031-0775 do not apply to any universal life policy that meets all the following requirements:

(A) Secondary guarantee period, if any, is five years or less;

(B) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on CSO valuation tables as defined in OAR 836-031-0760 and the applicable valuation interest rate; and

(C) The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

(c) OAR 836-031-0750 to 836-031-0775 do not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(d) OAR 836-031-0750 to 836-031-0775 do not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(e) OAR 836-031-0750 to 836-031-0775 do not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(2) The following conditions apply:

(a) Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of OAR 836-031-0770.

(b) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of OAR 836-031-0775.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.030, 733.210 & 733.300 - 733.322
Hist.: ID 7-1999, f. 12-29-99, cert. ef. 1-1-00; ID 9-2003, f. 12-26-03, cert. ef. 1-1-04

836-031-0760
Definitions

As used in OAR 836-031-0750 to 836-031-0775:

(1) "Basic reserves" means reserves calculated in accordance with ORS 733.306.

(2) "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined in this section. All calculations are made using the 1980 CSO valuation tables, as defined in section (6) of this rule, (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after January 1, 2000, and adopted by rule by the Director of the Department of Consumer and Business Services for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in OAR 836-031-0765(2). [Example not included. See ED. NOTE.]

(3) "Deficiency reserves" means the excess, if greater than zero, of minimum reserves calculated in accordance with ORS 733.320 over basic reserves.

(4) "Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

(5) "Maximum valuation interest rates" means the interest rates defined in ORS 733.310 (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

(6) "1980 CSO Valuation tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

(7) "Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in OAR 836-031-0775(1)(c), if any, or else the minimum premium described in OAR 836-031-0775(1)(d).

(8)(a) "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(A) The present value of the death benefits within the segment; plus

(B) The present value of any unusual guaranteed cash value (according to OAR 836-031-0770(4)) occurring at the end of the segment; less

(C) Any unusual guaranteed cash value occurring at the start of the segment; plus

(D) For the first segment only, the excess of subparagraph (i) over subparagraph (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(b) The length of each segment is determined by the "contract segmentation method," as defined in this section.

(c) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

(d) For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

(9) "Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

(10) "Ten-year select factors" means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

(11)(a) "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

(A) Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

(B) Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of subparagraph (i) over subparagraph (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(b) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

(12) "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

[ED. NOTE: Examples referenced are available from the agency.]

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.030, 733.210 & 733.300 - 733.322
Hist.: ID 7-1999, f. 12-29-99, cert. ef. 1-1-00; ID 9-2003, f. 12-26-03, cert. ef. 1-1-04

836-031-0765
General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves

(1) At the election of the insurer for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after January 1, 2000, and adopted by the Director of the Department of Consumer and Business Services by rule for this purpose). If select mortality factors are elected, they may be:

(a) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(b) The select mortality factors in the Appendix; or

(c) Any other table of select mortality factors adopted by the NAIC after January 1, 2000, and adopted by the Director of the Department of Consumer and Business Services by rule for the purpose of calculating basic reserves.

(2) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after January 1, 2000, and adopted by the Director of the Department of Consumer and Business Services by rule for this purpose). If select mortality factors are elected, they may be:

(a) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(b) The select mortality factors in the Appendix of this regulation;

(c) For durations in the first segment, X percent of the select mortality factors in the Appendix, subject to the following:

(A) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(B) X shall not be less than twenty percent (20%);

(C) X shall not decrease in any successive policy years;

(D) X is such that, when using the valuation interest rate used for basic reserves, subparagraph (i) is greater than or equal to subparagraph (ii):

(i) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(ii) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date.

(E) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five years after the valuation date;

(F) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of this subsection;

(G) The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of this subsection; and

(H) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(I) If X is less than 100 percent at any duration for any policy, the following requirements shall be met:

(i) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of OAR 836-031-0670; and

(ii) The appointed actuary shall annually opine for all policies subject to OAR 836-031-0750 to 836-031-0775 as to whether the mortality rates resulting from the application of X meet the requirements of this subsection. This opinion shall be supported by an actuarial

report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(d) Any other table of select mortality factors adopted by the NAIC after January 1, 2000, and adopted by the Director of the Department of Consumer and Business Services by rule for the purpose of calculating deficiency reserves.

(3) This section applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

(4) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

(5) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following:

(a) Reserves calculated ignoring the guarantee;

(b) Reserves assuming the guarantee was made at issue; and

(c) Reserves assuming that the policy was issued on the date of the guarantee.

(6) The Director of the Department of Consumer and Business Services may require that the insurer document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to January 1, 2000. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of OAR 836-031-0670.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.030, 733.210 & 733.300 - 733.322
Hist.: ID 7-1999, f. 12-29-99, cert. ef. 1-1-00

836-031-0770
Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)

(1) Basic Reserves. Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described as follows may be made:

(a) Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment; or

(b) Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2) Deficiency Reserves:

(a) The deficiency reserve at any duration shall be calculated:

(A) On a unitary basis if the corresponding basic reserve determined by section (1) of this rule is unitary;

(B) On a segmented basis if the corresponding basic reserve determined by section (1) of this rule is segmented; or

(C) On the segmented basis if the corresponding basic reserve determined by section (1) of this rule is equal to both the segmented reserve and the unitary reserve.

(b) This subsection applies to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in OAR 836-031-0565(2)) and rate of interest.

(c) Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in OAR 836-031-0565(2).

(d) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(3) Minimum Value. Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

(4) Unusual Pattern of Guaranteed Cash Surrender Values:

(a) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(b) The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, when:

(A) *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(i) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(ii) The mandatory expiration date of the policy; and

(B) The net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

(C) The net to gross ratio is equal to subparagraph (i) divided by subparagraph (ii) as follows:

(i) The present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the *n* year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period.

(ii) The present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period.

(c) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(A) 110 percent of the scheduled gross premium for that year;

(B) 110 percent of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(C) Five percent of the first policy year surrender charge, if any.

(5) This section creates an optional exemption for yearly renewable term reinsurance. At the option of the insurer, the following approach for reserves on yearly renewable term reinsurance may be used:

(a) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(b) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in section (3) of this rule.

(c) Deficiency reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with paragraph (A) of this subsection.

(d) For purposes of this section, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after January 1, 2000, and adopted by the Director of the Department of Consumer and Business Services by rule for this purpose.

(e) A reinsurance agreement shall be considered yearly renewable term reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(f) If the assuming insurer chooses the optional exemption described in this section, the ceding insurer's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming insurer for the affected policies.

(6) This section creates an optional exemption for attained-age-based yearly renewable term life insurance policies. At the option of the insurer, the following approach for reserves for attained-age-based yearly renewable term life insurance policies may be used:

(a) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(b) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in section (3) of this rule.

(c) Deficiency reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with paragraph (A) of this subsection.

(d) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after January 1, 2000, by the NAIC and adopted by the Director of the Department of Consumer and Business Services by rule for this purpose.

(e) A policy shall be considered an attained-age-based yearly renewable term life insurance policy for purposes of this subsection if:

(A) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(B) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

(f) For policies that become attained-age-based yearly renewable term policies after an initial period of coverage, the approach of this section may be used after the initial period if:

(A) The initial period is constant for all insureds of the same sex, risk class and plan of insurance, or the initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(B) After the initial period of coverage, the policy meets the conditions of subsection (e) of this section.

(g) If the election under this section is made, the approach in this section shall be applied in determining reserves for all attained-age-based yearly renewable term life insurance policies issued on or after January 1, 2000.

(7) This section creates an exemption from Unitary Reserves for Certain *n*-Year Renewable Term Life Insurance Policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

(a) The policy consists of a series of *n*-year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, *n* may be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the size of the earlier *n*-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(b) The guaranteed gross premiums in all *n*-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors; and

(c) There are no cash surrender values in any policy year.

(8) This section creates an exemption from Unitary Reserves for Certain Juvenile Policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

(a) At issue, the insured is age 24 or younger;

(b) Until the insured reaches the end of the juvenile period, which shall occur at or before age 25, the gross premiums and death benefits are level, and there are no cash surrender values; and

(c) After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.030, 733.210 & 733.300 - 733.322
Hist.: ID 7-1999, f. 12-29-99, cert. ef. 1-1-00

836-031-0775
Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies that Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period

(1) The following standards apply for purposes of this rule:

(a) Policies with a secondary guarantee include:

(A) A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(B) A policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after January 1, 2000, by the NAIC and adopted by the Director of the Department of Consumer and Business Services by rule for this purpose; or

(C) A policy with any combination of paragraphs (A) and (B) of this subsection.

(b) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in sections (2) and (3) of this rule shall be recalculated from issue to reflect these changes.

(c) Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(d) For purposes of this rule, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(e) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in OAR 836-031-

0765(2)(b), (c) and (d) may not be used to calculate the one-year valuation premiums.

(f) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(2) Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in OAR 836-031-0760(2).

(3) Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in OAR 836-031-0770(2) with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

(4) The minimum reserves during the secondary guarantee period are the greater of:

(a) The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(b) The minimum reserves required by other rules governing universal life plans.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.030, 733.210 & 733.300 - 733.322
Hist.: ID 7-1999, f. 12-29-99, cert. ef. 1-1-00

836-031-0855
Recoupment of Assessments by Oregon Insurance Guaranty Association

(1) This rule is adopted under the authority of ORS 731.244 and 734.579, for the purpose of implementing ORS 734.579, relating to the recoupment by insurers of assessments made by the Oregon Insurance Guaranty Association under ORS 734.570. For the purpose of this rule:

(a) "OIGA assessment" means the assessment imposed on an insurer by the Oregon Insurance Guaranty Association.

(b) "Recoupment assessment" means the assessment charged by the insurer to its policyholders.

(2) An insurer shall recoup an OIGA assessment from its policyholders on premiums written or renewed on or after the recoupment start date as provided in section (6) of this rule. The recoupment assessment shall be imposed on a pro-rata basis of net direct written premiums. For the purpose of this section, "net direct written premiums" are gross premiums, including policy and membership fees, less return premiums and premiums on policies not taken, as reported in column 1 of the Oregon State Page, Exhibit of Premium and Losses. An insurer may state the recoupment assessment to be charged to each policyholder in terms of a rate instead of a dollar amount and shall adjust the notice in section (5) of this rule as appropriate.

(3) An insurer may state the amount or rate of the recoupment assessment in the premium statement on the declaration page or other page of an insurance policy that serves as a declaration page rather than on the premium billing statement if the premium billing statement clearly informs the policyholder that the recoupment assessment is so located on the declaration page or other page. For the purpose of this section, the premium billing statement is the statement transmitted by the insurer to the policyholder that informs the policyholder of the premium due.

(4) If an insurer does not issue a premium billing statement, the insurer must state the amount or rate of the recoupment assessment on the declaration page, on a balance due notice or on a rate quote.

(5) An insurer shall include the following notice on or with the statement of recoupment assessment at the first time each year in which a recoupment assessment is made: Most insurers doing business in Oregon participate in the Oregon Insurance Guaranty Association. In the event an insurer fails, the Association settles unpaid claims on behalf of consumers. Oregon law requires that policies be surcharged directly to recover the costs of handling those claims. If your policy is surcharged, the term (Note: each insurer must insert here the descriptive term it uses to designate the surcharge) along with an indicated dollar amount will be displayed with the statement of your surcharge.

(6) An insurer shall begin recoupment of an OIGA assessment on a date that is on or after January 1 of the year following the year in which the OIGA assessment was imposed but not later than April 1 of that year and shall continue the recoupment assessment for the 12-month period following that date. On and after the date on which an insurer's recoupment period begins, the insurer must state the amount or rate of the recoupment billed to the policyholder. An insurer shall make a good faith effort to fully collect the OIGA assessment during that period and may adjust the amount or rate of a recoupment assessment in the course of the period as needed to make the recoupment more accurate or to add any additional recoupment assessment required by subsequent OIGA assessments against the insurer. Any such adjustment shall apply to all policies from which a recoupment assessment is collected on and after the date of the adjustment.

(7) The minimum threshold below which a recoupment assessment need not be made is the amount at which the cost of recouping the OIGA assessment exceeds the amount to be recouped. When an insurer decides not to recoup an amount under this section, the insurer shall record the amount not recouped as an expense on the income statement of the insurer. An insurer may not later recoup any amount so recorded.

(8) Not later than June 1 of each year in which a 12-month recoupment assessment period established by an insurer under section (6) of this section is completed, the insurer shall submit to the Director, on a form prescribed by the Director, the annual certification required by ORS 734.579, indicating the total recoupment assessed and recovered during that recoupment period.

(9) If the amount of recoupment assessments collected by an insurer within the 12-month period beginning on the date on which the insurer began the recoupment exceeds the total amount of the OIGA assessment against the insurer, the insurer shall do one of the following:

(a) Pay back the excess.

(b) Subject to section (10) of this rule, carry over the amount of the excess to a date that is not later than June 1 of the year following the year in which the insurer submits the annual certification under section (8) of this rule for the recoupment period to which the excess applies.

(10) Not later than June 1 of the year to which an insurer has carried over an amount of excess under section (9)(b) of this rule, the insurer must dispose of the excess carried over according to one of the following methods:

(a) By applying the excess to reduce any new recoupment assessment arising during the carry-over period.

(b) By returning the excess to its current policyholders.

(c) Except as provided in this subsection, by transferring the excess to the Oregon Insurance Guaranty Association, which shall hold all amounts so received for the purpose of paying covered claims arising under subsequent insurer insolvencies. If the amount of the excess divided by the number of policies from which recoupment assessments were collected is $10 or more, the insurer instead shall dispose of the excess according to the method in subsection (a) or (b) of this section.

(11) If the amount of recoupment assessments collected by an insurer within the 12-month period beginning on the date on which the insurer began the recoupment is less than the total amount of the assessment against the insurer, the insurer shall carry over the amount of the insufficiency to the next 12-month period in which the insurer imposes a new recoupment assessment. The amount carried over shall be applied to increase the new recoupment assessment. If the insurer determines, however, that the cost of recouping the remaining amount exceeds the amount of the insufficiency, the insurer need not carry over the insufficiency. The insurer instead shall record the amount not recouped as an expense on the income statement of the insurer. An insurer may not later recoup any amount so recorded.

(12) An insurer may take all or any part of a recoupment charge owing from a policyholder from the first payment of premium by the policyholder.

Stat. Auth.: ORS 731.244 & 734.579
Stats. Implemented: 734.579
Hist.: ID 5-2003(Temp), f. & cert. ef. 11-26-03 thru 5-15-04; ID 4-2004, f. 5-14-04, cert. ef. 5-15-04; ID 12-2006, f. & cert. ef. 6-26-06

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 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 percent 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 Association 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

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 Director in ORS 731.244.

(2) The purpose and applicability of OAR 836-042-0001 to 836-042-0035 is to effectuate orderly administration of the 1981 amendments to ORS 737.205, 737.225, 737.265 and 737.320 requiring insur-

ers 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.

Stat. Auth.: ORS 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; ID 19-2006, f. & cert. ef. 9-26-06

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

836-042-0015
Workers' Compensation Filings — Procedural Rules for Insurers and Rating Organizations

(1) Every workers' compensation insurer shall file with the Director copies of the workers' compensation insurance premium rates to be used by it. An insurer may satisfy this requirement by authorizing the Director to accept on its behalf the provisions for claims 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 Exhibits 1 and 2 or must be accompanied by the NAIC Loss Cost Data Entry Document and the NAIC Loss Cost Filing Document for Workers' Compensation.

(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 Director for review prior to becoming effective.

(4) The effective date of a workers' compensation insurance filing required by section (3) of this rule to be submitted to the Director for review shall be the date specified therein but not earlier than the 30th day after the date the filing is received by the Director, or the 30th day after the date of receipt of supporting information, whichever is later. If the Director has reviewed the filing prior to expiration of the waiting period, the Director 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 Director 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 Director within the waiting period or extension thereof.

(5) An insurer may authorize the Director 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 Director 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 Director 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 rule should be construed to require any insurer to adopt any rating plan or rating system filed by a rating organization and approved by the Director 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 Director, 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 Director 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 ORS chapter 737 and OAR 836-042-0035.

(10) Section (6) of this rule, as amended effective July 28, 1998, applies to actions taken by insurers under that section on and after June 24, 1998.

[ED. NOTE: Exhibits referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
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; ID 19-1997(Temp), f. 12-23-97, cert. ef. 1-1-98 thru 6-22-98; ID 9-1998, f. & cert. ef. 7-28-98; ID 10-2006, f. & cert. ef. 6-9-06

836-042-0020
Insurers Must Demonstrate Statistical 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, classification 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 731
Stats. Implemented: ORS 737.325(1)-(2), 737.325(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 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 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 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 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 Report Expanded (URE) Workers Compensation Statistical Plan, Edition of July 1, 2001 filed by the National Council on Compensation Insurance and approved by the Director to become effective January 1, 2002 is prescribed as the statistical plan for workers' compensation insurance. The January 1, 2004 edition of Part 8, Pension Tables, of the NCCI URE Workers Compensation Statistical Plan is prescribed as the pension tables effective in this state January 1, 2004. The January 1, 2006 edition of Part 4, Paragraph 6, Gross Losses, and Paragraph 35, Deductible Reimbursement, and Part 5, Paragraph 4, Correction Reports, is prescribed as the statistical plan for the Oregon Employer Paid Medical Program Limits effective January 1, 2006.

(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.

(3) The amendments in section (1) of this rule, which were filed in ID 7-2003 with the Secretary of State on December 3, 2003 to become effective on January 1, 2004, are re-adopted with the operative date of January 1, 2004.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 737.225
Stats. Implemented: ORS 737.225

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; ID 2-1998, f. & cert. ef. 2-6-98; ID 15-2001, f, 12-19-01, cert. ef. 1-1-02; ID 7-2003, f. 12-3-03 cert. ef. 1-1-04; ID 5-2005, f. & cert. ef. 4-7-05; ID 10-2006, f. & cert. ef. 6-9-06

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 Director in ORS 731.244 and the specific authority of ORS 737.310, which authorizes the Director 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 OAR 836-042-0050 to 836-042-0060 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 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; ID 12-1998, f. & cert. ef. 9-14-98

836-042-0055
Definitions, Payroll Inclusions and Exclusions

(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, and the State Accident Insurance Fund Corporation.

(d) "Interchange of labor" means an employee or employees who 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 that are payable to workers for their services and that 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 the 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;

(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; ID 12-1998, f. & cert. ef. 9-14-98

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 maintained by 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 and this rule.

(2) This rule does not apply to a single employee whose duties vary within exposure areas normally anticipated by the scope of a single classification or who spends only a limited amount of time, on an infrequent or irregular basis, in a classification exposure that is not a normal job function for that employee. As used in this section, "infrequent or irregular" means that the time spent in the classification exposure is limited, is not anticipated in the normal duties of the employee and occurs only randomly.

(3) When verifiable payroll records are required with respect to a single employee and the employer does not maintain them as required in this rule, the entire payroll of the employee shall be assigned to the highest rated classification exposure in accordance with the standards for rebilling set forth in OAR 836-043-0190.

(4) For purposes of this rule, payroll records of an employee are verifiable if they have the following characteristics:

(a) The records must establish a time basis, and the time basis must be hourly or a part thereof, daily or part thereof, weekly or part thereof, monthly or part thereof or yearly or part thereof;

(b) For each salaried employee, the records must also include time records in which the salary is converted to an hourly, daily, weekly, monthly or yearly rate and then multiplied by the time spent by the employee in each classification exposure;

(c) The records must include a description of duties performed by the employee, to enable the insurer to determine correct classification assignment. Records requiring additional explanation or interpretation are not considered to be verifiable; and

(d) The records must be supported by original entries from other records, including but not limited to time cards, calendars, planners or daily logs prepared by the employee or the employee's direct supervisor or manager. Estimated ratios or percentages do not comply with the requirement of this subsection and are not acceptable for verifica-

tion. Verifiable records must be summarized in the insured employer's accounting records.

(5) 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.

(6) 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; ID 1-1999, f. & cert. ef. 2-19-99

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 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 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 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.

(4) Report premium, deductible credit premium and reimbursements by policy year as of the end of each calendar quarter as specified in Exhibit 1 to this rule not later than the 45th day after the end of each quarter.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 737, 737.310 & 741.001 - 742.007
Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95; ID 5-2005, f. & cert. ef. 4-7-05

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 Director. The form must include the following wording, or substantially equivalent wording approved by the Director: "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 and nature 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; ID 3-1999, f. & cert. ef. 3-25-99

836-042-0220
Filing Requirements and Procedural Rules

(1) Before issuing any policies to group members that are to be rated by the combined experience of the group, the insurer must file the following with the Director for each group:

(a) The name and nature of the organization to which employers in the group belong;

(b) A copy of documentation forming the organization;

(c) The number of employers in the organization;

(d) A listing of employers in the organization that have signed consent-to-group-rating forms;

(e) The number of covered workers employed by employers that have signed consent-to-group-rating forms;

(f) An explanation of how the grouping of employers is likely to improve accident prevention and claims handling and reduce expenses;

(g) A specific description of how the combined experience of the group will be used for rating group members; and

(h) The initial group anniversary rating date.

(2) If the combined experience of a group of employers is used for experience rating, the following standards govern a group established under this rule:

(a) 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 that also are participating at the time of the supplemental rating calculation must be at least 50 percent of the current participants.

(b) A group must 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) The insurer of an organization or another insurer may request approval from the Director under section (1) of this rule to form a new group that will be experience-rated if the organization is composed of a group of employers that satisfies all requirements of ORS 737.316, if the employers are participants in an existing group that is experience-rated based on the combined experience of participants in the existing group and if the employers have signed consent to group rating forms for the formation of a new group. Formation of a group under this subsection is subject to the requirements of subsection (e) of this section.

(d) An insurer may request approval from the Director under section (1) of this rule to form a new group that will be experience-rated if the organization to which the members of the new group belong is composed of a group of employers that satisfies all requirements of ORS 737.316, if the organization has been in existence for one or more years, if more than 50 percent of the members have been members of the organization for one or more years, and if the employers have signed forms giving consent to group rating for the formation of a new group. Formation of a group under this subsection is subject to the requirements of subsection (e) of this section.

(e) The requirements for formation of a new group as provided in subsection (c) or (d) of this section include the following:

(A) The group experience rating supplemental modification factors shall be calculated as follows:

(i) The supplemental modification factor that applies on the new group's initial anniversary rating date shall use all the experience during the experience rating base period of each employer who has signed a consent to group rating form for the formation of the new group.

(ii) The supplemental modification factor that applies on the new group's second anniversary rating date shall use all the experience during the experience rating base period of each employer who has signed a consent to group rating form for the formation of the new group and each employer who began participating in the group effective prior to the time of the second supplemental modification factor calculation.

(iii) The supplemental modification factors that apply on the new group's third and fourth anniversary rating dates shall use all the experience during the experience rating base period of the employers participating in the group at the time of the supplemental modification factor calculation and the experience for the policy years during the experience rating base period that each employer participated in the new group for those employers who previously participated in the group but are not participants at the time of the calculation.

(B) The supplemental modification factor shall be calculated 90 days in advance of the group anniversary rating date, and for the second and subsequent supplemental rating calculations 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.

(C) Notwithstanding paragraphs (A) and (B) of this subsection, for a new group formed in accordance with subsection (c) or (d) of this section, the supplemental modification factors effective on the new group's initial anniversary rating date and on the new group's second anniversary rating date shall not be less than the simple average of the current supplemental modification factors for all approved experience rating groups as verified by the licensed rating organization during the previous four calendar quarters.

(f) From one group rating anniversary to the next, a supplemental experience modification factor for a group shall not increase by more than the greater of 0.01 or 50 percent of the difference between the factor and 1.00, or decrease by more than the greater of 0.05 or 50 percent of the difference between the factor and 1.00. This limitation does not apply if the supplemental modification factor calculated for a group before this limitation is 1.00 or greater for three consecutive group rating anniversaries or if supplemental experience rating factors are not applied to a group for a period of one or more years.

(g) 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 Director. The Director 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 Director finds the proposal does not meet the standards and requirements of ORS Chapter 737, the Director 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 Director finds the grouping proposal does not satisfy the requirements and standards of ORS Chapter 737, the Director 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 Director 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; ID 3-1999, f. & cert. ef. 3-25-99

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: Publications referenced are available from the agency.]
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 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 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 producer in connection with a mass marketing plan for any kind of insurance unless such person is licensed as an insurance producer to transact casualty insurance.

Stat. Auth.: ORS 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 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 insurance producer 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 731
Stats. Implemented: ORS 737.346(3)(d)
Hist.: IC 8-1983, f. & ef. 11-10-83; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 insurance producer 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 731
Stats. Implemented: ORS 737.346(3)(d)
Hist.: IC 8-1983, f. & ef. 11-10-83; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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.

(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); and

(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 731 & 737
Stats. Implemented: ORS 737.346
Hist.: ID 7-1987, f. & ef. 12-11-87; ID 19-2006, f. & cert. ef. 9-26-06

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 731 & 737
Stats. Implemented: ORS 737.346(3)(f) - 737.346(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 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 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 731 & 737
Stats. Implemented: ORS 737.346(3)(f) - 737.346(3)(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 731 & 737
Stats. Implemented: ORS 737.346(3)(f) - 737.346(3)(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 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 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 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 731 & 737
Stats. Implemented: ORS 737.207(1) - 737.207(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 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 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

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 implement-

ing 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 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 Insurance Producers

(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 insurance producer who is authorized to transact the class of casualty insurance is authorized to transact workers' compensation insurance offered by the Plan. The Director of the Department of Consumer and Business Services may terminate an insurance producer'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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer 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 insurance producer 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 insurance producers, 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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.

(e) Except as provided in subsection (6) of this section, the employer is required to obtain a license as a worker-leasing company and has yet to be licensed as a worker-leasing company.

(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.

(6) The Plan Administrator shall conditionally bind coverage of a worker-leasing company applicant for an initial worker-leasing company license under OAR 436-050-0440 pending issuance of the license by the Director.

[ED. NOTE: Exhibits referenced are available from the agency.]
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; ID 1-2003, f. & cert. ef. 1-17-03

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.

[ED. NOTE: Exhibits referenced are available from the agency.]
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.

[ED. NOTE: Exhibits referenced are available from the agency.]
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.

[ED. NOTE: Exhibits referenced are available from the agency.]
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) Except as provided in section (8) of this rule, 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.

(8) A binder issued to a worker-leasing company applicant in compliance with requirements for an initial worker-leasing company license under OAR 436-050-0440 is extended as provided in this section until the Director either licenses or refuses to license the applicant, as follows:

(a) The binder is conditional upon the subsequent initial worker-leasing company licensing by the Director. The binder does not obligate the Plan to provide coverage to the worker-leasing company for its clients until the worker-leasing company is licensed by the Director.

(b) Upon the conditional binding of the applicant worker-leasing company, the Plan Administrator shall send the binder to those entities listed in section (7) of this rule, except for the servicing carrier.

(c) Upon the Director's initial licensing of a worker-leasing company applicant and receipt of proof of licensing, the Plan Administrator shall assign an unconditional binder to a servicing carrier and send an unconditional binder to all entities listed in section (7) of this rule.

(d) Upon the Director's refusal to license a worker-leasing company applicant and upon receipt of proof of refusal, the Plan Administrator shall send notice to all entities listed in section (7) of this rule that the conditional binder has been rescinded and the applicant was not covered.

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; ID 1-2003, f. & cert. ef. 1-17-03

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.

[ED. NOTE: Exhibits referenced are available from the agency.]
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, 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 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 insurance producer, and with respect to any renewal of the assigned insurance, may change the designated insurance producer 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 insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 Workers' 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 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 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.

(2) For the purpose of determining the premium of an insured employer whose policy produces an annual earned premium of $10,000 or more, the insurer of the employer shall make a physical audit of the employer's records at least once annually, except as provided in this section. For as long as the insurer continues to provide coverage to an employer, when the insurer finds that the audit premium difference is less than five percent for each of two consecutive policy years for which the insurer provided coverage, the insurer need audit only every third renewal policy subsequent to the policy most recently audited. If the insurer finds at any audit that the audit premium difference is five percent or greater, the insurer must again audit the employer's policy at least annually until the insurer finds an audit premium difference of less than five percent for each of two consecutive policy years. For each policy year for which a policy is not audited, the insurer shall obtain a signed payroll statement from the employer. For purposes of this section, the basis for the audit premium difference for an employer shall be the audited standard premium as defined in each insurer's approved rating system.

(3) 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 section, the insurer shall first select such policies that show multiple classifications, high rates or indications of contract labor, or any combination of such criteria.

(4) When an insurer increases premium for an employer based on a premium audit, the insurer shall include in the final premium audit billing a notification to the employer of the following matters, as required by ORS 737.318:

(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.

(5) The final premium audit billing must be entitled "Final Premium Audit Billing" at the top of the front page. The notification required in section (4) 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 Consumer and Business Services, 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 Consumer and Business Services
c/o Hearings Unit
Insurance Division
350 Winter St. NE, Room 440
Salem, OR 97301-3883

Assistance is available on the Insurance Division's web page, at http://www.cbs.state.or.us/external/ins/ and by e-mail, at DCBS.INSMAIL@state.or.us

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.

(6) In addition to the requirements of section (4) 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 notification 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.

(7) 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 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; ID 17-1997, f. 11-25-97, cert. ef. 11-26-97; ID 1-2000, f. & cert. ef. 2-10-00

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 insurer 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 was 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, salesmen and drivers. The insurer shall:

(A) Verify the proper use of Classifications 8810 — Clerical Office Employee, 8742 — Salesmen, 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. 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) An audit review program designed to ensure the accuracy of the insurer's audits. If the insurer meets with the Insurance Division Administrator or the Administrator's designated representative under OAR 836-043-0155 to provide a detailed explanation of remedial measures that the insurer is taking, the Administrator may request a copy of the insurer's audit review program for review. If the Administrator determines that the insurer's program is inadequate, the Administrator may prescribe an audit review program for the insurer to use during the period in which the insurer must take remedial measures.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731 & 737
Stats. Implemented: ORS 737.318
Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 12-1998, f. & cert. ef. 9-14-98

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, as established in OAR 836-042-0060;

(d) The requirements for verifiable records, as established in OAR 836-042-0060;

(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 731.244, 737.310 & 737.318
Stats. Implemented: ORS 737.318(3)(a)
Hist.: ID 1-1988, f. & cert. ef. 1-20-88; ID 1-1999, f. & cert. ef. 2-19-99

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 a number of Oregon employers and insurers established according to the schedule in **Exhibit 2** of OAR 836-043-0130, 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 standards; and

(3) To improve audit proficiency through the evaluation of insurer auditing practices.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 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; ID 18-1997, f. 11-25-97, cert. ef. 11-26-97

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, a non-returnable copy of the employer's payroll statement and the premium invoice; and

(d) 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 the 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 the auditor's planned date of call. (See **Exhibit 6**.)

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 737.318
Stats. Implemented: ORS 737.318
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; ID 18-1997, f. 11-25-97, cert. ef. 11-26-97; ID 12-1998, f. & cert. ef. 9-14-98

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: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 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 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: Exhibits referenced are available from the agency.]
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: Exhibits referenced are available from the agency.]
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.

(3) For the purposes of this rule, only policies that exceed $5,000 in annual premium after test audit will be used to determine whether an insurer achieves the *Minimum Standard*.

[ED. NOTE: Exhibits referenced are available from the agency.]

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; ID 18-1997, f. 11-25-97, cert. ef. 11-26-97

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 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 to the Director under ORS 737.505. 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 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 737.318 and 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 contains all of the elements specified in this section. Failure by the insurer to include any of the elements renders the billing incomplete as a final premium audit billing for purposes of ORS 737.318 and 737.505 and renders the debt uncollectible until all elements are included. The elements are as follows:

(a) The results of the audit;

(b) 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; and

(c) The notification required in ORS 737.318 and OAR 836-043-0110.

(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, the statement of account and the letter together are the final premium audit billing and:

(a) The insurer may provide the notification required in ORS 737.318 and OAR 836-043-0110 either in the statement of account or in the letter; and

(b) If the statement of account and the letter are received separately, the 60-day period within which the Director must receive the request for a hearing 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 60th day after the date on which the Director received the initial request from the employer for a hearing on the final premium audit billing.

(10) An employer may file any petition, motion, request for stay of collection, exception to a proposed order or any other hearing paper, other than a request for a hearing, by mail or delivery to the Insurance Division Hearings Unit at the address stated in OAR 836-043-0110. A delivery may be accomplished by facsimile transmission if the delivery meets the requirements of this section. The date of service of a delivery by facsimile transmission is the date of transmission. As used in this section, "facsimile transmission" means any method of transmitting images or printed matter by electronic means. The following requirements apply to a delivery by facsimile transmission for purposes of this section:

(a) The top of the transmitted document must indicate that the document has been delivered by facsimile transmission and must show that the facsimile transmission number used was that of the Insurance Division; and

(b) The original of the transmitted document must be mailed to the Insurance Division Hearings Unit or an assigned hearings officer at the same time that the facsimile transmission of the document is made, and must be accompanied by a copy of the original confirmation of delivery by facsimile transmission and a certificate of service listing the parties served.

Stat. Auth.: ORS 731.244 & 737.318

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; ID 13-1998, f. & cert. ef. 9-23-98; ID 1-2000, f. & cert. ef. 2-10-00

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) & 737.310(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) & 737.310(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: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 737.310(12) & 737.310(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) & 737.310(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: Publications referenced are available from the agency.]
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.

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.

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

Rating and Rating Organizations

836-043-0300
Qualifications for Workers' Compensation Rating Oganizations

(1) Prior to operating in Oregon, a worker's compensation rating organization shall apply to the Director for a license. The Director shall act on the application within 60 days of the application. Prior to approving any applicant's license, the Director shall determine that the organization meets the qualifications and requirements of ORS 737.355(1).

(2) The rating organization shall include with its application the following documents:

(a) Copies of its articles of incorporation;

(b) Bylaws;

(c) Biographies of its corporate officers;

(d) A description of its operation;

(e) Copies of its last three quarterly financial statements;

(f) A copy of its two most recent annual report;

(g) Copies of its Securities and Exchange Commission filings, if any.

(3) The rating organization's application shall demonstrate to the Director's satisfaction:

(a) The level of professional staffing that the rating organization will dedicate to serving insurers within Oregon, including the number of actuaries, statisticians and economists, the number of years of experience of each professional staff member and the professional designations of its staff;

(b) The capacity and quality of the rating organization's electronic data processing system dedicated to the workers' compensation rating system in Oregon;

(c) The rating organization's knowledge of insurance ratemaking both generally and within Oregon; and

(d) The rating organization's availability to its clients in Oregon.

Stat. Auth.: ORS 731.244 & 737.355
Stats. Implemented: ORS 737.355
Hist.: ID 3-2000, f. & cert. ef. 3-29-00

836-043-0310
Exchange of Data Among Workers' Compensation Rating Organizations

(1) Not later than the 25th day of each month, each licensed workers' compensation rating organization shall report to the statistical agent all edited data reported by its member insurers under OAR 836-042-0045 during the prior month that the rating organization finds useable for experience rating.

(2) The data to be reported by each rating organization under section (1) of this rule includes all financial data by policy year, accident year and calendar year.

Stat. Auth.: ORS 731.244 & 737.355
Stats. Implemented: ORS 737.355
Hist.: ID 3-2000, f. & cert. ef. 3-29-00

836-043-0320
Competitive Selection Process; Designation of a Workers' Compensation Statistical Agent

(1) When the Director licenses more than one workers' compensation rating organization, the Director shall notify each licensed rating organization of the Director's intent to begin a competitive process for selecting a statistical agent for gathering workers' compensation insurance data. Only a licensed workers' compensation rating organization may apply for designation as the statistical agent.

(2) The notification required in section (1) of this rule shall describe the competitive process and establish a deadline for applications and related submissions.

(3) Upon receipt of notice of the Director's intent to begin a selection process, and licensed rating organization may, in writing to the Director, waive its right to pursue selection as the designated statistical agent.

(4) Each applicant for designation as the statistical agent must submit the following with its proposal:

(a) A compilation plan that provides for:

(A) A flow of required data to the state;

(B) A flow of statewide compiled data to all rating organizations and their member insurers, and interested agents and insured employers; and

(C) A flow of individual insured employer data necessary for employerexperience rating and other individual employer rating of the insured employers of each rating organization's members to each rating organization and their member insurers, and the authorized agents of the insured employers and the insured employers;

(b) A plan for assuring timeliness, oversight and quality control of data received from the rating organizations;

(c) A description of the level of professional staffing the applicant will dedicate as statistical agent to serving the State of Oregon and rating organizations;

(d) A description of the capacity and quality of the applicant's electronic data processing system dedicated to the workers' compensation rating system in Oregon;

(e) A description of the applicant's availability to rating organizations in Oregon and its ability to assist them with their operations;

(f) A waiver of all intellectual property rights in compilations of Oregon data required to be prepared by the statistical agent; and

(g) A statement of fees that the applicant will charge rating organizations for statistical agent services with adequate itemization of the components of the fees to demonstrate they are reasonable and not excessive for the services provided

(5) The Director, upon completing a review of all applications with supporting material and such other information as the Director may require, shall designate one rating organization to serve as the statistical agent for a period of three years.

(6) The Director may extend the designation of the current statistical agent pending the competitive selection process. In the event the current statistical agent is unable or unwilling to continue, the Director may designate a temporary statistical agent pending the completion of the competitive selection process.

(7) The statistical agent may establish and assess reasonable fees against all licensed rating organizations. The statistical agent must first demonstrate to the Director that the fees will minimize costs to rating organizations without compromising data quality controls and its performance of other statutory responsibilities.

Stat. Auth.: ORS 731.244 & 737.225
Stats. Implemented: ORS 737.225
Hist.: ID 3-2000, f. & cert. ef. 3-29-00

DIVISION 50

GENERAL PROVISIONS

Assumption Reinsurance

836-050-0000
Purpose, Statutory Authority and Implementation

OAR 836-050-0000 to 836-050-0020 are adopted under the authority of ORS 731.244, 742.156 and 742.158, for the purpose of implementing ORS 742.156 and 742.158, relating to assumption reinsurance.

Stat. Auth.: ORS 731.244, 742.156, 742.158
Stats. Implemented: ORS 742.156, 742.158
Hist.: ID 4-1996, f. & cert. ef. 2-28-96; ID 15-2006, f. & cert. ef. 7-27-06

836-050-0010
Notice of Transfer

(1) An insurer transferring obligations or risks through an assumption reinsurance agreement subject to ORS 742.150, 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 insurance producer 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 insurance producer 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 ORS 742.150 to 742.162 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: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & Sec. 5 & 6, Ch. 30, OL 1995
Stats. Implemented: ORS 742.156, 742.158
Hist.: ID 4-1996, f. & cert. ef. 2-28-96; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 15-2006, f. & cert. ef. 7-27-06

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 reinsurance agreement to which ORS 742.150 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: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 742.156, 742.158
Stats. Implemented: ORS 742.156, 742.158
Hist.: ID 4-1996, f. & cert. ef. 2-28-96; ID 15-2006, f. & cert. ef. 7-27-06

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: Exhibits referenced are available from the agency.]

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: Exhibits referenced are available from the agency.]

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: Exhibits referenced are available from the agency.]

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

Notice of Advance Payment for Death or Personal Injury or Destruction of Property on Running of Period of Limitation

836-050-0150
Advance Payments

(1) The notice required by ORS 12.155 shall contain the following:

(a) The time and location of the occurrence in regard to which the advance payment is made.

(b) A statement to the effect that the amount of any advance payment will be credited against any judgment entered in favor of the payee.

(c) 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 Director of the Department of Consumer and Business Services approves.

(d) The signature of a person authorized to act for the insurer.

(e) The date on which notice is transmitted to the party entitled to the advance payment.

(2) The type size used in the portion of the notice described in section (1)(c) 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; ID 22-2002, f.& cert. ef. 11-27-02, Renumbered from 836-020-0900

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 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

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.

Stat. Auth.: ORS 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; ID 2-1999, f. & cert. ef. 3-25-99

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 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 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 pre-existing 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 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 producers 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.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 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, insurance producer 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 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 8-2005, f. 5-18-05, cert. ef. 8-1-05

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, are 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 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 anoth-

er 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 or urine 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. [Exhibit not included. See ED. NOTE.] 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, oral specimen or urine 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.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 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; ID 2-1999, f. & cert. ef. 3-25-99

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 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 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 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

DIVISION 51

LIFE, INDIVIDUAL AND GROUP; ANNUITIES

Life Disclosure Requirements

836-051-0005
Statutory Authority; Purpose; Applicability

(1) OAR 836-051-0005 to 836-051-0020 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 OAR 836-051-0005 to 836-051-0020 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. OAR 836-051-0005 to 836-051-0020 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) OAR 836-051-0005 to 836-051-0020 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; ID 19-2006, f. & cert. ef. 9-26-06

836-051-0010
Definitions

As used in OAR 836-051-0005 to 836-051-0020:

(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 Director.

(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 producer or, if no insurance producer 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 731 & 743
Stats. Implemented: ORS 742.009(2)
Hist.: IC 3-1978, f. & ef. 6-9-78; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 19-2006, f. & cert. ef. 9-26-06

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, except that if the policy for which application is made contains an unconditional refund provision effective for at least ten days or if the Policy Summary contains such an unconditional refund provision, 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 request of the prospective buyer.

(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 731 & 743
Stats. Implemented: ORS 742.009(2)
Hist.: IC 3-1978, f. & ef. 6-9-78; ID 19-2006, f. & cert. ef. 9-26-06

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 836-051-0020. Each such document shall be retained in the file for at least three years following the date of its last authorized use.

(2) An insurance producer shall inform a prospective buyer, prior to the beginning a life insurance sales presentation, that the insurance producer is acting as a life insurance producer, and shall inform the prospective buyer of the full name of the insurer that the insurance producer is representing to the buyer. In sales situations in which an insurance producer is not involved, the insurer 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 producer 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 836-051-0020, 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 731 & 743
Stats. Implemented: ORS 742.009(2)
Hist.: IC 3-1978, f. & ef. 6-9-78; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 19-2006, f. & cert. ef. 9-26-06

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 733.306 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; ID 9-2003, f. 12-26-03, cert. ef. 1-1-04

836-051-0106
Life Insurance Valuation and Nonforfeiture Standards

(1) The following definitions apply in this rule:

(a) "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and the age-last-birthday bases of the mortality tables.

(b) "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(c) "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(d) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(e) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

(2) The 2001 CSO Mortality Table may be used as follows:

(a) At the election of the insurer for any one or more specified plans of insurance and subject to the conditions stated in this rule, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2004 and before January 1, 2009 and to which ORS 733.306 and 743.215, and OAR 836-031-0765(1) and (2), are applicable. If the insurer elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this rule, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which ORS 733.306 and 743.215, and OAR 836-031-0765(1) and (2), are applicable.

(3) Conditions governing use of tables are as follows:

(a) For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(A) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(B) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by ORS 733.312 and 733.322 and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(C) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(b) For plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

(c) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the insurer for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of section 4 of this rule, ORS 733.306 and 743.215 and OAR 836-031-0770 relative to use of the select and ultimate form.

(d) When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for an insurer, the actuarial opinion in the annual statement filed with the Director shall be based on an asset adequacy analysis as specified in OAR 836-031-0670. The Director may exempt an insurer from this requirement if it only does business in this state and in no other state.

(4) The 2001 CSO Mortality Table applies to OAR 836-031-0750 to 836-031-0775 as follows:

(a) The 2001 CSO Mortality Table may be used in applying OAR 836-031-0750 to 836-031-0775 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in section (2) of this rule:

(A) OAR 836-031-0755(1)(b)(B): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(B) OAR 836-031-0760(2): All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in OAR 836-031-0770(1)(d). The value of "qx+k+t-1" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(C) OAR 836-031-0765(1): The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(D) OAR 836-031-0765(2): The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in OAR 836-031-0765(2)(c). In demonstrating compliance with these conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by rule or necessary to be in compliance with relevant Actuarial Standards of Practice.

(E) OAR 836-031-0770(3): The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

(F) OAR 836-031-0770(5)(d): The calculations specified in OAR 836-031-0770(5) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(G) OAR 836-031-0770(6)(d): The calculations specified in OAR 836-031-0770(6) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(H) OAR 836-031-0770(7)(b): The calculations specified in OAR 836-031-0770(7) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(I) OAR 836-031-0775(1)(a)(B): The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

(b) Nothing in this section shall be construed to expand the applicability of OAR 836-031-0750 to 836-031-0775 to include life insurance policies exempted under OAR 836-031-0755(1).

(5) The following provisions apply to an insurer's use of Gender-Blended Tables

(a) For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2004, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the insurer for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this section of this rule.

(b) The insurer may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the NAIC in December 2002.

(c) It shall not, in and of itself, be a violation of ORS 746.015 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

[ED. NOTE: Table referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 733.306 & 743.215
Stats. Implemented: ORS 733.306
Hist.: ID 9-2003, f. 12-26-03, cert. ef. 1-1-04

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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731, 733 & 743
Stats. Implemented: ORS 733.306(1)-(2) & 733.306(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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731, 733 & 743
Stats. Implemented: ORS 733.306(1)-(2) & 733.306(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: Tables referenced 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: Tables referenced 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: Tables referenced 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: Tables referenced 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 - AAx)**n** where the qx**1994** and AAxs are as specified in the 1994 GAR Table.

[ED. NOTE: Tables referenced 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 insurance producer, 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 insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer 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 insurance producer 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 insurance producer in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 insurance producers 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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

Authorization, Genetic Testing

836-051-0700
Authorization, Genetic Testing

(1) A person who asks an applicant for insurance to take a genetic test in connection with an application for insurance shall obtain the specific authorization of the applicant by use of the form in Exhibit 1 to this rule, or a form that is substantively similar.

(2) This rule implements ORS 746.135.

Stat. Auth.: ORS 746.135
Stats. Implemented: ORS 746.135
Hist.: ID 5-2004, f. & cert. ef. 6-14-04

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 and competitive medical plans provides Medicare services under the authority of Title XVIII Part C of the Social Security Act or 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 and competitive medical plans must file with the Director, for information purposes, a copy of the Medicare contract forms and rates that the plan or 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.

(6) OAR 836-052-0103 to 836-052-0194 are effective on August 1, 2005. Insurers may continue using current forms, or may make changes to current forms if offering Plan K or L, as appropriate, through 2005. Insurers may offer any authorized plan upon approval by the Director of the Department of Consumer and Business Services.

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; ID 10-2005, f. & cert. ef. 7-26-05

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) "Bankruptcy" occurs when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(3) "Certificate" means any certificate delivered or issued for delivery under a group Medicare supplement policy.

(4) "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(5) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no break in coverage greater than 63 days.

(6)(a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) A group health plan;

(B) Health insurance coverage;

(C) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(D) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

(E) Chapter 55 of Title 10 United States Code (CHAMPUS);

(F) A medical care program of the Indian Health Service or of a tribal organization;

(G) A state health benefits risk pool;

(H) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(I) A public health plan as defined in federal regulation; and

(J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(b) "Creditable coverage" does not include one or more, or any combination of the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics; and

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other medical benefits.

(c) "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate or contact of insurance or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community based care, or any combination thereof; and

(C) Such other similar, limited benefits as are specified in federal regulations.

(d) "Creditable coverage" does not include the following benefits if offered as independent noncoordinated benefits:

(A) Coverage only for a specified disease or illness; and

(B) Hospital indemnity or other fixed indemnity insurance.

(e) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(B) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

(C) Similar supplemental coverage provided to coverage under a group health plan.

(7) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

(8) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(9) "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.

(10) "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.

(11) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(12) Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C.1395w-28(b)(1), and includes:

(a) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(b) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(c) Medicare Advantage private fee-for-service plans.

(13) "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. "Medicare Supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under sec. 1833(a)(1)(A) of the Social Security Act.

(14) "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

(15) "Secretary" means the Secretary of the United States Department of Health and Human Services.

[Publications: Publications referenced are available from the agency.]
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 21-1998(Temp), f. 12-8-98, cert. ef. 1-1-99 thru 6-25-99; ID 4-1999, f. & cert. ef. 4-29-99; ID 6-2001, f. & cert. ef. 5-22-01; ID 10-2005, f. & cert. ef. 7-26-05

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 insured 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 injuries shall not include 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, for OAR 836-052-0145, expenses of health maintenance organizations associated with the delivery of health care services which expenses are analogous to incurred losses of insurers.

(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 Parts A and B, 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; ID 10-2005, f. & cert. ef. 7-26-05

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.

(4)(a) Subject to OAR 836-052-0133(2)(d) and (e), and 836-052-0134(2)(d), (e) and (g), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 may be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(b) A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005.

(c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(A) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(B) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

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; ID 10-2005, f. & cert. ef. 7-26-05

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.

(G) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.

(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. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(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;

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for the period provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If the suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(D) Reinstitution of the coverage:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of 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 benefit plans A to J. 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 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance. Billing the insured for any such balance is an unfair practice in the transaction of insurance that is injurious to the insurance-buying public, and is a violation of ORS 746.240;

(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, or in the case of hospital outpatient department services under a prospective payment system, the copayment 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 post-hospital 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. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006;

(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. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(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 that are not covered by Medicare. 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) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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.

(5) Standards for Plans K and L:

(a) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(A) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;

(E) Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;

(F) Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;

(G) Coverage for 50 percent, under Medicare Part A or B, of 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 until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;

(H) Except for coverage provided in paragraph (I) of this subsection, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in paragraph (J) of this subsection;

(I) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(b) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(A) The benefits described in subsection (a)(A), (B), (C), and (I) of this section;

(B) The benefit described in subsection (a)(D), (E), (F), (G), and (H) of this section, but substituting 75 percent for 50 percent; and

(C) The benefit described in subsection (a)(J) of this section, but substituting $2000 for $4000.

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; ID 4-1999, f. & cert. ef. 4-29-99; ID 6-2001, f. & cert. ef. 5-22-01; ID 10-2005, f. & cert. ef. 7-26-05

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 benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(g) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.

(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; ID 10-2005, f. & cert. ef. 7-26-05

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 section (6) of this rule 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 "L" 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) or (5) and list the benefits in the order shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement, 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 high deductible plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in OAR 836-052-0133(3), plus the Medicare Part A Deductible, skilled nursing facility care, the Medicare 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). The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. The deductible shall be adjusted annually thereafter according to the method prescribed in 42 U.S.C. 1395ss(p)(11)(C) to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with

August of the preceding year, and rounded to the nearest multiple of $10.

(h) 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).

(i) 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). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005;

(j) 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). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005;

(k) 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). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(l) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include 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 outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at home recovery benefit, each as defined in OAR 836-052-0133(4). The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. The deductible shall be adjusted annually thereafter according to the method prescribed in 42 U.S.C. 1395ss(p)(11)(C) to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(6) Make-up of two additional Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(a) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in OAR 836-052-0133(5).

(b) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in OAR 836-052-0133(5).

(7) New or innovative benefits. 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. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

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; ID 21-1998(Temp), f. 12-8-98, cert. ef. 1-1-99 thru 6-25-99; ID 4-1999, f. & cert. ef. 4-29-99; ID 6-2001, f. & cert. ef. 5-22-01; ID 10-2005, f. & cert. ef. 7-26-05

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, nor 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)(a) If an applicant qualifies under section (1) of this rule and submits an application during the time period referenced in section (1) of this rule and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition;

(b) If the applicant qualifies under section (1) of this rule and submits an application during the time period referenced in section (1) of this rule and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subsection shall be the manner prescribed in 42 USC 300gg(a)(3) as of the effective date of this rule.

(3) Except as provided in section 2 of this rule and OAR 836-052-0142 and 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.

(4) 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 charge 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.

(5) 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; ID 21-1998(Temp), f. 12-8-98, cert. ef. 1-1-99 thru 6-25-99; ID 4-1999, f. & cert. ef. 4-29-99; ID 6-2001, f. & cert. ef. 5-22-01; ID 10-2005, f. & cert. ef. 7-26-05

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 practice in the local area. 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 subparagraph 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) Shall file with the Director at least quarterly, an updated list of network providers.

(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. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L;

(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.

(13) 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.

(14)(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 at-home recovery services or coverage for Part B excess charges.

(15) 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 at-home recovery services or coverage for Part B excess charges.

(16) 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; ID 10-2005, f. & cert. ef. 7-26-05

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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240
Stats. Implemented: ORS 743.683(2) & 743.683(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

836-052-0142
Guaranteed Issue for Eligible Persons

(1) Guaranteed issue:

(a) Eligible persons are those individuals described in section (2) of this rule who seek to enroll under the policy during the period specified in section (3) of this rule and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

(b) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in section (5) of this rule that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(2) Eligible persons. An eligible person is an individual described in any of the following paragraphs:

(a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual.

(b) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described in this subsection that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan has been terminated;

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets such other exceptional conditions as the Secretary may provide.

(c)(A) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section (2)(b) of this rule.

(d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A)(i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy.

(B) The issuer of the policy substantially violated a material provision of the policy; or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(e)(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(B) The subsequent enrollment under paragraph (A) of this subsection is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851 (e) of the federal Social Security Act); or

(f) The individual, upon first becoming enrolled for benefits under Medicare part A, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(g) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in section (5)(d) of this rule.

(3) Guaranteed Issue Time Periods.

(a) In the case of an individual described in section (2)(a) of this rule, the guaranteed issue period begins on the later of:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or

(B) The date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

(b) In the case of an individual described in section (2)(b), (c), (e) or (f) of this rule whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(c) In the case of an individual described in section (2)(d)(A), the guaranteed issue period begins on the earlier of:

(A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and

(B) The date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(d) In the case of an individual described in section (2)(b), (d)(B), (d)(C), (e) or (f) of this rule, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; and

(e) In the case of an individual described in section (2)(g) of this rule, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

(f) In the case of an individual described in section (2) of this rule but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(4) Extended Medigap access for interrupted trial periods.

(a) In the case of an individual described in section (2)(e) of this rule (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in section (2)(e)(A) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section (2)(e) of this rule.

(b) In the case of an individual described in section (2)(f) of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in section (2)(f) of this rule is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in section (2)(f) of this rule; and

(c) For purposes of sections (2)(e) and (f) of this rule, no enrollment of an individual with an organization or provider described in section (2)(e)(A) of this rule, or with a plan or in a program described in section (2)(f) of this rule, may be deemed to be an initial enrollment under this paragraph after the two year period beginning on the date on which the individual first enrolled with such an organization provider, plan or program.

(5) Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:

(a) Section (2)(a), (b), (c) (except for coverage described in (c)(iv)) and (d) of this rule is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer;

(b) Section (2)(c)(iv) and (f) of this rule is any Medicare supplement policy described in OAR 836-052-0136 offered by any issuer;

(c)(A) Subject to paragraph (B) of this subsection, section (2)(e) of this rule is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection (a) of this section.

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this paragraph is:

(i) The policy available from the same issuer but modified to remove prescription drug coverage; or

(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

(d) Section (2)(g) of this rule is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the indi-

vidual's Medicare supplement policy with outpatient prescription drug coverage.

(6) Notification provisions:

(a) At the time of an event described in section (2) of this rule because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this rule, and of the obligations of issuers of Medicare supplement policies under section (1) of this rule. Such notice shall be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in section (2) of this rule because of which an individual ceases enrollment under a contract or agreement, policy or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this rule, and of the obligations of issuers of Medicare supplement policies under section (1) of this rule. Such notice shall be communicated within ten working days of the issuer's receiving notification of disenrollment.

Stat. Auth.: ORS 743.684
Stats. Implemented: ORS 743.010 & 743.684
Hist.: ID 21-1998(Temp), f. 12-8-98, cert. ef. 1-1-99 thru 6-25-99; ID 4-1999, f. & cert. ef. 4-29-99; ID 6-2001, f. & cert. ef. 5-22-01; ID 24-2002, f. & cert. ef. 12-13-02; ID 10-2005, f. & cert. ef. 7-26-05

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:

(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) A percentage under subsection (a) of this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(A) Home office and overhead costs;

(B) Advertising costs;

(C) Commissions and other acquisition costs;

(D) Taxes;

(E) Capital costs;

(F) Administrative costs; and

(G) Claims processing costs.

(c) 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;

(d) 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;

(e) 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.

[ED. NOTE: Exhibits referenced are available from the agency.]

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; ID 8-2001(Temp), 6-15-01, cert. ef. 6-18-01 thru 12-10-01; ID 11-2001, f. & cert. ef. 9-24-01; ID 10-2005, f. & cert. ef. 7-26-05

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 file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the Insurance Commissioner in the state in which the policy or certificate was issued.

(3) 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.

(4) 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.

(5) 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.

(6) 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) - 743.684(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 10-2005, f. & cert. ef. 7-26-05

836-052-0156
Permitted Compensation Arrangements

(1) An issuer or other entity may provide commission or other compensation to an insurance producer 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 insurance producers and an insurance 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 CMS 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) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(4) 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.

(5) 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.

[ED. NOTE: Exhibits and Appendices referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
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; ID 21-1998(Temp), f. 12-8-98, cert. ef. 1-1-99 thru 6-25-99; ID 4-1999, f. & cert. ef. 4-29-99; ID 6-2001, f. & cert. ef. 5-22-01; ID 8-2001(Temp), f. 6-15-01, cert. ef. 6-18-01 thru 12-10-01; ID 11-2001, f. & cert. ef. 9-24-01; ID 10-2005, f. & cert. ef. 7-26-05

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 currently has Medicare supplement, Medicare Advantage, Medicaid coverage or another 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) If, after purchasing this policy, you become eligible for Medicaid, 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 suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your

policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(E) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(F) 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.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in ore or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No below with an "X"

To the best of your knowledge,

(1)(a) Did you turn age 65 in the last six months?
Yes_____ No_____
(b) Did you enroll in Medicare Part B in the last six months?
Yes_____ No_____
(c) If yes, what is the effective date? _____
(2) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)
Yes_____ No_____
If yes,
(a) Will Medicaid pay your premiums for this Medicare supplement policy?
Yes_____ No_____
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
Yes_____ No_____
(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START ___/___/___ END ___/___/___
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
Yes_____ No_____
(c) Was this your first time in this type of Medicare plan?
Yes_____ No_____
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?
Yes_____ No_____
(4)(a) Do you have another Medicare supplement policy in force?
Yes_____ No_____
(b) If so, with what company, and what plan do you have (optional for Direct Mailers)?_____
(c) If so, do you intend to replace your current Medicare supplement policy with this policy?
Yes_____ No_____
(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
Yes_____ No_____
(a) If so, with what company and what kind of policy?
_____
_____
_____
_____
(b) What are your dates of coverage under the other policy?
START ___/___/___ END ___/___/___
(If you are still covered under the other policy, leave "END" blank.)

(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.

(6) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[ED. NOTE: Exhibits referenced are available from the agency.]

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; ID 8-2001(Temp), f. 6-15-01, cert. ef. 6-18-01 thru 12-10-01; ID 11-2001, f. & cert. ef. 9-24-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 10-2005, f. & cert. ef. 7-26-05

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 insurance 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 producer 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), 743.010(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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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.

(3) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240
Stats. Implemented: ORS 743.010(1)(c), 743.010(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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 10-2005, f. & cert. ef. 7-26-05

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: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 743.010, 743.013, 743.680 - 743.689 & 746.240
Stats. Implemented: ORS 743.010(1)(c) & 743.010(2)
Hist.: ID 11-1990, f. 5-11-90, cert. ef. 9-1-90; ID 7-1992, f. & cert. ef. 5-8-92; ID 8-2001(Temp), f. 6-15-01, cert. ef. 6-18-01 thru 12-10-01; ID 11-2001, f. & cert. ef. 9-24-01

836-052-0190
Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement 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), 743.010(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

LongTerm Care Insurance General Terms

836-052-0500
Statutory Authority; Applicability

(1) OAR 836-052-0500 to 836-052-0786 are adopted pursuant to the requirements and authority of ORS 731.244,742.003, 742.005, 742.023, 743.013, 743.655, 743.656 and 746.240.

(2) OAR 836-052-0500 to 836-052-0786 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.

(3) OAR 836-052-0500 to 836-052-0786 apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance if:

(a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(b) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(c) Benefits under the policy may commence after the policyholder has reached normal retirement age for Social Security unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

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; ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance Policy Terms

836-052-0516
Policy Definitions

A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth in this rule unless the terms are defined in the policy according to the definitions in this rule and satisfy the requirements in OAR 836-052-0596:

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(2) "Acute condition" means that the individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

(3) "Adult day care" means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

(4) "Adult foster care" means any family home or facility in which residential care is provided in a homelike environment for five or fewer adults who are not related to the provider by blood or marriage.

(5) "Assisted living" services means services to persons with unique needs, such as, but not limited to, dementia or traumatic brain injury.

(6) "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

(7) "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(8) "Continence" means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(9) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(10) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(11) "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(12) "Home care" services means medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(13) "Medicare" means "**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.

(14) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(15) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(16) "Residential care" means the provision of room and board and services that assist the resident in activities of daily living, such as assistance with bathing, dressing, grooming, eating, medication management, money management or recreation.

(17) "Skilled nursing care," "intermediate care," "personal care," "home care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(18) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(19) "Transferring" means moving into or out of a bed, chair or wheelchair.

(20) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility" and "home care agency," shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0526
Policy Practices and Provisions

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the requirements of OAR 836-052-0546. In addition:

(a) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(d) The term "level premium" may be used only when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(a) Preexisting conditions or diseases as allowed in OAR 836-052-0546(4);

(b) Alcoholism and drug addiction;

(c) Illness, treatment or medical condition arising out of:

(A) War or act of war (whether declared or undeclared);

(B) Participation in a felony, riot or insurrection;

(C) Service in the armed forces or units auxiliary thereto;

(D) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(E) Aviation (this exclusion applies only to non-fare-paying passengers).

(d) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(e) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(f) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(3) Section (2) of this rule does not prohibit exclusions and limitations by type of provider or territorial limitations.

(4) Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

(5) Continuation or conversion of coverage is governed as follows:

(a) Group long-term care insurance issued in this state on or after September 1, 2005 shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and that is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(c) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy that it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(d) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. When the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day

following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. When the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except when:

(A) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(B) The terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

(i) That provides benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of subsection (f) of this section.

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall be included in the converted policy only if the converted policy also provides for a premium decrease or refund that reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(k) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(6) Discontinuance and Replacement. If a group long-term care insurance policy is replaced by another group long-term care insurance policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(a) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(7)(a) The premium charged to an insured shall not increase due to either:

(A) The increasing age of the insured at ages beyond 65; or

(B) The duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under OAR 836-052-0746, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under OAR 836-052-0746, the initial annual premium shall be based on the reduced benefits.

(8) Electronic enrollment for group policies is governed by the following provisions:

(a) In the case of a group defined in ORS 743.652(6)(a) , any requirement that a signature of an insured be obtained by an insurance producer or insurer shall be deemed satisfied if:

(A) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(B) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(C) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by ORS 746.600, is maintained.

(b) The insurer shall make available, upon request of the Director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

(9) Request for termination of coverage. When the policyholder, insured or beneficiary requests termination of coverage, any unearned premiums for that insured shall be promptly refunded to the payee or beneficiary.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0536
Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1)(a) Notice before lapse or termination. An individual long-term care insurance policy or certificate shall not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate one or more additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation no less often than once every two years.

(b) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subsection (a) of this section need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. An individual long-term care insurance policy or certificate shall not lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subsection (a) of this section, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid. Notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirement in section (1)(a) of this rule, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional

capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0546
Required Policy Provisions

(1) Renewability. Each individual long-term care insurance policy shall contain a renewability provision. The following requirements apply to such a provision:

(a) The provision shall be appropriately captioned, shall appear on the first page of the policy and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to a policy that does not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

(2) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in a writing that is signed by the insured, unless 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, rider or endorsement.

(3) Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations of preexisting condition shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider, outline of coverage and any other related documents. This section does not apply to qualified long-term care insurance contracts.

(7) Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care, shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in the same paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this requirement too shall be specified.

(8) A qualified long-term care insurance contract shall include a statement in the policy and in the outline of coverage as contained in OAR 836-052-0776 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance contract shall include a statement in the policy and in the outline of coverage as contained in OAR 836-052-0776 that the policy is not intended to be a qualified long-term care insurance contract.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0556
Required Disclosure of Rating Practices to Consumers

(1) This rule applies as follows:

(a) Except as provided in subsection (b) of this section, this rule applies to any long term care policy or certificate issued in this state on or after March 1, 2006.

(b) For certificates issued on or after March 1, 2005 under a group long-term care insurance policy as defined in ORS 743.652(6)(a), which policy was in force on March 1, 2005, the provisions of this rule shall apply on the policy anniversary following March 1, 2006.

(2) Other than policies for which no applicable premium rate or rate schedule increases can be made, an insurer shall provide all of the information listed in this section to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, the insurer shall provide all of the information listed in this rule to the applicant not later than at the time of delivery of the policy or certificate. The information is as follows:

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision.

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.

(d) A general explanation for applying premium rate or rate schedule adjustments, which shall include:

(A) A description of when premium rate or rate schedule adjustments will be effective (e.g. next anniversary date, next billing date, etc.); and

(B) The right to a revised premium rate or rate schedule as provided in subsection (b) of this section if the premium rate or rate schedule is changed.

(e)(A) Information regarding each premium rate increase on this policy form over the past ten years for this state or any other state that at a minimum identifies

(i) The policy forms for which premium rates have been increased.

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(B) The insurer may provide additional explanatory information related to the rate increases.

(C) An insurer shall have the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(D) If an acquiring insurer files for a rate increase on a long term care insurance policy form acquired from a nonaffiliated insurer or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the effective date of this rule or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure.

The nonaffiliated selling insurer shall include the disclosure of that rate increase in accordance with paragraph (A) of this subsection.

(E) If the acquiring insurer in paragraph (D) of this subsection files for a subsequent rate increase whether within the 24-month period or later, the acquiring insurer must make all disclosures required by section (5) of this rule, on the same policy form acquired from nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers referenced in paragraph (D) of this subsection, including disclosure of the earlier rate increase referenced in paragraph (D) of this subsection.

(3) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection (2)(a) and (e) of this section. If owing to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign an acknowledgement no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the forms in **Exhibits 1** and **2** to comply with sections (1) and (2) of this rule.

(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by section (2) of this rule when the rate increase is implemented.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance Practices

836-052-0566
Initial Rate Filing Requirements

(1) This rule applies to any long-term care insurance policy issued in this state on or after March 1, 2006.

(2) An insurer shall provide the following information to the Director for prior approval before making a long-term care insurance form available for sale:

(a) A copy of the disclosure documents required in OAR 836-052-0556; and

(b) An actuarial certification consisting of at least the following:

(A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase except for attained-age rating when permitted; and

(iv) A statement that the differences between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations in which this does not occur, as follows:

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Director may request a demonstration under section (3) of this rule, based on a standard age distribution; and

(E)(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for policy forms that are currently available from the insurer with an explanation of the differences.

(3) An insurer shall provide an actuarial demonstration showing that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claims experience on similar policy forms adjusted for any premium and benefit differences, or relevant and credible data from other studies, or both.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0576
Prohibition Against Post-Claims Underwriting, Applications

(1) Each application for a long-term care insurance policy, rider or certificate, except those that are guaranteed issue, 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, it must also ask the applicant to list the medication that has been prescribed;

(3) If the medications listed 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.

(4) When an application for a long-term care insurance policy, rider or certificate asks any health questions, the following shall apply:

(a) Each completed application shall be submitted to the insurer for underwriting review. Field issuance by an insurance producer is not allowed.

(b) 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.

(c) 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).

(5) 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.

(6) 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.

(7) Every insurer or other entity selling 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 in **Exhibit 1** or similar form approved by the Director.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731, 742 & 743
Stats. Implemented: ORS 743.655(10)(a)
Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; Renumbered from 836-052-0645, ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance Benefits and Service Standards

836-052-0586
Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

(1) A long-term care insurance policy, certificate or rider that provides benefits for home care services or community care services may not limit or exclude those benefits:

(a) By requiring that the insured or claimant would need care in a skilled nursing facility if home care services were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or either service or simultaneously receive both services, in a home, community, or institutional setting before home 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 care aide or other licensed or certified home care worker acting within the scope of the licensure or certification;

(e) By requiring that the insured or claimant have an acute condition before home care services are covered;

(f) By excluding coverage for personal care services provided by a home care aide;

(g) By requiring that the provision of home care services be at a level of certification or licensure greater than that required by the eligible service;

(h) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) A provision in a long-term care insurance policy, certificate or rider for home care or community care services shall provide total home care or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy, certificate or rider, at the time covered home care or community care services are being received. This requirement does not apply to policies, certificates or riders issued to residents of continuing care retirement communities.

(3) Home care coverage may be applied to the nonhome 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 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; Renumbered from 836-052-0535, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0596
Standards for Covered Services

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:

(1) 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;

(2) 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;

(3) 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;

(4) 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; and

(5) Services through a residential care facility, 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 services through a residential care facility as that term is defined in ORS 443.400. 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.

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; Renumbered from 836-052-0583, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0606
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 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; Renumbered from 836-052-0580, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0616
Requirement to Offer Inflation Protection

(1) An insurer may not offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection offered by the insurer, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. An insurer must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than a feature that does one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) When the policy is issued to a group, the required offer in section (1) of this rule shall be made to the group policyholder, except that if the policy is issued to a group defined in ORS 743.652(6)(d) other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(3) The offer in section (1) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4)(a) An insurer shall include the following information in or with the outline of coverage:

(A) A graphic comparison of the benefit levels of a policy that increases benefits by five percent compounded over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(B) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(5) Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7)(a) Inflation protection as provided in section (1)(a) of this rule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this section. The rejection may be either in the application or on a separate form.

(b) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans_____, and I reject inflation protection.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0626
Requirements for Application Forms and 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 insurance producer, except when the coverage is sold without an insurance producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by ORS 743.652(6)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, but only if the certificate holder has been notified of the replacement. The questions are as follows:

(a) Do you have another long-term care insurance policy, rider or certificate in force (including health care service contract, health maintenance organization contract)?

(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 insurance producer shall list any other health insurance policies that the insurance producer has sold to the applicant:

(a) List such policies sold that are still in force, and;

(b) List such policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement of long-term care insurance coverage, the insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the form shown in **Exhibit 1** to this rule.

(4) Direct Response Solicitations. An insurer using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the form shown in Exhibit 2 to this rule.

(5) When replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be sent within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(6) Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of OAR 836-080-0001 to 0043. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

(7) Sections (1) through (6) do not apply when the application is to the existing insurer that issued the existing policy, certificate or rider when the transaction meets the following:

(a) A contractual change or a conversion privilege is being exercised, or

(b) When the existing policy, certificate or rider is being replaced by the same insurer and unearned premium is credited toward the new coverage.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 731, 742 & 743
Stats. Implemented: ORS 743.010(1), 743.013(3) & 743.655(1)(a)
Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; Renumbered from 836-052-0615, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0636
Reporting Requirements

(1) Every insurer shall maintain records for each insurance producer of that insurance producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(2) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(3) Every insurer shall report annually by June 30 the ten percent of its agents with the greatest percentages of lapses and replacements as measured by Subsection (1) above using Exhibit 1 to this rule or a similar form including the following information:

(a) The number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(b) The number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(4) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied using Exhibit 2 to this rule or a similar form.

(5) As used in this rule:

(a) "Claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(b) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(c) "Report" means on a statewide basis.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0646
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, 743.656 & 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; Renumbered from 836-052-0588, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0656
Reserve Standards

(1) Each insurer shall use the following standards for determining policy reserves for long-term care insurance: When long-term care benefits are provided through the acceleration of benefits under a group or individual life insurance policy or a rider to such a policy, policy reserves for the benefits shall be determined in accordance with ORS 733.322. Claim reserves shall also be established in the case when the policy or rider is in claim status.

(b) Reserves for policies and riders subject to this section 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. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(c) In the development and calculation of reserves for long-term care insurance policies and riders subject to this section, an insurer shall consider the applicable policy and rider provisions, marketing methods, administrative procedures and all other considerations that affect projected claim costs, including but not limited to the following:

(A) Definition of insured events;

(B) Covered long-term care facilities;

(C) Existence of home care and home care coverage. For purposes of this paragraph, "home" has the meaning provided in OAR 836-052-0606;

(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; and

(S) Guaranteed insurability option.

(2) For purposes of section (1) of this rule, an applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a qualified actuary.

(3) When long term care benefits are provided other than as in section (1) of this rule, reserves shall be determined in accordance with OAR 836-031-0200 to 836-031-0300.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 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; Renumbered from 836-052-0545, ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance Loss Ratio, Rate Filings

836-052-0666
Loss Ratio

(1) This rule applies to all long-term care insurance policies, certificates and riders except those that are subject to OAR 836-052-0566 and 836-052-0676.

(2) Benefits under long-term care insurance policies and riders shall be deemed reasonable in relation to premiums only if the expected 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) In evaluating the expected 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.

(4) 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.

(5) 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.

(6) The effect on loss ratios of all requirements necessary to qualify for benefits shall be included in the calculations required under this rule.

(7) Sections (1) to (6) of this rule do not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of ORS 743.204 or 743.275;

(c) The policy or rider meets the Long-Term Care disclosure requirements;

(d) Any life policy illustration meets the applicable requirements of OAR 836-051-0500 to 836-051-0600; and

(e) The actuarial memorandum filed with the insurance department must be submitted by a qualified actuary in good standing with the American Academy of Actuaries. The memorandum must include:

(A) A description of the basis on which the long-term care rates were determined;

(B) Description of the basis for the reserves;

(C) A summary of the type of policy, benefits, renewability, general marketing method and limits on ages of issuance;

(D) 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, if any;

(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(F) The estimated average annual premium per policy and the average issue age;

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall 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 shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Stat. Auth.: ORS 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; Renumbered from 836-052-0530, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0676
Premium Rate Schedule Increases

(1) This rule applies as follows:

(a) Except as provided in subsection (b) of this section, this rule applies to any long-term care insurance policy or certificate issued in this state on or after March 1, 2006.

(b) For certificates issued on or after March 1, 2005 under a group long-term care insurance policy as defined in ORS 743.652(6)(a) that was in force on March 1, 2005, this rule applies on the policy anniversary following March 1, 2006.

(2) An insurer shall obtain approval of a premium rate schedule increase from the Director, including an exceptional increase as defined in section (3) of this rule prior to the notice to the policyholders and shall include the following in the submission to the Director:

(a) Information required by OAR 836-052-0556;

(b) Certification by a qualified actuary that:

(A) If the requested premium rate schedule increase is implemented and the underlying assumptions that reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated; and

(B) The premium rate filing is in compliance with this rule.

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale, as follows:

(i) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio according to OAR 836-052-0666, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with section (3) of this rule; and

(iv) For exceptional increases:

(I) The projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the Director determines as provided in OAR 836-052-0505(1)(a) that offsets may exist, the insurer shall use appropriate net projected experience.

(B) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(C) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary;

(D) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(E) Composite rates reflecting projections of new certificates, in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase.

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Director; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the Director.

(3) As used in this rule, "exceptional increase" means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified, owing to changes in statutes or rules applicable to long-term care insurance in this state or owing to increased and unexpected utilization that affects the majority of insurers of similar products. An exceptional increase is subject to the following provisions:

(a) Except as provided in this rule, an exceptional increase is subject to the same requirements as other premium rate schedule increases.

(b) The Director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(c) The Director, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(4) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Each exceptional increase shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Each premium rate schedule increase shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times 58 percent;

(B) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(C) The present value of future projected initial earned premiums times 58 percent; and

(D) 85 percent of the present value of future projected premiums not in paragraph (C) of this subsection on an earned basis.

(c) In the event that a policy form has both exceptional and other increases, the values in subsection (b)(B) and (D) of this section will also include 70 percent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate specified in ORS 733.310 for the valuation of life insurance issued on the same date as the long-term care insurance. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(5) For each rate increase that is implemented, the insurer shall file for review and approval by the Director updated projections, as defined in section (2)(c)(A) of this rule, annually for the next three years and include a comparison of actual results to projected values. The Director may extend the period to greater than three years if actual results are not consistent with projections values from prior projections. For group insurance policies that meet the conditions in section (12) of this rule, the projections required by this section shall be provided to the policyholder in lieu of filing with the Director.

(6) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in section (2)(c)(A) of this rule, shall be filed for review and approval by the Director every five years following the end of the required period in section (5) of this rule. For group insurance policies that meet the conditions in section (12) of this rule, the projections required by this section shall be provided to the policyholder in lieu of filing with the Director.

(7)(a) If the Director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projection under moderately adverse conditions demonstrates that incurred claims will not exceed proportions of premiums specified in section (4) of this rule, the Director may require the insurer to implement any of the following:

(A) Premium rate schedule adjustments; or

(B) Other methods to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration shall be given to section (2)(c)(E) of this rule, if applicable.

(8) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increase, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect, otherwise the Director may impose the condition in section (9) of this rule; and

(b) The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to section (4) of this rule had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in section (4)(a)(A) and (C) of this rule.

(9)(a) For a rate increase filing that meets the following criteria, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(A) The rate increase is not the first rate increase requested for the specific policy form or forms;

(B) The rate increase is not an exceptional increase; and

(C) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Director may determine that a rate spiral exists. Following the determination that a rate spiral exists:

(A) The Director may require the insurer to offer, without underwriting, to all in force insureds subjected to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(B) An offer under paragraph (A) of this subsection shall:

(i) Be subject to the approval of the Director;

(ii) Be based on actuarially sound principles, but not be based on attained age;

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and

(iv) Shall credit any unearned premium to the new coverage.

(C) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

(10) If the Director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Director may, in addition to the provisions of section (9) of this rule, prohibit the insurer from doing either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(11) Sections (1) to (10) of this rule do not apply to policies for which long-term care benefits provided by the policy are incidental if the policy complies with all of the provisions of this section. For the purpose of this section, "Incidental" means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue. The provisions are as follows:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, must be guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.

(b) The portion of the policy that provides insurance benefits other than long-term care coverage must meet the nonforfeiture requirements for those benefits.

(c) The policy must meet the disclosure requirements under OAR 836-052-0706 for long-term care insurance policies.

(d) The portion of the policy that provides insurance benefits other than long term care coverage must meet the requirements as applicable for life and annuity policies.

(e) An actuarial memorandum that includes the following items must be filed with the Director:

(A) A description of the basis on which the long term care rates were determined.

(B) A description of the basis for the reserves.

(C) A summary of the type of policy, benefits, renewability, general marketing method and limits on ages of issuance.

(D) 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, if any.

(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives.

(F) The estimated average annual premium per policy and the average issue age.

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall 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 shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

(H) A description of the effect of the long term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long term care claim status.

(12) Sections (6) and (8) of this rule do not apply to group insurance policies as defined in ORS 743.652(6)(a) when:

(a) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(b) The policyholder and not the certificate holders pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 742.005, 743.018, 743.650 & 743.652
Hist.: ID 3-2005, f. & cert. ef. 3-1-05; ID 12-2005(Temp), f. & cert. ef. 10-3-05 thru 3-20-06; ID 5-2006, f. 3-15-06, cert. ef. 3-20-06

836-052-0686
Filing Requirements for Out-of-State Group Policies

Each insurer providing group long-term care insurance benefits to a resident of this state under an exempt master group policy pursuant to ORS 731.486 issued outside 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 entities filing in this state.

Stat. Auth.: ORS 731, 742 & 743
Stats. Implemented: ORS 731.244 & 743.653
Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; Renumbered from 836-052-0550, ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance Sales

836-052-0696
Filing Requirements for Advertising

At the 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 as authorized 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 & 742.009
Stats. Implemented: ORS 742.009 & 743.655(1)(a)
Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; Renumbered from 836-052-0620, ID 3-2005, f. & cert. ef. 3-1-05; ID 12-2005(Temp), f. & cert. ef. 10-3-05 thru 3-20-06; ID 5-2006, f. 3-15-06, cert. ef. 3-20-06

836-052-0700
Physician Credentialing, Health Care Service Contractors

(1) The Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPCI) on September 28, 2004, and both of which carry that date, are adopted with respect to health care service contractors as Exhibits 1 and 2 to this rule.

(2) Each health care service contractor shall use the application forms adopted in section (1) of this rule.

(3) This rule is adopted pursuant to the authority of ORS 442.807 for the purpose of enabling the collection of uniform information necessary for health care service contractors to credential physicians seeking designation as a participating provider for a health plan, thereby implementing ORS 442.800 to 442.807 with respect to health care service contractors.

Stat. Auth.: ORS 442.807
Stats. Implemented: ORS 442.800 - 442.807

Hist.: ID 12-2001, f. & cert. ef. 10-15-01; ID 1-2004, f. & cert. ef. 2-3-04; ID 2-2005, f. & cert. ef. 3-1-05

836-052-0706
Standards for Marketing

(1) Every insurer marketing long-term care insurance coverage in this state, directly or through its insurance producers, shall:

(a) Establish marketing procedures and insurance producer training requirements to assure that:

(A) Any marketing activities, including any comparison of policies by its insurance producers, will be fair and accurate;

(B) Excessive insurance is not sold or issued; and

(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, or certificate if a group, the following:

"**Notice to buyer:** This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(c) Provide copies of the disclosure forms required in OAR 836-052-0556(4) (**Exhibits 1** and **2**) to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has health insurance is not required.

(e) Establish auditable procedures for verifying compliance with this section.

(f) At solicitation, provide written notice to the prospective policyholder and certificate holder that a senior insurance counseling program approved by the Director is available and the name, address and telephone number of the program.

(g) For long-term care insurance policies, certificates and riders, use the terms "noncancellable" or "level premium" only when the policy, certificate or rider conforms to OAR 836-052-0526(1)(c).

(h) Provide an explanation of contingent benefit upon lapse provided for in OAR 836-052-0746(4)(c).

(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) 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 insurer or insurance producer.

(d) Misrepresentation of a material fact in selling or offering to sell a long-term care insurance policy.

(3) An association, as defined in ORS 743.652(6)(b), and the insurer endorsing or selling long-term care insurance are subject to the following requirements and obligations:

(a) The primary responsibility of an association shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. An association shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by the association to ensure that its members receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The insurer shall file with the Director the following material:

(A) The policy, certificate, and riders;

(B) A corresponding outline of coverage; and

(C) All advertisements requested by the Director.

(c) The association shall disclose in any long-term care insurance solicitation:

(A) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(B) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(d) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(e) The board of directors of an association selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(f) The association shall also:

(A) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(B) Actively monitor the marketing efforts of the insurer and its producers; and

(C) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies, certificates, or riders.

(g) Subsection (f) of this section does not apply to qualified long-term care insurance contracts.

(h) A group long term care insurance policy, certificate or rider may not be issued to an association unless the insurer files with the director the information required in this section.

Stat. Auth.: ORS 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; Renumbered from 836-052-0640, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0716
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 used in accordance with OAR 836-052-0526. The terms must be stated on the first page of the policy and must be one of the following, defined as follows:

(A) 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;

(B) 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;

(o) Option to apply for new benefits

(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 836-052-0546(6).

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 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; Renumbered from 836-052-0605, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0726
Suitability

(1) This rule does not apply to life insurance policies that accelerate benefits for long-term care.

(2) Each insurer shall:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) Train its insurance producers in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the Director.

(3)(a) To determine whether an applicant meets the standards developed by the insurer, an insurance producer and insurer shall develop procedures that take the following into consideration:

(A) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(B) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(C) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The insurer, and when an insurance producer is involved, the insurance producer, shall make reasonable efforts to obtain the information set out in subsection (a) of this section. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer shall contain, at a minimum, the information in the format contained in OAR 836-052-0556(4), Exhibit 1, in not less than 12 point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet shall be filed with the Director.

(c) A completed personal worksheet shall be returned to the insurer prior to the insurer's consideration of the applicant for coverage, except that the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(d) An insurer or insurance producer shall not sell or disseminate information obtained through the personal worksheet outside the insurer or agency.

(4) An insurer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(5) An insurance producer shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(6) At the same time that the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall also be provided to the applicant. The form shall be in the format contained in Exhibit 1, in not less than 12 point type.

(7) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application. In the alternative, the insurer shall send the applicant a letter similar to Exhibit 2. However, if the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's intent. The insurer shall make either the applicant's returned letter or a record of the alternative method of verification a part of the applicant's file.

(8) The insurer shall report annually by May 1 to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0736
Prohibition Against Preexisting Conditions, Waiting Periods and Probationary 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 that similar exclusions have been satisfied 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, waiting periods and probationary periods that would have been covered under the group policy being replaced.

Stat. Auth.: ORS 731, 742 & 743
Stats. Implemented: ORS 743.655(1)(a)
Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; Renumbered from 836-052-0575, ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance
Nonforfeiture Benefit; Benefit Triggers

836-052-0746
Nonforfeiture Benefit Requirement

(1) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(2) A long-term care policy, certificate or rider offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits, subject to the following:

(a) The nonforfeiture benefit included in the offer must be the benefit described in section (6) of this rule; and

(b) The offer must be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made is rejected, the insurer shall provide the contingent benefit upon lapse described in this rule.

(4)(a) After rejection of an offer for an individual or group policy without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in this subsection based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, a policyholder shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase. [Table not included. See ED. NOTE.]

(d) On or before the effective date of a substantial premium increase as defined in subsection (c) of this section, the insurer shall:

(A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the provisions of section (6)

of this rule. This option may be elected at any time during the 120-day period referenced in subsection (c) of this section; and

(C) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in subsection (c) of this section shall be deemed to be the election of the offer to convert in paragraph (B) of this subsection.

(6) Benefits that must be continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this section as follows:

(a) For purposes of this section, attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(b) For purposes of this section, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) must be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (c) of this section.

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of section (7) of this rule.

(d)(A) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(B) Notwithstanding paragraph (a) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth year following the policy or certificate issue date; or

(ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(7) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium paying status.

(8) There shall be no difference in the minimum nonforfeiture benefits as required under this rule for group and individual long term care insurance policies.

(9) The requirements set forth in this rule become effective March 1, 2006, after adoption of this provision and shall apply as follows:

(a) Except as provided in subsection (b) of this section, the provisions of this rule apply to any long-term care policy issued in this state on or after March 1, 2005.

(b) For certificates issued on or after March 1, 2006 under a group long-term care insurance policy as defined in ORS 743.652(6)(a), which policy was in force March 1, 2005, the provisions of this rule do not apply.

(10) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of OAR 836-052-0666, treating the policy as a whole.

(11) To determine whether contingent nonforfeiture upon lapse provisions are triggered under section (5)(c) of this rule, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(12) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(a) The nonforfeiture provision shall be appropriately captioned;

(b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Director for the same contract form; and

(c) The nonforfeiture provision shall provide at least one of the following:

(A) Reduced paid-up insurance;

(B) Extended term insurance;

(C) Shortened benefit period; or

(C) Other similar offerings approved by the Director.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240

Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240

Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0756

Standards for Benefit Triggers

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(2)(a) Activities of daily living shall include at least the following as defined in OAR 836-052-0516 and in the policy:

(A) Bathing;

(B) Continence;

(C) Dressing;

(D) Eating;

(E) Toileting; and

(F) Transferring;

(b) An insurer may use activities of daily living to trigger covered benefits in addition to those contained in subsection (a) of this section as long as they are defined in the policy.

(c) For purposes of this rule, a cognitive impairment must be a result of a clinically diagnosed organic dementia, including but not limited to Alzheimer's Disease or a related progressive degenerative dementia 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.

(3) An insurer may use additional provisions for determining when benefits are payable under a policy, certificate or rider, but the provisions shall not restrict, and are not in lieu of, the requirements contained in sections (1) and (2) of this rule.

(4) For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(b) Requiring that if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) A long term care insurance policy shall include a clear description of the process for appealing and resolving benefit determinations.

(7) The requirements set forth in this rule are effective March 1, 2006, except for the following:

(a) The requirements of this rule apply to a long-term care policy or rider issued in this state on or after March 1, 2005.

(b) This rule does not apply to a certificate issued on or after March 1, 2006, under a group long-term care insurance policy as defined in ORS 743.652(6)(a) that was in force on March 1, 2005.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240

Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240

Hist.: ID 3-2005, f. & cert. ef. 3-1-05

836-052-0766
Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

(1) For purposes of this section the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2)(a) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(i) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

(ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(b) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

(3) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(4) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(5) A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(6) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

(7) Certifications regarding activities of daily living and cognitive impairment required pursuant to section (6) of this rule shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

(8) Certifications required pursuant to section (6) of this rule may be performed by a licensed health care professional at the direction of the insurer as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

(9) A qualified long-term care insurance contract shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 746.240
Stats. Implemented: ORS 731.244, 742.003, 742.005, 742.009, 743.010(3), 743.013(3), 743.650, 743.653, 743.655, 743.656 & 746.240
Hist.: ID 3-2005, f. & cert. ef. 3-1-05

Long Term Care Insurance Outline of Coverage and Shopper's Guide

836-052-0776
Standard Format 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 insurance producer, 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 must be presented in the format prescribed in Exhibit 1 to this rule and must be a free-standing document;

(b) The outline must be printed in no smaller than ten-point type;

(c) The outline may not contain material of an advertising nature;

(d) Text that is capitalized or underscored in the standard format outline of coverage in **Exhibit 1** to this rule may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(e) Use of the text and sequence of text of the standard format outline of coverage in **Exhibit 1** is mandatory, unless otherwise specifically indicated.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.656 & 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; Renumbered from 836-052-0600, ID 3-2005, f. & cert. ef. 3-1-05

836-052-0786
Requirement to Deliver Shopper's Guide

(1) A long-term care insurance Shopper's Guide in a form approved by the Director shall be provided to all prospective applicants of a long term care insurance policy, certificate or rider as provided in this rule.

(3) 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.

(4) The Shopper's Guide shall be provided as follows:

(a) In the case of insurance producer solicitations, an insurance producer must deliver the Shopper's Guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the Shopper's Guide must be presented in conjunction with any application or enrollment form.

(5) The requirement of a Shopper's Guide under this rule does not apply with respect to a life insurance policy or rider containing accelerated long-term care benefits but the insurer or producer shall furnish the policy summary required under OAR 836-052-0716.

Stat. Auth.: ORS 731, 742 & 743
Stats. Implemented: ORS 743.655(1)(a)
Hist.: ID 20-1990, f. 12-13-90, cert. ef. 1-1-91; Renumbered from 836-052-0610, ID 3-2005, f. & cert. ef. 3-1-05

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, 743.562 and 743.565.

(2) OAR 836-052-0800 to 836-052-0860 apply to the termination of any group health insurance policy occurring on or after January 30, 2002.

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; ID 5-2002, f. & cert. ef. 2-6-02

836-052-0810
Replacement Upon Termination

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:

(1) 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

(2) 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; ID 5-2002, f. & cert. ef. 2-6-02

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 indicating 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; ID 5-2002, f. & cert. ef. 2-6-02

836-052-0840
Termination of Coverage

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 certificate holders 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; ID 5-2002, f. & cert. ef. 2-6-02

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

(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;

(b) A statement to the effect that the group coverage provided through the group policyholder by the insurer has terminated or will terminate, and the effective date of termination. If termination will occur because of nonpayment of premium, the statement must also provide that the premium was not received, that the policy will be terminated as of the premium due date if the premium is not received by the end of the grace period applicable to the policy and that the insurer will furnish no further notice as to termination, and must include the date of termination. The effective date of a termination for a reason other than nonpayment of premium 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 certificate holders under federal law and state law regarding the continuation of coverage.

(2) In the notice to a group policyholder under this rule, the insurer need include only the information that applies to the group policyholder and certificate holder,

(3) An insurer may satisfy the notice requirements of ORS 743.560(2) and (3) in a single notice that is given at least 10 days prior to the end of the grace period under the policy. The notice must also satisfy the requirements of ORS 743.565.

(4) Notice of the availability of portability coverage is satisfied by compliance with the notice requirements of OAR 836-053-0750, relating to portability coverage.

(5) An insurer may give the notice required by ORS 743.560 electronically if each of the parties to the insurance policy has agreed to accept electronic notice pursuant to ORS 84.013 and the notice and procedures followed by the parties otherwise satisfy the provisions of the Uniform Electronic Transactions Act at ORS 84.001 to 84.070.

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; ID 5-2002, f. & cert. ef. 2-6-02; ID 19-2006, f. & cert. ef. 9-26-06

DIVISION 53

HEALTH BENEFIT PLANS

836-053-0001
Modification of a Health Benefit Plan

(1) A modification of a health benefit plan is defined in this rule for the purposes of:

(a) ORS 743.737, regarding small employer health benefit plans;

(b) ORS 743.754, regarding group health benefit plans covering two or more certificate holders;

(c) ORS 743.760, regarding portability plans; and

(d) ORS 743.766, regarding individual health benefit plans.

(2) One or more decreases or increases described in this section in the services or benefits covered in a health benefit plan are a modification and not a discontinuance when the decrease or decreases, or the increase or increases, or any combination thereof, occur at the time of renewal and the change or changes together alter the actuarial valuation of the health benefit plan by less than ten percent in the aggregate to the policyholder. This section applies to a decrease or increase that:

(a) Eliminates or adds benefits payable under the plan;

(b) Decreases or increases benefits payable under the plan, including a decrease or increase that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations;

(c) Increases or decreases deductibles, copayments or other amounts to be paid by an enrollee; or

(d) Establishes new conditions or requirements, such as preauthorization requirements, to obtaining services or benefits under the plan, or eliminates such conditions or requirements.

(3) A carrier must give the policyholder notice of a modification to which this rule applies not later than the 30th day before the date of renewal of the plan to which the modification applies.

(4) A change in a requirement for eligibility is not a modification for purposes of this rule but instead is a discontinuance if the change will result in the exclusion of a class or category of enrollees covered under the current plan.

(5) A decrease or increase described in this section in the services or benefits covered in a health benefit plan is a modification and not a discontinuance, but the decrease or increase is not subject to section (2) of this rule. This section applies to the following:

(a) A carrier's normal and customary administrative changes that do not have an actuarial impact, such as formulary changes or utilization management protocols.

(b) A decrease or increase required by state or federal law.

Stat. Auth.: ORS 731.244, 743.566 & 743.773
Stats Implemented: ORS 743.737, 743.754, 743.760 & 743.766
Hist.: ID 7-2002, f. & cert. ef. 2-15-02

836-053-0003
Prohibition of Exclusion Period for Pregnancy

A carrier may not impose an exclusion period or a waiver in a health benefit plan for pregnancy and childbirth expenses, for which coverage is required by ORS 743.693.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.693, 743.737, 743.754 & 743.766
Hist.: ID 9-2006, f. 4-27-06, cert. ef. 5-1-06

836-053-0005
Prescription Drug Identification Cards

(1) This rule establishes minimum standards for prescription drug identification cards or other technologies that are required by ORS

743.788 to be issued by carriers, administrators of health benefit plans, third party administrators for self-insured plans, pharmacy benefits managers and administrators of state administered plans. This rule is adopted pursuant to the rulemaking authority of ORS 743.790 for the purpose of implementing ORS 743.788.

(2) A prescription drug identification card or other technology required by ORS 743.788 must contain the following information:

(a) The data element consistent with the "BIN, "IIN/BIN" or "RxBIN," which is the American National Standards Institute-assigned international identification number identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide, and labeled as RxBIN or BIN.

(b) The enrollee's name and identification number.

(c) A telephone number of the carrier or other issuer of the card or technology that a pharmacist may use to contact the carrier or other issuer, and a telephone number for after hour calls from a pharmacist (if that number is different from the first), unless the telephone number or numbers are provided electronically to the pharmacist at the time of processing.

(d) If required by the claims processor of the carrier or other issuer of the card, the processor control number labeled as RxPCN, and the pharmacy group number if different from the medical group number labeled as RxGrp.

(e) Any other information and any other data element of the National Council for Prescription Drug Programs Guide required by the issuer of the card for the processing of claims.

(3) This rule becomes operative on July 1, 2003.

Stat. Auth.: ORS 743.790
Stats. Implemented: ORS 743.788
Hist.: ID 3-2003, f. 4-14-03 cert. ef. 7-1-03

836-053-0010
Purpose; Statutory Authority; Enforcement

(1) 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.

(2) Violation of any provision of OAR 836-053-0021 to 836-053-0065 is an unfair trade practice under ORS 746.240.

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; ID 5-1998, f. & cert. ef. 3-9-98

836-053-0016
Categories of Small Employers

As used in OAR 836-053-0016 to 836-053-0070:

(1) "Oregon small employer" means a small employer as defined in ORS 743.730. In general, an Oregon small employer is an employer with at least two and no more than 25 eligible employees, as defined in ORS 743.730, who work on a regularly scheduled basis of 17.5 or more hours per week. For purposes of determining if an employer is an Oregon small employer, the proprietor or partners of a business may be included as employees, as provided in ORS 743.730.

(2) "HIPAA small employer" means a small employer as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 42 U.S.C. 300gg-91) who does not otherwise qualify as an Oregon small employer. In general, a HIPAA small employer is an employer with at least two and no more than 50 partial- and full-time employees. For purposes of determining if an employer is a HIPAA small employer, the proprietor or partners of a business are not included as employees, as provided in federal regulations at 29 CFR 2510.3-3.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240
Stats. Implemented: ORS 743.730 et seq.
Hist.: ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-0021
Plans Offered to Oregon Small Employers

The following provisions apply to health benefit plans offered to Oregon small employers:

(1) A small employer carrier shall issue a plan to a small employer if the employee eligibility criteria established by the small employer meet the requirements of this section. The eligibility criteria must be based solely on weekly work hours and completion of a group eligibility waiting period, if applicable, and those criteria must meet the following standards:

(a) The work hours requirement may range from 17.5 to 40 hours per week, but a single, uniform requirement must apply to all employees of the employer; and

(b) A waiting period requirement may not exceed 90 days and a single, uniform requirement must apply to all employees of the employer.

(2) Employee eligibility criteria must be limited to those described in section (1) of this rule. Impermissible criteria include:

(a) Employee classifications or categories, such as salaried, hourly, management, and non-management;

(b) Health status;

(c) Disability; and

(d) A requirement that an employee be actively at work when coverage would otherwise begin.

(3) A small employer carrier may provide different health benefit plans to different categories of employees of an employer, as determined by the employer, if the categories do not relate to the actual or expected health status of the employees or their dependents. All eligible employees, in accordance with the criteria established by the employer under section (1) of this rule, however, must be offered coverage.

(4) A small employer carrier may enforce reasonable employer participation and contribution requirements, as specified in OAR 836-053-0040. Such requirements, however, shall be applied uniformly to all Oregon small employers with the same number of eligible employees. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan.

(5) Premium rates for plans issued to Oregon small employers are subject to the rating and filing requirements of ORS 743.737 and OAR 836-053-0065 and 836-053-0910.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240
Stats. Implemented: ORS 743.730 et seq.
Hist.: ID 5-1998, f. & cert. ef. 3-9-98; ID 23-2002, f. & cert. ef. 11-27-02

836-053-0026
Plans Offered to HIPAA Small Employers

The following provisions apply to health benefit plans offered to HIPAA small employers:

(1) A small employer carrier shall issue a plan to a small employer if the employee eligibility criteria established by the small employer meet the following requirements:

(a) Permissible employee eligibility criteria include:

(A) Employee classifications or categories, such as salaried, hourly, management, and non-management;

(B) A work hours requirement of 17.5 to 40 hours per week, which may vary for different classifications or categories of employees; and

(C) A group eligibility waiting period requirement, which may vary for different classifications or categories of employees.

(b) Impermissible employee eligibility criteria include:

(A) Health status;

(B) Disability; and

(C) A requirement that an employee be actively at work when coverage would otherwise begin.

(2) A small employer carrier may provide different health benefit plans to different categories of employees, as determined by the employer, if the categories do not relate to the actual or expected health status of the employees or their dependents.

(3) A small employer carrier may enforce reasonable employer participation and contribution requirements, as specified in OAR 836-053-0040. Such requirements, however, shall be applied uniformly to all HIPAA small employers with the same number of eligible employees.

(4) Premium rates for plans issued to HIPAA small employers are not subject to the rating and filing requirements of ORS 743.737 and OAR 836-053-0065 and 836-053-0910.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240
Stats. Implemented: ORS 743.730 et seq.
Hist.: ID 5-1998, f. & cert. ef. 3-9-98

836-053-0030
Marketing

The following requirements apply to health benefit plans offered to Oregon small employers and to HIPAA small employers:

(1) A small employer carrier may offer different small employer health benefit plans in different geographic areas. However, the Basic plan required under ORS 743.734 and a point-of-service plan required of certain carriers under ORS 743.808 must be offered in every geographic area in which the carrier offers or renews its small employer health benefit plans. A small employer carrier may not cease offering or renewing, or offering and renewing, its Basic plan in a geographic area unless the carrier discontinues all plans in the geographic area as provided in ORS 743.737(5)(e).

(2) A small employer carrier must offer all of its approved small employer health benefit plans and plan options, including the Basic plan required under ORS 743.734 and a point-of-service plan required of certain carriers under ORS 743.808, to all small employers on a guaranteed issue basis. A carrier may not serve only a portion of the small employer market, such as employers with more than 25 employees, and a carrier may not establish or maintain a closed plan or plan option or a closed book of business in the small employer market. For purposes of this section, a "closed" arrangement is one in which coverage is maintained and renewed for currently enrolled small employers, but the coverage is not offered or issued to other small employers.

(3) A small employer carrier may not require a small employer to purchase or maintain other lines of coverage, such as group life insurance, in order to purchase or maintain a small employer health benefit plan.

(4) A small employer carrier that offers a particular health benefit plan in the small employer market only through one or more bona fide associations is not required to offer that plan, on a guaranteed issue basis or otherwise, to small employers that are not members of the association.

(5) A small employer carrier must market fairly all of its small employer health benefit plans and plan options and shall not engage in any practice that:

(a) Restricts a small employer's choice of such plans and plan options; or

(b) Has the effect or is intended to influence a small employer's choice of such plans and plan options for reasons of risk selection.

(6) A small employer carrier shall not provide to any insurance producer any financial or other incentive that conflicts with the requirements of section (5) of this rule.

(7) A small employer carrier must use the same sales compensation methodology for all small employer health benefit plans offered by the carrier.

(8) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with an insurance producer 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), 743.736(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; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-053-0040
Underwriting

The following requirements apply to health benefit plans offered to Oregon small employers and to HIPAA small employers:

(1) A small employer carrier shall not use health statements when offering small employer health benefit plans, except for late enrollees as provided in ORS 743.734. A health statement that is used for a late enrollee must comply with the requirements of OAR 836-053-0510. After enrollment, health statements or other information may be used by a carrier for the purpose of providing services or arranging for the provision of services under a small employer health benefit plan.

(2) The crediting of prior coverage, as specified in ORS 743.737, shall be applied in either of the following cases:

(a) If creditable coverage remains in effect on the enrollment date, as specified in ORS 743.737(1); or

(b) If creditable coverage terminated no more than 63 days prior to the enrollment date, as specified in ORS 743.737(1).

(3) All policy forms and enrollee summaries for small employer health benefit plans that contain a preexisting conditions provision must clearly disclose how prior creditable coverage will be counted. A carrier may use the following statement, or another similar disclosure, for this purpose:

> The duration of the preexisting conditions provision in this policy will be reduced by the amount of your prior "creditable coverage" if:
> (a) Your creditable coverage is still in effect on your date of enrollment in this policy; or
> (b) Your creditable coverage ended no more than 63 days before your date of enrollment in this policy. "Creditable coverage" means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance.

(4) To expedite the accurate crediting of prior coverage, in accordance with section (2) of this rule, a small employer carrier shall:

(a) Include a question about potential creditable coverage in all enrollment forms that are used in conjunction with any small employer health benefit plan containing a preexisting conditions provision; and

(b) Include a notice about potential creditable coverage whenever the carrier notifies an enrollee that a claim has been denied because of a preexisting conditions provision. The notice of claim denial shall also include a telephone number at the carrier that the enrollee may use for additional information regarding the denied claim.

(5) Except as permitted under a preexisting conditions provision, a small employer carrier shall not modify health insurance with respect to an employee or any eligible dependent of an employee by means of a rider, endorsement or otherwise, for the purpose of restricting or excluding coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(6) 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) 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. The carrier must apply the participation and eligibility requirements uniformly to all categories of eligible employees and their dependents and may establish and apply contributions for different categories of employees and dependents that exceed the minimum contribution; and

(e) 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.

(7) 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 836-053-0065 shall be implemented for each policyholder on the next renewal date. For the purposes of this rule, the next renewal date means the first renewal date of the policy issued to the policyholder that occurs on or after the operative date of the governing statutory provision (i.e., October 1, 1996 for SB 152 (1995); August 1, 1997, for SB 98 (1997)). In addition, for small employer health benefit plans, 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 743.737 and such crediting of time shall be effective as of the next renewal date.

(8) 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. A health statement may be used to determine a late enrollee's preexisting conditions, but not to determine a late enrollee's eligibility to enroll or enrollment date. If a late enrollee is subject to a preexisting conditions provision, credit for prior creditable coverage must be applied to such provision.

(9) An enrollee who qualifies under a special enrollment period, as specified in ORS 743.737, must be accepted for coverage in a small employer health benefit plan and shall not be considered a late enrollee. Such an enrollee, however, is subject to the preexisting conditions provision, if any, and the creditable coverage requirements that apply to regular enrollees.

(10) A small employer health benefit plan shall be renewable at the option of the policyholder and shall not be discontinued by the carrier during or at the termination of the contract period except in the circumstances specified in ORS 743.737 and consistent with the requirements of HIPAA (42 U.S.C. 300gg-12).

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.736(4), 743.736(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; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-0050
Trade Practices

The following requirements apply to health benefit plans offered to Oregon small employers and to HIPAA small employers:

(1) When offering plans to small employers, a carrier must briefly describe the variety of small employer plans and plan options that are available from the carrier and must specify that all plans and plan options are offered on a guaranteed issue basis.

(2) A small employer health benefit plan must be issued with an effective date no later than 31 days after the carrier actually receives the application.

(3) Neither a small employer carrier nor an insurance producer 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.

(4) Neither a small employer carrier nor an insurance producer 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.

(5) 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. This limitation also applies to a small employer that discontinues coverage with a carrier, or forfeits coverage because of non-payment of premiums, and then requests new coverage with the same carrier.

Stat. Auth.: ORS 731.244, 743.731(4) & 746.240
Stats. Implemented: ORS 743.736(5)&(7), 743.737(2)-(4), 743.737(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; ID 5-1998, f. & cert. ef. 3-9-98; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-053-0060
Benefit Design

The following provisions apply to health benefit plans offered to Oregon small employers and to HIPAA small employers:

(1) No limitations or exclusion period may be placed on any benefit in the Basic health benefit plan other than those contained in ORS 743.737 and as specified in **Exhibit 1** of this rule.

(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) For small employer plans other than the Basic plan, a carrier may impose an exclusion period for specified covered services, other than for pregnancy and maternity, 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 creditable coverage must be applied if the excluded service was covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan, and:

(a) Creditable coverage remains in effect on the enrollment date, as specified in ORS 743.737(3); or

(b) Creditable coverage terminated no more than 63 days prior to the enrollment date, as specified in ORS 743.737(3).

(4) 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 creditable coverage for 12 months, the applicable exclusion period would be 12 months.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 743.731(4) & 746.240
Stats. Implemented: ORS 743.731(4) & 743.737(1) - 743.737(3)
Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-0065
Rating

The following provisions apply to health benefit plans offered to Oregon small employers:

(1) A small employer carrier shall file a single geographic average rate (GAR) for each health benefit plan that is offered to Oregon small employers within a geographic area. The GAR must be determined on a pooled basis and the pool shall include:

(a) All of the carrier's business in the Oregon small employer market; and

(b) Any other business in the Oregon group market that the carrier wishes to include in the pool.

(2) 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.

(3) 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 shall not include differences based on the risk characteristics or claims experience of the actual or expected enrollees in a particular plan.

(4) A small employer carrier shall file its geographic average rates for small employer health benefit plans in accordance with the rate filing requirements of OAR 836-053-0910.

(5) A small employer carrier shall assess administrative expenses in a uniform manner to all small employer health benefit plans, including the Basic health plan. Administrative expenses shall be expressed as a percentage of premium and the percentage may not vary with the size of the small employer.

(6) Plans shall be rated within the following geographic areas comprising counties as follows:

(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, 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.

(g) Area 7 shall include: Douglas, Jackson and Josephine.

(7) A small employer carrier may use five digit zip code groupings to define the carrier's geographic areas. The zip code groupings may vary from the county areas defined in section (6) of this rule 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 and shall not modify the geographic areas in any other manner.

(8) A small employer carrier may use the same geographic average rate for multiple rating areas.

(9) A small employer carrier may deviate from the requirements of the rate bands specified in ORS 743.737 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.

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. ef. 9-23-96; Renumbered from 836-053-0020; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

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; ID 5-1998, f. & cert. ef. 3-9-98

Group Health Benefit Plans (Other than Small Employer Plans)

836-053-0210
Purpose; Statutory Authority; Enforcement

(1) OAR 836-053-0210 to 836-053-0250 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) Violation of any provision of OAR 836-053-0230 to 836-053-0250 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.522 & 743.751 - 743.754
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98

836-053-0220
Definitions

As used in OAR 836-053-0210 to 836-053-0250:

(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; ID 5-1998, f. & cert. ef. 3-9-98

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 not use health statements, except for late enrollees as provided in ORS 743.751. A health statement used for a late enrollee must comply with the requirements of OAR 836-053-0510. After enrollment, health statements or other information may be used by a carrier for the purpose of providing services or arranging for the provision of services under a group health benefit plan.

(3) A carrier offering a group health benefit plan shall not use health statements or other information revealing 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;

(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; or

(c) Delay enrollment for an otherwise eligible employee or dependent who is disabled when enrollment would normally occur.

(6) The crediting of prior coverage, as specified in ORS 743.754, shall be applied in either of the following cases:

(a) If creditable coverage remains in effect on the enrollment date, as specified in ORS 743.754(1); or

(b) If creditable coverage terminated no more than 62 days prior to the enrollment date, as specified in ORS 743.754(1).

(7) All policy forms and enrollee summaries for group health benefit plans that contain a preexisting conditions provision must clearly disclose how prior creditable coverage will be applied. A carrier may use the following statement, or other similar disclosure, for this purpose:

> The duration of the preexisting conditions provision in this policy will be reduced by the amount of your prior "creditable coverage" if:
> (a) Your creditable coverage is still in effect on your date of enrollment in this policy; or
> (b) Your creditable coverage ended no more than 62 days beforeyour date of enrollment in this policy. Creditable coverage means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance.

(8) To expedite the accurate crediting of prior coverage, in accordance with section (6) of this rule, a carrier shall:

(a) Include a question about potential creditable coverage in all enrollment forms that are used in conjunction with any group health benefit plan containing a preexisting conditions provision; and

(b) Include a notice about potential creditable coverage whenever the carrier notifies an enrollee that a claim has been denied because of a preexisting conditions provision. The notice of claim denial shall also include a telephone number at the carrier that the enrollee may use for additional information regarding the denied claim.

(9) 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. A health statement may be used to determine a late enrollee's preexisting conditions, but not to determine a late enrollee's eligibility to enroll or enrollment date. If a late enrollee is subject to a preexisting conditions provision, credit for prior creditable coverage must be applied to the preexisting condition period applicable to the enrollee.

(10) An enrollee who qualifies under a special enrollment period, as specified in ORS 743.754, must be accepted for coverage in a group health benefit plan and shall not be considered a late enrollee. Such an enrollee, however, is subject to the preexisting conditions provision, if any, and the creditable coverage requirements that apply to regular enrollees.

(11) 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 836-053-0250 shall be implemented for each policyholder on the next renewal date. For the purposes of this subsection, the next renewal date means the first renewal date of the policy issued to the policyholder that occurs on or after the operative date of the governing statutory provision (i.e., October 1, 1996, for SB 152 (1995); August 1, 1997, for SB 98 (1997)). 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 otherwise covered by the plan shall be eliminated and deemed ineffective as of the next renewal 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 next renewal 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 next renewal date.

(12) A group health benefit plan shall be renewable at the option of the policyholder and shall not be discontinued by the carrier during or at the termination of the contract period except in the circumstances specified in ORS 743.754 and consistent with the requirements of HIPAA (42 U.S.C. 300gg-12).

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.522 & 743.751 - 743.754
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98

Group Health Benefit Plans (Other than Small Employer Plans)

836-053-0250
Benefit Design

(1) A carrier may impose an exclusion period for specified covered services, other than for pregnancy and maternity, that applies to all eligible members 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 creditable coverage must be applied if the excluded service was covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan, and:

(a) Creditable coverage remains in effect on the enrollment date, as specified in ORS 743.754(3); or

(b) Creditable coverage terminated no more than 63 days prior to the enrollment date, as specified in ORS 743.754(3).

(2) 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 creditable 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; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

Individual Health Benefit Plans

836-053-0410
Purpose; Statutory Authority; Enforcement

(1) OAR 836-053-0410 to 836-053-0465 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.

(2) Violation of any provision of OAR 836-053-0430 to 836-053-0465 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 743.769
Stats. Implemented: ORS 743.766 - 743.769
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98

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 briefly describe the variety of individual health benefit plans and optional benefit riders offered by the carrier and inform the applicant that additional information is available.

Stat. Auth.: ORS 743.769
Stats. Implemented: ORS 743.766 - 743.769
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 23-2002, f. & cert. ef. 11-27-02; ID 2-2004, f. & cert. ef. 2-20-04

836-053-0440
Underwriting

(1) Except as permitted under a preexisting conditions provision, 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) If an applicant has been accepted for coverage, a carrier may offer a rider for wrap-around occupational coverage to the applicant. The carrier may refuse to issue such a rider to accepted applicants who work in certain occupations that have been designated by the carrier.

(3) The crediting of prior coverage, as specified in ORS 743.766, shall be applied in either of the following cases:

(a) If creditable coverage remains in effect on the effective date of coverage; or

(b) If creditable coverage terminated no more than 63 days prior to the effective date of coverage.

(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) All policy forms and enrollee summaries for individual health benefit plans that contain a preexisting conditions provision must clearly disclose how prior creditable coverage will be applied. A carrier may use the following statement, or other similar disclosure, for this purpose:

The duration of the preexisting conditions provision in this policy will be reduced by the amount of your prior "creditable coverage" if:

(a) Your creditable coverage is still in effect on your date of enrollment in this policy; or

(b) Your creditable coverage ended no more than 63 days before your date of enrollment in this policy. "Creditable coverage" means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance.

(6) To expedite the accurate crediting of prior coverage, in accordance with section (3) of this rule, a carrier offering individual health benefit plans shall:

(a) Include a question about potential creditable coverage in all application forms that are used in conjunction with any individual health benefit plan containing a preexisting conditions provision; and

(b) Include a notice about potential creditable coverage whenever the carrier notifies an enrollee that a claim has been denied because of a preexisting conditions provision. The notice of claim denial shall also include a telephone number at the carrier that the enrollee may use for additional information regarding the denied claim.

(7) A carrier may impose an individual coverage waiting period on the coverage of certain new enrollees in an individual health benefit plan, in accordance with ORS 743.766 and 743.767. The terms of such a waiting period must be specified in the policy form and enrollee summary. 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.

(8) If a carrier imposes an individual coverage 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) Credit must be given for the individual's prior creditable coverage, including any individual coverage waiting period connected with the prior coverage;

(b) The credit must apply equally to the waiting period and the related surcharge, if any, that applies in accordance with ORS 743.767(4); and

(c) The credit must be applied on a prorated basis. For example, if the enrollee qualifies for a 50 percent reduction in the waiting period because of prior creditable coverage, then the surcharge must also be reduced by 50 percent.

(9) An enrollee in an individual health benefit plan may request enrollment in another individual plan or optional benefit rider offered by the enrollee's carrier, but such a request may be handled by the carrier as a new application for coverage.

(10) A modification to an existing individual health benefit plan must be implemented on the next anniversary or fixed renewal date of the plan that occurs on or after the operative date of the governing statutory provision (i.e., October 1, 1996, for SB 152 (1995); August 1, 1997, for SB 98 (1997)). 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 next renewal date; 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.

(11) An individual health benefit plan shall be renewable at the option of the policyholder and shall not be discontinued by the carrier except in the circumstances specified in ORS 743.766 and consistent with the requirements of HIPAA (42 U.S.C. 300gg-42). In accordance with applicable federal law, renewal or continuation of an individual plan shall not be denied on the basis of Medicare eligibility. An individual plan, however, may contain a Medicare non-duplication provision.

(12) A small employer carrier that issues individual health benefit plans to employees of a small employer may not provide a billing to an employer that lists premium due for the employer's individual employees.

Stat. Auth.: ORS 743.769
Stats. Implemented: ORS 743.766 - 743.769
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 23-2002, f. & cert. ef. 11-27-02

836-053-0460
Benefit Design

(1) When a carrier applies an exclusion period for a specified covered service to all individuals upon enrollment in an individual health benefit plan, if the excluded service was covered under prior creditable coverage under another policy, the carrier may determine the excluded service and the duration of the exclusion period and must apply credit for the prior creditable coverage without regard to the level or use of coverage in the prior plan if:

(a) Creditable coverage remains in effect on the effective date of coverage; or

(b) Creditable coverage terminated no more than 63 days prior to the effective date of coverage.

(2) 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 creditable coverage for 12 months, the applicable exclusion period would be 12 months.

(3) A carrier must incorporate coverages newly required by law not later than the anniversary date if a rolling schedule is used, or the fixed schedule date established by the carrier pursuant to OAR 836-053-0465 for implementing premium rate increases.

Stat. Auth.: ORS 743.769
Stats. Implemented: ORS 743.766 - 743.769
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 9-2006, f. 4-27-06, cert. ef. 5-1-06

836-053-0465
Rating

(1) Individual health benefit plans shall be rated in accordance with the geographic areas specified in OAR 836-053-0065. A carrier shall file a single geographic average rate (GAR) for each health benefit plan that is offered to individuals within a geographic area. The GAR must be determined on a pooled basis and the pool shall include all of the carrier's business in the Oregon individual market.

(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 shall 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 anniversary of the date coverage is issued to each enrollee or on another anniversary date established by the carrier; 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 836-053-0910.

(5) A carrier may use the same geographic average rate for multiple rating areas.

(6) A carrier shall offer its insureds the opportunity to pay premium on a monthly basis for an individual health benefit plan in addition to any other mode offered by the carrier.

Stat. Auth.: ORS 731.244 & 743.769
Stats. Implemented: ORS 743.766 - 743.769, 746.015 & 746.240
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; Renumbered from 836-053-0420, ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 7-2001(Temp), f. 5-30-01, cert. ef. 5-31-01 thru 11-16-01; ID 14-2001, f. & cert. ef. 11-20-01

836-053-0510
Oregon Standard Health Statement

(1) The Oregon Standard Health Statement is included as **Exhibit 1** to this rule.

(2) The Oregon 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. In all instances in which a carrier uses the Oregon Standard Health Statement, the cost of processing the statement shall be borne by the carrier.

(3) In evaluating the Oregon 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.

(5) A carrier may use, until April 1, 2005, the Oregon Standard Health Statement that was authorized under this rule prior to amendments adopted on October 29, 2004.

(6) Violation of any provision of this rule is an unfair trade practice under ORS 746.240.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 743.766
Stats. Implemented: ORS 743.766
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; Renumbered from 836-053-0470, ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 9-2004, f. & cert. ef. 11-19-04

Portability Health Benefit Plans

836-053-0700
Statutory Authority, Implementation; Enforcement

(1) OAR 836-053-0700 to 836-053-0800 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, 836-053-0710, and 836-053-0750 to 836-053-0800 apply to carriers issuing portability plans.

(3) Violation of any provision of OAR 836-053-0750 to 836-053-0800 is an unfair trade practice under ORS 746.240.

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; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

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

836-053-0750
Notification

(1) 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 directly to an individual losing group coverage, for any reason other than group replacement of coverage, within 10 days following the date of any administrative action taken by a carrier to initiate or document the loss of coverage.

(2) The explanation 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 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; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-0760
Portability Plans Benefit Matrix

(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 OAR 836-010-0011; and

(b) A low cost benefit portability plan that conforms to the matrix for that plan established in OAR 836-010-0011.

(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 836-053-0780.

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; ID 5-1998, f. & cert. ef. 3-9-98

836-053-0780
Rating

(1) Portability health benefit plans shall be rated in accordance with the geographic areas specified in OAR 836-053-0065. A carrier shall file a single geographic average rate (GAR) for each health benefit plan that is offered to eligible individuals within a geographic area. The GAR must be determined on a pooled basis in accordance with ORS 743.760.

(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 particular plan.

(3) For portability health benefit plans issued in accordance with ORS 743.761, the premium rates that apply to portability policyholders in the individual health benefit plan shall be identical to the rates that apply to non-portability policyholders.

(4) A carrier shall implement premium rate increases for a portability health benefit plan in a consistent manner for all policyholders in the plan. A carrier may use either of the following methods to schedule premium rate increases for all policyholders in a plan:

(a) A rolling schedule that is based on the anniversary of the date coverage is issued to each policyholder or on another anniversary date established by the carrier; or

(b) A fixed schedule that applies concurrently to all policyholders in a plan. If a fixed schedule is used, a carrier may adjust an policyholder's premium during the rating period if the policyholder 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 836-053-0910.

(6) A carrier may use the same geographic average rate for multiple rating areas.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.731 & 743.760
Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-0785
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 and to continue portability coverage.

(2) Oregon group health benefits plans include insured plans that have been issued to group policyholders that are located in Oregon.

(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 who is eligible for enrollment in the federal Medicare program is not eligible to enroll in portability coverage.

(5) All portability health benefit plans shall be renewable at the option of the policyholder and shall not be discontinued by the carrier except in the circumstances specified in ORS 743.760 and consistent with the requirements of HIPAA (42 U.S.C. 300gg-42). In accordance with applicable federal law, renewal or continuation of a portability plan shall not be denied on the basis of Medicare eligibility. A portability plan, however, may contain a Medicare non-duplication provision.

(6) An individual who is otherwise eligible to enroll in portability coverage is not an eligible individual if the individual is also covered under another group or individual health benefit plan when such enrollment would occur.

(7) 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.

(8) 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, when the dependent meets the dependent eligibility requirements of the portability health benefit plan.

(9) 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.

(10) 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 dependent eligibility requirements of the plan.

(11) 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.

(12) In accordance with ORS 743.760 and 743.763 and 42 USC 300gg-41, individuals who have lost self-insured group coverage and individuals who qualify for portability coverage under HIPAA must exhaust their federal or state continuation coverage in order to qualify for portability coverage. To exhaust continuation coverage, an individual:

(a) Must exhaust the standard period of continuation coverage (6, 12 or 18 months, depending on eligibility status);

(b) Must exhaust the 29 month disability extension under the Social Security Act if the individual qualifies for that extension; and

(c) Must not have forfeited continuation coverage because of non-payment of premiums.

(13) In accordance with ORS 743.760 and 743.763 and 42 U.S.C. 300gg-41, an individual who remains eligible for the individual's prior group coverage is not eligible for portability coverage. For example, an enrollee or covered dependent whose enrollment in an ongoing group plan was voluntarily discontinued is not eligible for portability coverage.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.731 & 743.760
Hist.: ID 2-1997, f. & cert. ef. 3-28-97; Renumbered from 836-053-0715, ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-0790
Underwriting

(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 take effect on the first day following the termination of the enrollee's prior group coverage and premiums shall be payable by the enrollee for the period of time between the effective date of coverage and the date of enrollment.

(5) An eligible individual who has enrolled in the Prevailing plan option may elect to replace that coverage with coverage in the Low Cost plan option. Such election shall be made in writing and shall take effect on the first day following the date through which premium has been paid for the Prevailing plan option coverage.

(6) An eligible individual who has enrolled in the Low Cost plan option may apply to replace that coverage with coverage in the Prevailing plan option. Such application may be handled by the carrier as a new application for individual coverage.

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; ID 5-1998, f. & cert. ef. 3-9-98

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) A carrier shall offer its insureds the opportunity to pay premium on a monthly basis for a portability health benefit plan in addition to any other mode offered by the carrier.

(5) 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, 746.015 & 746.240
Hist.: ID 13-1996(Temp), f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97; ID 7-2001(Temp), f. 5-30-01, cert. ef. 5-31-01 thru 11-16-01; ID 14-2001, f. & cert. ef. 11-20-01

Quality Assessment and Improvement

836-053-0900
Purpose; Statutory Authority

OAR 836-053-0900 and 836-053-0910 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, individual and portability health benefit 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; ID 5-1998, f. & cert. ef. 3-9-98, Renumbered from 836-053-0180

836-053-0910
Rate Filing

(1) A carrier shall file with the Director:

(a) The appropriate checklists and certification statements, as established in OAR 836-010-0011;

(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.

(4) Violation of any provision of this rule is an unfair trade practice under ORS 746.240.

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; ID 5-1998, f. & cert. ef. 3-9-98, Renumbered from 836-053-0185

836-053-1000
Statutory Authority and Implementation

(1) OAR 836-053-1000 to 836-053-1200 are adopted under the authority of ORS 731.244, 743.814, and 743.819, for the purpose of implementing ORS 743.699, 743.804, 743.807, 743.814, 743.817, 743.819, 743.821, 743.829, and 743.837. The filing and reporting requirements in this rule and in OAR 836-053-1070, 836-053-1130, 836-053-1170, and 836-053-1190 apply to all domestic insurers transacting health benefit plans, including health care service contractors, to all foreign carriers transacting health benefit plans who transacted $2 million or more in annual health benefit plan premium in Oregon, and to other carriers transacting health benefit plans as determined by the Director.

(2) When an insurer maintains more than one type of health benefit plan, the insurer shall comply with OAR 836-053-1000 to 836-053-1200 on a plan-by-plan basis.

(3) Not later than June 30 of each year, each insurer shall file with the Director for the immediately preceding calendar year the following information as required of the insurer:

(a) An annual summary relating to grievances and appeals, required by ORS 743.804(9) of all insurers;

(b) An annual summary relating to the insurer's utilization review policies, required by ORS 743.807(1) of each insurer that provides utilization review or has utilization review provided on its behalf;

(c) An annual summary relating to the insurer's quality assessment activities required by ORS 743.814(2) of each insurer that offers managed health insurance;

(d) The results of all publicly available federal Health Care Financing Administration reports and accreditation surveys by national accreditation organizations required by ORS 743.814(3)(a) of each insurer that offers managed health insurance;

(e) The insurer's health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities covered by the insurer, required by ORS 743.814(3)(b) of each insurer that offers managed health insurance. The insurer may submit the summary required in this subsection in the format of the insurer's choosing, including a summary prepared for another purpose. The summary required in this subsection shall include the following activities, to the extent the insurer engages in them, and may include any additional information that the insurer deems significant in describing its health promotion and disease prevention activities:

(A) Tobacco use and cessation;

(B) Cancer screening, including mammography;

(C) Diabetes education and home monitoring;

(D) Immunizations;

(E) Childbirth education and parenting support;

(F) Nutrition;

(G) Cardiovascular health; and

(H) Injury prevention; and

(f) An annual summary relating to the scope of the insurer's network and to the accessibility of services, required by ORS 743.817(1) of each insurer that offers managed health insurance.

(4) In order to minimize duplicative reporting requirements, an insurer may submit a copy of a report prepared for a national accreditation organization to meet the reporting requirements of section (3)(e) of this rule relating to the insurer's health promotion and disease prevention activities, OAR 836-053-1130(1) relating to the insurer's utilization review policies, OAR 836-053-1170(1) relating to the insurer's quality assessment activities and OAR 836-053-1190(1) relating to the insurer's provider network and the accessibility of services. To the extent that a report prepared for a national accreditation organization does not include information required by the department, the insurer must submit an addendum to the report that provides this information.

(5) If information required to be filed annually with the department pursuant to this rule has not changed since an insurer's previous annual filing, an insurer may satisfy the reporting requirements of this rule by indicating that the information has not changed, or if some but not all information has changed, by submitting an addendum to the previous annual filing indicating only the information that has changed since the previous filing . However, every third year the insurer must file all required information, including information that may not have changed since the previous filing. For example, if an insurer made an annual filing in 1998, it is sufficient to indicate in 1999 and 2000 that certain information has not changed since the previous annual filing or to submit an addendum indicating the information that has changed, but the filing in 2001 must contain all information required by the department pursuant to this rule.

(6) All filings required in section (3) of this rule must be made on computer disk.

(7) For purposes of OAR 836-053-1000 to 836-053-1200, "insurer" also includes a health care service contractor as defined in ORS 750.005 and a multiple employer welfare arrangement as defined in ORS 750.301.

(8) OAR 836-053-1000 to 836-053-1200 apply to a self-insured public entity to the extent provided in ORS 731.036.

(9) An insurer shall administer the plan in compliance with ORS 743.699, 743.804, 743.807, 743.814, 743.817, 743.821, 743.829, and 743.837 and OAR 836-053-1000 to 836-053-1200.

(10) An insurer shall comply with the federal Newborns' and Mothers' Health Protection Act of 1996, as referred to in ORS 743.823 with respect to group health insurance plans and individual health insurance plans.

Stat. Auth.: ORS 731.244, 743.814 & 743.819
Stats. Implemented: ORS 743.699, 743.804, 743.807, 743.814, 743.817, 743.819, 743.821, 743.829 & 743.837
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-1010
Insurer Policies

(1) The written policy recognizing the rights of enrollees, which is required of an insurer by ORS 743.804, must be an official corporate policy of the insurer.

(2) An insurer must provide a written summary of the policy required by ORS 743.804 to:

(a) Each participating provider, upon request of the provider; and

(b) Each enrollee, as part of the written general information that is furnished as required by ORS 743.804(5) and OAR 836-053-1030, relating to services, access thereto and related charges and scheduling.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1020
Drug Formularies

(1) For purposes of OAR 836-053-1000 to 836-053-1200:

(a) "Open formulary" means a method used by an insurer to provide prescription drug benefits in which all prescribed FDA approved prescription drug products are covered except for any drug product that is excluded by the insurer pursuant to the insurer's policy regarding medical appropriateness or by the terms of a specific health benefit plan, or except for an entire class of drug product that is excluded by the insurer. For example, an insurer with an open formulary may exclude all contraceptive drugs; and

(b) "Closed formulary" means a method used by an insurer to provide prescription drug benefits in which only specified FDA approved prescription drug products are covered, as determined by the insurer, but in which medical exceptions are allowed. Maximum benefits or coverage may be limited to formulary drugs in a health benefit plan with a closed formulary; and

(c) "Mandatory closed formulary" means a method used by an insurer to provide prescription drug benefits in which only specified FDA approved prescription drug products are covered, as determined by the insurer, and in which no exceptions are allowed.

(2) An insurer that uses an open formulary must have a written procedure that includes the written criteria or explains the review process established by the insurer for determining when an item will be limited or excluded pursuant to the insurer's policy regarding medical appropriateness.

(3) An insurer that uses a closed formulary must have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary. The procedure must also describe how the insurer determines the content of the closed formulary and how the insurer determines the application of a medical exception. The procedure must describe how a provider may request inclusion of a new item in the closed formulary and must ensure that the insurer will issue a timely written response to a provider making such a request.

(4) An insurer that uses a mandatory closed formulary must have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary and that no exception is allowed. The procedure must describe how the insurer determines the content of the mandatory closed formulary. The procedure must also describe how a provider may request inclusion of a new item in the formulary and must ensure that the insurer will issue a timely written response to a provider making such a request.

(5) An insurer must furnish a copy of the procedures it has adopted under section (2), (3), or (4) of this rule to a provider with authority to prescribe drugs and medications, upon the request of the provider.

(6) An insurer that uses a drug formulary must include a summary of formulary provisions in the information required in ORS 743.804(5)(p) and OAR 836-053-1030, relating to drug prescriptions,

and in the information regarding drug formulary rules required by ORS 743.804(6)(a), relating to the insurer's drug formulary.

(7) Nothing in this rule shall require an insurer to use a formulary or to construct a formulary in a particular way. For purposes of this section, a method that provides for coverage of all prescribed FDA approved prescription drugs without regard to the limitations described in section (1) of this rule does not constitute a formulary. A plan may contain open, closed or mandatory closed formularies. If a plan combines more than one of these formularies, sections (2), (3), and (4) of this rule, as applicable, shall apply to the relevant portion of the plan.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1030
Written Information to Enrollees

(1) Each insurer must furnish the written general information to policyholders that is required by ORS 743.804(2), relating to enrollee rights and responsibilities, and ORS 743.804(5), relating to services, access thereto and related charges and scheduling, as provided in this rule. An insurer:

(a) Must furnish the information regarding an individual health insurance policy to each policyholder; and

(b) Must furnish the information regarding a group health insurance policy to the group policyholder for distribution to enrollees of the group policy.

(2) The written general information referred to in section (1) of this rule must be included either in the policy or in other material that is delivered to the policyholder.

(3) The written general information must disclose the following in relation to referrals for specialty care, behavioral health services, hospital services and other services, in addition to other relevant information regarding referrals:

(a) If applicable, how gatekeeping or access controls apply to referrals and whether and how the controls differ for specialty care, behavioral health services and hospital services; and

(b) Any limitation on referrals if a plan has a defined network of participating providers and if referrals for specialty care may be limited to a portion of the network, such as to those specialists who contract with an enrollee's primary care group.

(4) The written general information must include the information required by ORS 743.699, relating to coverage of emergency medical conditions and obtaining emergency services, including a statement of the prudent layperson standard for an emergency medical condition, as that term is defined in ORS 743.801. An insurer may meet the requirement of providing information in ORS 743.699 by providing adequate disclosure in the written general information required by ORS 743.804(5) and this rule. An insurer may use the following statement regarding the use of the emergency telephone number 9-1-1, or other wording that appropriately discloses its use:

> If you or a member of your family needs immediate assistance for a medical emergency, call 9-1-1 or go directly to an emergency room.

(5) The written general information must include information regarding the use of the insurer's grievance process, including the assistance available to enrollees in filing written grievances in accordance with OAR 836-053-1090 and the utilization review appeal procedures required by ORS 743.807(2)(c). The information must be contained in a separate section of the written information and captioned in a manner that clearly indicates that the section addresses grievances and appeals.

(6) The written general information must include a notice that states the right to file a complaint with or seek assistance from the Director of the Department of Consumer and Business Services. An insurer may use the following statement or other appropriate wording for this purpose:

> You have the right to file a complaint or seek other assistance from the Oregon agency. Assistance is available:
> By calling (503) 947-7984 or the toll free message line at (888) 877-4894;
> By writing to the Oregon agency, Consumer Protection Unit,
> 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;
> Through the Internet at http://www.cbs.state.or.us/external/ins/; or
> By e-mail at: DCBS.INSMAIL@state.or.us

(7) The written general information for an insurance policy providing managed health care must include a description of the procedures by which enrollees, purchasers and providers may participate in the development and implementation of insurer policy and operation.

(8) The portion of the written general information that describes how an insurer makes decisions regarding coverage and payment for treatment or services must include a notice to enrollees that they may request an additional written summary of information that the insurer may consider in its utilization review of a particular condition to the extent the insurer maintains such criteria. The notice to enrollees must include the name and telephone number of the administrative section of the insurer that handles enrollee requests for information.

(9) If a plan has a defined network of participating providers, the written general information must include a list of all primary care providers and direct access providers, and may also include a list of all specialty care providers. For the purposes of this section, a primary care provider or direct access provider is a participating provider under the terms of the plan who an enrollee may designate as the primary care provider for the enrollee or from whom an enrollee may obtain services without referral. The list of providers must include for each provider the provider's name, professional designation, category of practice and the city in which the practice of the provider is located. If the information does not list participating specialty care providers, the information must state that fact and must disclose the manner in which an enrollee may obtain information about participating specialty care providers.

(10) If a plan includes risk-sharing arrangements with physicians or other providers, the written general information must contain a statement to that effect, including a brief description of risk-sharing in general, and must notify enrollees that additional information is available upon request. For the purpose of this requirement, a risk-sharing arrangement does not include a fee-for-service arrangement or a discounted fee-for-service arrangement. An insurer may use the following statement to describe risk-sharing, or other appropriate wording:

> This plan includes "risk-sharing" arrangements with physicians who provide services to the members of this plan. Under a risk-sharing arrangement, the providers that are responsible for delivering health care services are subject to some financial risk or reward for the services they deliver. An example of a risk sharing arrangement is a contract between an insurer and a group of heart surgeons in which the surgeons agree to provide all of the heart operations needed by plan members and the insurer agrees to pay a fixed monthly amount for those services.

(11) If the insurer of a plan uses a mandatory closed formulary, the written general information for that plan must prominently disclose and explain the formulary provision. The disclosure and explanation must be in boldfaced type or otherwise emphasized.

(12) The written general information must include a notice disclosing that additional information is available to enrollees upon request to the insurer. The notice must include the name and telephone number of the insurer's administrative section that handles enrollee requests for information. For the notice required in the written general information disclosing information available from the Department of Consumer and Business Services, an insurer may use the following statement, or other appropriate wording:

> The following information regarding the health benefit plans of (insurer's name) is available from the Oregon agency:
> 1. An annual summary of grievances and appeals;
> 2. (if applicable) An annual summary of utilization review policies;
> 3. (if applicable) An annual summary of quality assessment activities;
> 4. (if applicable) The results of all publicly available accreditation surveys;
> 5. (if applicable) An annual summary of the insurer's health promotion and disease prevention activities;
> 6. (if applicable) An annual summary of scope of network and accessibility of services.
> This information is available:
> By calling (503) 947-7984 or the toll free message line at (888) 877-4894;
> By writing to the Oregon agency, Consumer Protection Unit,
> 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;
> Through the Internet at http://www.cbs.state.or.us/external/ins/; or
> By e-mail at: DCBS.INSMAIL@state.or.us

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.699, 743.804 & 743.807
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-1040
Information Available Upon Request

The information that an insurer must provide an enrollee or prospective enrollee pursuant to ORS 743.804(6), relating to the insurer's drug formulary, referrals for specialty care and other services, is subject to the following requirements:

(1) Information relating to the insurer's provisions for referrals, if any, for specialty care and other services must meet the requirements

applicable to the disclosure required by ORS 743.804(5)(b) and OAR 836-053-1030(3).

(2) The wording and style of information relating to the insurer's risk-sharing arrangements with physicians and other providers must be consistent with that required by the federal Health Care Financing Administration under 42 CFR 417.479(h)(3). (42 CFR 417.479(h)(3) is the relevant citation for this purpose rather than the citation in ORS 743.804(6)(d).)

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1060
Definitions

For purposes of grievance procedures under OAR 836-053-1000 to 836-053-1200, and ORS 743.804:

(1) "Complaint" means an expression of dissatisfaction to an insurer that is about a specific problem encountered by an enrollee or about a decision by an insurer or by an insurance producer acting on behalf of the insurer and th at includes a request for action to resolve the problem or change the decision. "Complaint" does not include an inquiry as that term is defined in this rule.

(2) "Grievance" has the meaning given in ORS 743.801, which states that "grievance" means a written complaint submitted by or on behalf of an enrollee regarding:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(3) "Inquiry" means a written request for information or clarification about any subject matter related to the enrollee's health benefit plan.

Stat. Auth.: ORS 731.244 & 743.819
Stats. Implemented: ORS 743.801 & 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-053-1070
Reporting of Grievances; Format and Contents

(1) For the purpose of complying with the requirement in ORS 743.804(9) that each insurer provide an annual summary of the insurer's aggregate data regarding grievances and appeals, an insurer must report the data required in section (2) of this rule for grievances closed in the previous calendar year ending December 31. The data must be reported in a format prescribed by the Director. For purposes of this rule:

(a) The number of grievances means the total number of written complaints closed by the insurer that qualify as a "grievance" as that term is defined in ORS 743.801; and

(b) A grievance is "closed" if a determination regarding the grievance has been made and the determination is not appealed or has been appealed through all available grievance appeal levels, or the insurer determines that the complainant is no longer pursuing the grievance.

(2) The data to be included in the annual summary are as follows:

(a) The total number of grievances closed in the reporting year;

(b) The number of grievances closed in each of the categories listed in section (3) of this rule;

(c) The number and percentage of grievances in each of the categories listed in section (3) of this rule in which the insurer's initial decision is upheld and the number and percentage in which the initial decision is reversed at closure of the grievance;

(d) The number and percentage of all grievances that are closed at the initial grievance stage;

(e) The number and percentage of all grievances that are closed at the first level of appeal;

(f) The number and percentage of all grievances that are closed at the second level of appeal; and

(g) The average length of time between filing of a grievance and closure of the grievance.

(3) An insurer must report each grievance according to the nature of the grievance. The nature of the grievance shall be determined according to the categories listed in this section. The insurer must report each grievance in one category only and must have a system that allows the insurer to report accurately in the specified categories. If a grievance could fit in more than one category, an insurer shall report the grievance in the category established in this section that the insurer determines to be most appropriate for the grievance. The categories of grievances are as follows:

(a) Access problems, including timeliness and the availability of a provider;

(b) Denials based on medical necessity;

(c) Denials based on other coverage issues, including denials based on the service being out of plan, out of area or not a covered benefit;

(d) Eligibility;

(e) Quality of clinical care;

(f) Quality of plan services, not including the quality of clinical care as provided in subsection (e) of this section;

(g) Referral issues;

(h) Emergency services; and

(i) Administrative issues and issues other than those otherwise listed in this section.

(4) Nothing in this rule prohibits an insurer from creating or using its own system to categorize the nature of grievances in order to collect data if the system allows the insurer to report grievances accurately according to the categories in section (3) of this rule and if the system enables the Director to track the grievances accurately.

Stat. Auth.: ORS 731.244 & 732.819
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1080
Tracking Grievances

An insurer shall record data relating to all grievances and significant actions taken from each initial grievance filing through the appeals process, as required by ORS 743.804, in a manner sufficient for the insurer to report grievances accurately as required by ORS 743.804 and OAR 836-053-1070, and for the insurer to track individual files in response to a market conduct examination or other inquiry by the Director under ORS 733.170 and OAR 836-080-0215.

Stat. Auth.: ORS 731.244 & 743.819
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1090
Assistance in Filing Grievances

For the purpose of providing assistance to enrollees in filing written grievances, as required by ORS 743.804, an insurer must promptly:

(1) Provide information regarding the use of the insurer's grievance process to an enrollee who wants to submit a grievance; and

(2) Assist an enrollee in the filing of a grievance when the enrollee states a complaint and requests assistance in putting that complaint into writing.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1100
Time Requirements for Grievance Review

(1) The minimum standards for timeliness of response by an insurer to grievances and appeals by its enrollees, for purposes of the system of resolving grievances and appeals required by ORS 743.804 are as follows:

(a) An insurer shall acknowledge receipt of an initial grievance or the first or second appeal from an enrollee not later than the seventh day after receiving the grievance or the first or second appeal;

(b) An insurer shall make a decision on the initial grievance or the first or second appeal not later than the 30th day after receiving notice of the initial grievance or the appeal. In the event of an initial grievance, the insurer may have an additional 15 days to resolve the issue if before the 30th day the insurer gives a notice of delay to the enrollee or representative of the enrollee that includes a specific reason for the delay.

(2) An otherwise applicable standard for timeliness in section (1) of this rule does not apply when:

(a) The period of time is too long to accommodate the clinical urgency of the situation;

(b) The enrollee does not reasonably cooperate; or

(c) Circumstances beyond the control of a party prevent that party from complying with the standard, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

(3) An insurer shall treat an appeal from a decision by a medical consultant or peer review committee pursuant to OAR 836-053-1140(1)(b) as a second appeal under the insurer's grievance procedures under ORS 743.804(3).

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00

836-053-1110
Notice of Complaint Filing with Director

(1) A written decision by an insurer in response to a grievance, a first appeal and a second appeal must prominently disclose the following:

You have the right to file a complaint or seek other assistance from the Oregon agency. Assistance is available:
By calling (503) 947-7984;
By writing to the Oregon agency, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97310; or
Through the Internet at http://www.cbs.state.or.us/external/ins/.

(2) The information stated in section (1) of this section is subject to change upon notice from the Director.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1130
Annual Summary, Utilization Review

(1) The annual summary required by ORS 743.807(1) shall:

(a) Describe the insurer's utilization review policies, to the extent the insurer has relevant policies, in the following areas:

(A) Corporate oversight;
(B) Development and implementation of criteria;
(C) Use of clinical information;
(D) Provider participation;
(E) Qualifications of decision-makers;
(F) Time frames for decisions;
(G) Communication with enrollees and providers; and
(H) Program evaluation; and

(b) Document the insurer's procedures for monitoring of utilization review activities, including delegated activities.

(2) In order to minimize duplicative reporting requirements, the insurer may submit the summary required in this rule in the format of the insurer's choosing, including the format of a summary prepared for another purpose. If an insurer files a summary prepared for another purpose, the insurer shall comply with OAR 836-053-1000(3) and (5). The insurer may include in the summary any additional information that the insurer deems significant in describing its utilization review policies or monitoring activities.

Stat. Auth.: ORS 731.244 & 743.819
Stats. Implemented: ORS 743.804 & 743.807
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1140
Appeal, Utilization Review Determinations

(1) When a patient or a provider first appeals the decision of an insurer to deny treatment or payment for services as not medically necessary or experimental under ORS 743.807(2)(c):

(a) The insurer shall acknowledge receipt of the notice of appeal not later than the seventh day after receiving the notice; and

(b) An appropriate medical consultant or peer review committee shall review the appeal and decide the issue not later than the 30th day after the insurer receives notice of the appeal.

(2) A standard for timeliness in section (1) of this rule does not apply when:

(a) The period of time is too long to accommodate the clinical urgency of the situation;

(b) The patient or provider does not reasonably cooperate; or

(c) Circumstances beyond the control of a party prevent that party from complying with the standard, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

(3) An insurer shall treat an appeal from a decision by a medical consultant or peer review committee pursuant to section (1)(b) of this rule as a second appeal under the insurer's grievance procedures under ORS 743.804(3).

(4) Nothing in this rule shall prevent a patient from filing a grievance under the insurer's regular grieva nce procedure established pursuant to ORS 743.804(3) when the grievance concerns an insurer's denial of treatment or payment for services as not medically necessary or as experimental, but this rule does not entitle a person not otherwise allowed to file a grievance or to appeal a decision by a medical consultant or peer review committee to file such a grievance or appeal.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.804 & 743.807
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

836-053-1170
Annual Summary, Quality Assessment Activities

(1) The annual summary required by ORS 743.814(2) shall:

(a) Describe the insurer's quality assessment program that enables the insurer to evaluate, maintain and improve the quality of health services provided to enrollees;

(b) Identify the specific quality-improvement goals chosen by the insurer and report any progress on those goals as measured by the insurer's data gathering;

(c) Describe the insurer's quality assessment activities, to the extent the insurer engages in relevant activities, in the following areas:

(A) Corporate oversight;
(B) Credentialing of providers;
(C) Provider participation;
(D) Use of clinical practice guidelines;
(E) Identification of priorities;
(F) Assessment of enrollee satisfaction;
(G) Communication with enrollees and providers;
(H) Program evaluation.

(2) An insurer shall include the following in the annual information required by ORS 743.814(3):

(a) The results of all publicly available federal Health Care Financing Administration reports and accreditation surveys by national accreditation organizations; and

(b) The reporting of the insurer's health promotion and disease prevention activities, if any, specified in section (3) of this rule.

(3) The activities to be reported as required by section (2)(b) of this rule are all contained in the National Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS), and are selected for their standardized definitions and data collection protocols in order to facilitate collection of comparable data from all plans. The activities are as follows:

(a) The following preventive measures:

(A) Childhood immunizations, including the percentage of children in the insurer's managed care health plans who have received appropriate immunizations by their second birthdays; and

(B) Tobacco use, including the percentage of adult smokers and recent quitters who received advice to quit smoking from a health professional in health plans of the insurer.

(b) Chronic conditions, as follows:

(A) For calendar year 1999 only, the chronic condition of breast cancer including the percentage of the insurer's health plans' female members between the ages of 52 and 69 who had at least one mammogram during the past two years; and

(B) For calendar year 2000 and each calendar year thereafter, the chronic condition of diabetes as specified in the HEDIS.

(c) The acute condition of pregnancy care. The information shall include the percentage of pregnant women in the insurer's health plans that began prenatal care during the first 13 weeks of pregnancy.

(4) In order to minimize duplicative reporting requirements, the insurer may submit the summary required in section (1) of this rule and the information required in section (2)(b) of this rule in the format of the insurer's choosing. For purposes of this section:

(a) The insurer may submit a summary prepared by the insurer for another purpose. If the insurer submits such a summary, the insurer shall comply with OAR 836-053-1000(3) and (5). The insurer may include in the summary any additional information that the insurer deems significant in describing its quality assessment and improvement activities;

(b) The summary may include information prepared by the insurer for HEDIS and may be submitted on the basis of any sampling method recognized by HEDIS. A multi-state or regional HEDIS report

may be used for reporting under this subsection if the insurer furnishes with the report the number or an estimate of the number of regional members and Oregon members to whom the report applies.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244, 743.814 & 743.819
Stats. Implemented: ORS 743.804 & 743.814
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 17-1998, f. & cert. ef. 11-16-98

836-053-1190
Annual Summary, Uniform Indicators of Network Adequacy

An insurer offering managed health insurance or preferred provider organization insurance shall submit its annual summary required under ORS 743.817 on March 1 of each year. The annual summary shall include the following matters for the immediately preceding calendar year as of December 31, according to the following uniform indicators:

(1) Whether the insurer has established a requirement or goal for accessibility that providers must meet, in terms of hours, days or weeks, or in the alternative an indication that the insurer does not establish and maintain such a requirement or goal, for the following categories:

(a) Preventive care;

(b) Routine primary care; and

(c) Urgent care.

(2) Whether accessibility to urgent care services outside of regular business hours differs by region or geographical area of the state that the insurer serves, and if so, a description of the differences among the regions or areas.

(3) The number of communications expressing a concern regarding difficulty in obtaining an appointment with a provider, including but not limited to the inability to find a provider with a open practice or to an unreasonable length of time to wait for an appointment. Communications under this section include but are not limited to complaints, grievances and appeals from enrollees.

(4) Whether the insurer has a process for ensuring network adequacy that includes oversight, communication and monitoring, and the following information about the process:

(a) The position and department of the individual with the responsibility of ensuring and monitoring the network;

(b) The phone number, address or website that enrollees are requested to use in order to express concerns regarding network adequacy;

(c) The website at which enrollees can locate the provider directory, and the frequency with which the website is updated.

(d) How often an enrollee is specifically notified of changes to the insurer's provider network and the medium or media by which an enrollee is informed.

(e) Information regarding the insurer's monitoring of its network adequacy, including:

(A) The intervals between formal reviews (monthly, quarterly, annually or other);

(B) Whether the results of the reviews are reported to senior management or the board of directors, or both, or neither; and

(C) How the insurer uses its formal reviews to monitor and improve accessibility for clients.

(5) Whether the insurer's provider directory and updates to the directory disclose which providers are fluent in languages other than English and, if so, what languages are available.

(6) Whether the insurer keeps information on which of the physicians in its network have open practices, and if so:

(a) How often does the insurer update the information; and

(b) Whether enrollees have access to the information. If enrollees have access, please explain how enrollees may seek access.

(7) Any other information that the insurer determines to be significant in documenting the scope of its network or its monitoring of access to services.

Stat. Auth.: ORS 731.244 & 743.819
Stats. Implemented: ORS 743.817
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1200
Prior Authorization Requirements

(1) The provisions of this rule implement the requirements of ORS 743.837 and 743.807, relating to prior authorization determinations. "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(2) ORS 743.837 and 743.807 apply to prior authorization determinations that:

(a) Are issued orally or in writing by an insurer to a provider regarding the benefit coverage or medical necessity of a medical or mental health service to be provided to an enrollee; and

(b) Are required under and obtained in accordance with the terms of a health benefit plan.

(3) A prior authorization may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer.

(4) Nothing in this rule shall require a health benefit plan to contain a prior authorization requirement.

(5) Except in the case of misrepresentation relevant to a request for prior authorization, a prior authorization determination shall be binding on the insurer for the period of time specified in section (6) of this rule.

(6) A prior authorization determination shall be binding on the insurer for:

(a) The lesser of the following periods:

(A) Five business days; or

(B) The period during which the enrollee's coverage remains in effect, provided that when the insurer issues the prior authorization, the insurer has specific knowledge that the enrollee's coverage will terminate sooner than five business days following the day the authorization is issued and the insurer specifies the termination date in the authorization; and

(b) The period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of thirty calendar days.

(7) For purposes of counting days under section (6) of this rule, day 1 occurs on the first business or calendar day, as applicable, following the day on which the insurer issues a prior authorization determination.

(8) An insurer may not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations in ORS 743.837 and this rule.

(9) When an insurer answers requests by providers for prior authorization of nonemergency services as required by ORS 743.807(2)(d), the insurer must answer the request within two business days and must have qualified health care personnel available for same day telephone responses to inquiries concerning certification of continued length of stay. The answer to a request by a provider for prior authorization of nonemergency services must be one of the following:

(a) The requested service is authorized.

(b) The requested service is not authorized.

(c) The entire requested service is not authorized, but a specified portion of the requested service or a specified alternative service is authorized.

(d) The requested service is not authorized because the insurer needs additional specified information in order to make a decision on the request.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.837 & 743.807
Hist.: ID 1-1998, f. & cert. ef. 1-15-98

Independent Review

836-053-1300
Purpose and Scope; Application

(1) OAR 836-053-1300 to 836-053-1365 are adopted by the Director of the Department of Consumer and Business Services to implement ORS 743.857 to 743.862, governing the Director's contracting with independent review organizations for the purpose of resolving disputes relating to adverse decisions by insurers in one or more of the issues specified in ORS 743.857.

(2) OAR 836-053-1300 to 836-053-1365 are operative with respect to disputes for which the initial grievance is filed on or after July 1, 2002 under health benefit plans in existence, issued or renewed on or after July 1, 2002.

Stat. Auth.: ORS 731.244 & 743.858 - 743.862
Stats. Implemented: ORS 743.857 - 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1305
Definitions; Authority to Act for Enrollee

(1) As used in OAR 836-053-1300 to 836-053-1365, "medical reviewer" means any of the following persons who is assigned to an independent review case by an independent review organization:

(a) A doctor of medicine or osteopathy licensed under ORS Chapter 677 or under the laws of another state.

(b) A provider as defined in ORS 743.801.

(c) A health care professional licensed, certified or otherwise authorized or permitted by the laws of another state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(2) An action that may be taken by an enrollee under ORS 743.857 to 743.862 or under OAR 836-053-1300 to 836-053-1365 may be taken on behalf of the enrollee by a representative of the enrollee.

Stat. Auth.: ORS 731.244 & 743.858 - 743.862
Stats. Implemented: ORS 743.857 - 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1310
Contracting Requirements

(1) To be considered for contracting with the Director as an independent review organization under ORS 743.858 for the purpose of providing independent review under ORS 743.857, an independent review organization must submit to the Director a response to the Director's request for proposal according to its requirements. The response must include:

(a) For an independent review organization that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(b) The name of any holder of bonds or notes of the independent review organization that exceed $100,000;

(c) The name and type of business of each corporation or other organization that the independent review organization controls or is affiliated with and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer and executive of the independent review organization and any entity listed under subsection (c) of this section and a description of any relationship the named individual has with:

(A) An insurer;

(B) A utilization review agent;

(C) A nonprofit or for-profit hospital or other health care corporation;

(D) A doctor of medicine or osteopathy, a provider or other health care professional;

(E) A drug or device manufacturer; or

(F) A group representing any of the entities described by paragraph (A) to (E) of this subsection;

(e) The percentage of the independent review organization's revenues that the independent review organization anticipates will be derived from reviews conducted under ORS 743.862;

(f) A description of the areas of expertise of the medical reviewers making review determinations for the independent review organization, as well as policies and standards of the independent review organization that address qualifications, training and assignment of all types of medical reviewers and that are compliant with requirements of OAR 836-053-1317;

(g) The procedures that the independent review organization will use in making review determinations regarding reviews conducted under ORS 743.862;

(h) Attestations that all requirements will be met;

(i) Evidence of accreditations, certifications and government independent review organization contracts that the independent review organization relies upon to demonstrate compliance with applicable requirements of ORS 743.862 and OAR 836-053-1315;

(j) Other documentation, including but not limited to legal and financial information, policies and procedures, and data that are pertinent to requirements of ORS 743.862 and OAR 836-053-1315; and

(k) Any other requirements established by the Director that demonstrate the independent review organization's ability to meet all requirements for contracting as an independent review organization in this state.

(2) In order to enable the Director to consider the response of an independent review organization under section (1) of this rule:

(a) The independent review organization must authorize release of information from primary sources, including full reports of site visits, inspections and audits; and

(b) The Director may require the independent review organization to indicate which documents demonstrate compliance with specific statutory requirements under ORS 743.862 and OAR 836-053-1315.

(3) Investigation and verification activities of the Director regarding the independent review organization may include, but are not limited to:

(a) Review of the response of the independent review organization to the request for proposals and its filings for completeness and compliance with standards;

(b) On-site survey or examination;

(c) Primary-source verification with accreditation or regulatory bodies of compliance with requirements that are used to demonstrate compliance with applicable standards established in ORS 743.862 and OAR 836-053-1315; and

(d) Other means of determining regulatory and accreditation histories.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1315
Performance Criteria

The following are performance criteria that an independent review organization must satisfy when demonstrating its eligibility for contracting with the Director to perform independent review responsibilities under ORS 743.862, and in order to continue performing those responsibilities under the contract with the Director. For purposes of this rule, an independent review organization must:

(1) Demonstrate its capability of and expertise in reviewing health care, and a history of such review, in terms of the coverage issues that are subject to independent review pursuant to ORS 743.857, in terms of the application of other health plan coverage provisions and in terms of health insurance contract law.

(2) Demonstrate the ability to handle a full range of review cases occurring in this state. An independent review organization may contract with a more specialized review organization, but the independent review organization must ensure that each review conducted meets all the requirements of ORS 743.857, 743.858 and 743.862 and OAR 836-053-1300 to 836-053-1365.

(3) Comply with all conflict of interest provisions in OAR 836-053-1320.

(4) Maintain and assign an adequate number and range of qualified medical reviewers in compliance with OAR 836-053-1310 and 836-053-1315 in order to:

(a) Make determinations regarding the full range of independent review cases occurring in this state under ORS 743.857; and

(b) Meet timelines specified in ORS 743.862 and OAR 836-053-1340, including timelines for expedited review.

(5) Conduct reviews, reach determinations and document determinations consistent with OAR 836-053-1325 and 836-053-1330.

(6) Maintain administrative processes and capabilities in compliance with OAR 836-053-1325 and 836-053-1330.

Stat. Auth.: ORS 731.244, 743.858 & 743.862
Stats. Implemented: ORS 743.858 & 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1317
Professional Qualifications

(1) A doctor of medicine or osteopathy licensed under ORS Chapter 677 or under the laws of another state that govern the licensing of doctors of medicine or osteopathy shall be responsible for each final independent review determination made by an independent review organization, and in making a determination shall consult with other medical reviewers as appropriate.

(2) An independent review organization shall have a medical director who holds a current unrestricted license as a medical doctor or osteopathic physician and has had experience in direct patient care. The medical director shall provide guidance for clinical aspects of the

independent review process and oversee the independent review organization's quality assurance and credentialing programs.

(3) An independent review organization shall maintain policies and practices that assure that each medical reviewer:

(a) Holds a current, unrestricted license, certification or registration in this state, or current, unrestricted credentials from another state;

(b) Has at least five years of recent clinical experience;

(c) Is certified by an appropriate member board of the American Board of Medical Specialties if board certification is available for the specialty or profession in which the medical reviewer is engaged; and

(d) Has the ability to apply scientific standards of evidence in judging research literature pertinent to review issues, as demonstrated through relevant training or professional experience.

(4) A medical reviewer who is assigned to a case must have at least five years of recent clinical experience dealing with the same health conditions under review or similar conditions. Exceptions may be made to this requirement in unusual situations when the only experts available for a highly specialized review are in academic or research work and do not meet the clinical experience requirement.

(5) An independent review organization must maintain a training program for staff and medical reviewers, addressing at least:

(a) Confidentiality;

(b) Neutrality and conflict of interest;

(c) Appropriate conduct of reviews; and

(d) Documentation of evidence for determination.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1320
Conflict of Interest

(1) An independent review organization:

(a) Must not be a subsidiary of, or in any way owned or controlled by, an insurer or an association of insurers or of doctors, providers or other health care professionals;

(b) Must provide information to the Director on its own organizational affiliations and potential conflicts of interest at the time of its response to the Director's request for proposals and thereafter when material changes occur;

(c) Must immediately turn down a case referred by the Director if accepting it would constitute an organizational conflict of interest; and

(d) Must ensure that medical reviewers are free from any actual or potential conflict of interest in assigned cases.

(2) In connection with a case, neither an independent review organization nor any of its medical reviewers may have any material professional, familial or financial affiliation with the health insurer, enrollee, enrollee's provider, that provider's medical or practice group, the facility at which the service would be provided or the developer or manufacturer of a drug or device under review. For the purpose of this section, an affiliation with any director, officer or executive of an independent review organization shall be considered to be an affiliation with the independent review organization.

(3) Except as provided in section (4) of this rule, the following do not constitute violations of this rule:

(a) Staff affiliation with an academic medical center or National Cancer Institute-designated clinical cancer research center;

(b) Staff privileges at a health facility; or

(c) An independent review organization's receipt of an insurer's payment for independent reviews assigned by the Director.

(4) A potential medical reviewer shall be considered to have a conflict of interest in connection with a case with regard to a facility or health plan, regardless of revenue from that source, if the potential reviewer is a member of a standing committee of the facility or the health plan, or a provider or other health care professional network that contracts with the health plan.

(5) A conflict of interest may be waived only if both the enrollee and the health plan agree in writing after receiving full disclosure of the conflict, and only if:

(a) The conflict involves a medical reviewer, and no alternate reviewer with necessary special expertise is available; or

(b) The conflict involves an independent review organization and the Director determines that seeking a waiver of conflict is preferable to reassigning the dispute to a different independent review organization.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1325
Procedures for Conducting Independent Reviews

(1) An independent review organization is subject to the following decision-making standards and procedures:

(a) The independent review process is intended to be neutral and independent of influence by any affected party or by state government. The Director may conduct investigations as authorized by law but has no involvement in the disposition of specific cases.

(b) Independent review is a document review process. An enrollee, a health plan or an attending provider may not participate in or attend an independent review in person or obtain reconsideration of a determination by an independent review organization.

(c) An independent review organization shall present cases to medical reviewers in a way that maximizes the likelihood of a clear, unambiguous determination. This may involve stating or restating the questions for review in a clear and precise manner that encourages yes or no answers.

(d) An independent review organization may uphold an adverse determination if the patient or any provider refuses to provide relevant medical records that are available and have been requested with reasonable opportunity to respond. An independent review organization may overturn an adverse determination if the insurer refuses to provide relevant medical records that are available and have been requested with reasonable opportunity to respond.

(e) An independent review organization must maintain written policies and procedures covering all aspects of review.

(2) Once the Director refers a dispute, the independent review organization must proceed to final determination unless requested otherwise by both the insurer and the enrollee.

(3) An independent review organization is subject to the following standards with respect to information to be considered for reviews:

(a) An independent review organization must request as necessary and must accept and consider the following information as relevant to a case referred:

(A) Medical records and other materials that the insurer is required to submit to the independent review organization under ORS 743.857(3), including information identified in that section that is initially missing or incomplete as submitted by the insurer.

(B) For cases in which the insurer's decision addressed whether a course or plan of treatment was medically necessary:

(i) A copy of the definition of medical necessity from the relevant health insurance policy;

(ii) An explanation of how the insurer's decision conformed to the definition of medical necessity; and

(iii) An explanation of how the insurer's decision conformed to the requirement that the definition of medical necessity be uniformly applied. definition of medical necessity be uniformly applied.

(C) For cases in which the insurer's decision addressed whether a course or plan of treatment was experimental or investigational:

(i) A copy of the definition of experimental or investigational from the relevant health insurance policy;

(ii) An explanation of how the insurer's decision conformed to that definition of experimental or investigational; and

(iii) An explanation of how the insurer's decision conformed to the requirement that the definition of experimental or investigational be uniformly applied.

(D) Other medical, scientific and cost-effectiveness evidence, as described in subsection (4) of this section, that is relevant to the case.

(b) After referral of a case, an independent review organization must accept additional information from the enrollee, the insurer or a provider acting on behalf of the enrollee or at the enrollee's request, but only if the information is submitted within seven days of the referral or, in the case of an expedited referral, within 24 hours. The additional information must be related to the case and relevant to statutory criteria.

(c) An independent review organization must ensure the confidentiality of medical records and other personal health information

received for use in reviews, in accordance with applicable federal and state laws.

(4) If a course or plan of treatment is determined to be subject to independent review, a determination of whether the adverse decision of an insurer should be upheld or not must be based upon expert clinical judgment, after consideration of relevant medical, scientific and cost-effectiveness evidence and medical standards of practice in the United States. As used in this section:

(a) "Medical, scientific, and cost-effectiveness evidence" means published evidence on results of clinical practice of any health profession that complies with one or more of the following requirements:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

(D) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

(E) Findings, studies or research conducted by or under the auspices of a federal government agency or a nationally recognized federal research institute, including the Federal Agency for Healthcare Research and Quality, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Center for Medicaid and Medicare Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services;

(F) Clinical practice guidelines that meet Institute of Medicine criteria; or

(G) In conjunction with other evidence, peer-reviewed abstracts accepted for presentation at major scientific or clinical meetings.

(b) Medical standards of practice include the standards appropriately applied to physicians or other providers or health care professionals, as pertinent to the case.

(5) The following standards govern the assignment by an independent review organization of appropriate medical reviewers to a case:

(a) A medical reviewer assigned to a case must comply with the conflict of interest provisions in OAR 836-053-1320.

(b) An independent review organization shall assign one or more medical reviewers to each case as necessary to meet the requirements of this subsection. The medical reviewer assigned to a case, or the medical reviewers assigned to a case together, must meet each of the following requirements:

(A) Have expertise to address each of the issues that are the source of the dispute.

(B) Be a clinical peer. For purposes of this paragraph, a clinical peer is a physician or other medical reviewer who is in the same or similar specialty that typically manages the medical condition, procedures or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category, as the attending provider. In a profession that has organized, board-certified specialties, a clinical peer generally will be in the same formal specialty.

(C) Have the ability to evaluate alternatives to the proposed treatment.

(c) Each independent review organization must have a policy specifying the methodology for determining the number and qualifications of medical reviewers to be assigned to each case. The number of reviewers shall be governed by what it takes to meet the following requirements:

(A) The number of reviewers must reflect the complexity of the case and the goal of avoiding unnecessary cost.

(B) The independent review organization may consider, but shall not be bound by, recommendations regarding complexity from the insurer or attending provider.

(C) The independent review organization shall consider situations such as review of experimental and investigational treatments that may benefit from an expanded panel.

(6) An independent review organization shall notify the enrollee and the insurer of its determination of the enrollee's case and provide documentation and reasons for the determination, including the clinical basis for the determination unless the decision is wholly based on application of coverage provisions. In addition:

(a) Documentation of the basis for the determination shall include references to supporting evidence, and if applicable, the reasons for any interpretation regarding the application of health benefit plan coverage provisions, but shall avoid recommending a course of treatment or otherwise engaging in the practice of medicine.

(b) If the determination overrides the health benefit plan's standards governing the coverage issues that are subject to independent review, the reasons shall document why the health benefit plan's standards are unreasonable or inconsistent with sound, evidence-based medical practice.

(c) The written report shall include the qualifications of each medical reviewer but shall not disclose the identity of the reviewer.

(d) Notification of the determination shall be provided initially by phone, e-mail or fax, followed by a written report by mail. In the case of expedited reviews, the initial notification shall be immediate and by phone, followed by a written report.

(7) Except as provided in this section, an independent review organization shall not disclose the identity of a medical reviewer unless otherwise required by state or federal law. The Director shall not require reviewers' identities as part of the contracting process but may examine identified information about reviewers as part of enforcement activities. The identity of the medical director of an independent review organization shall be disclosed upon request of any person.

(8) An independent review organization shall promptly report any attempt at interference by any party, including a state agency, to the Director.

(9) An independent review organization must maintain business hours, methods of contact (including telephone contact), procedures for after-hours requests and other relevant procedures to ensure timely availability to conduct expedited as well as regular reviews.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 731.244 & 743.858

Stats. Implemented: ORS 743.858

Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02; ID 13-2006, f. 7-14-06 cert. ef. 1-1-07

836-053-1330
Criteria and Considerations for Independent Review Determinations

(1) The following criteria and considerations apply to determinations by an independent review organization:

(a) An independent review organization must use fair procedures in making a determination, and the determination must be consistent with the standards in ORS 743.862 and OAR 836-053-1300 to 836-053-1365.

(b) An independent review organization may override the standards of a health benefit plan governing the coverage issues that are subject to independent review pursuant to ORS 743.857(1) only if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(2) A determination by an IRO of a dispute relating to an adverse decision by an insurer is subject to enforcement under ORS 743.857 to 743.864 if:

(a) The dispute relates to an adverse decision on one or more of the following:

(A) Whether a course or plan of treatment is medically necessary;

(B) Whether a course or plan of treatment is experimental or investigational; or

(C) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854; and

(b) The decision by the independent review organization is made in accordance with the coverage described in the health benefit plan, including limitations and exclusions expressed in the plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment, if the independent review organization determines that:

(A) The standards of the insurer are unreasonable or are inconsistent with sound medical practice; or

(B) For cases in which the insurer's decision addressed whether a course or plan of treatment was medically necessary:

(i) The insurer's decision did not conformed to the insurer's definition medically necessary in the relevant health insurance policy, or

(ii) The insurer's decision did not conform to the requirement that the definition of medical necessity be uniformly applied; or

(C) For cases in which the insurer's decision addressed whether a course or plan of treatment was experimental or investigational:

(i) The insurer's decision did not conformed to the insurer's definition of experimental or investigational in the relevant health insurance policy, or

(ii) The insurer's decision did not conform to the requirement that the definition of experimental or investigational be uniformly applied.

(3) No provision of OAR 836-053-013 to 836-053-1365 establishes a standard of medical care or creates or eliminates any cause of action.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02; ID 13-2006, f. 7-14-06 cert. ef. 1-1-07

836-053-1335
Procedures for Complaint Investigation

(1) The Director may audit, examine and conduct an on-site review of records to investigate complaints alleging that an independent review organization or medical reviewer committed conduct contrary to ORS 743.857 to 743.862, OAR 836-053-1300 to 836-053-1365 or the contract between the Director and the independent review organization.

(2) A person, including, but not limited to, an enrollee, insurer or provider, may submit a written complaint to the Director alleging that an independent review organization committed conduct described in this rule. The Director may consider the complaint in relation to the terms of the contract with the independent review organization and in relation to ORS 743.857 to 743.862 and OAR 836-053-1300 to 836-053-1365 and take action as appropriate under the contract. The Director shall notify the complainant of the results of the Director's determinations and of any action taken or to be taken.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1337
Preliminary Review by Insurer

When an enrollee applies to an insurer for independent review of a dispute, the insurer shall review the application and advise the enrollee that the application does or does not meet any of the criteria for independent review. The insurer shall send the application to the independent review organization as provided in ORS 743.857 unless the enrollee withdraws the application.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.861
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1340
Timelines and Notice for Dispute That is Not Expedited

(1) An insurer shall give the Director notice of an enrollee's request for independent review by delivering a copy of the request to the Director not later than the second business day of the insurer after the insurer receives the request for the independent review.

(2) If an insurer reverses its final adverse determination before expiration of the deadline for sending the notice to the Director under section (1) of this rule, the insurer must notify the enrollee not later than the next business day of the insurer after its reversal. The notice to the enrollee may be given electronically, by facsimile or by telephone, followed by a written confirmation.

(3) Not later than the next business day of the Department after the Director has received a request for independent review from an insurer, the Director shall assign the review to one of the independent review organizations with whom the Director has contracted. The Director shall notify the insurer in writing of the name and address of the independent review organization to which the request for the independent review should be sent. If sending written notice will unduly delay notification, the Director shall give the notice electronically, by facsimile or by telephone, followed by a written confirmation.

(4) The Director shall notify the enrollee, not later than the second business day of the Department after the Director gave notice under section (3) of this rule of the assignment of the request. The notice must include a written description of the independent review organization selected to conduct the independent review and information explaining how the enrollee may provide the Director with documentation regarding any potential conflict of interest of the independent review organization as described in OAR 836-053-1320.

(5) Not later than the third calendar day following receipt of notice from the Director under section (4) of this rule, or the subsequent business day of the Department if any of the days is not a normal business day of the Department, the enrollee may provide the Director with documentation regarding a potential conflict of interest of the independent review organization. The documentation shall be sent in written form. If sending written documentation will unduly delay the process, the enrollee shall give the notice electronically, by facsimile or by telephone, followed by a written confirmation. If the director determines that the independent review organization presents a conflict of interest as described in OAR 836-053-1320, the Director shall assign another independent review organization not later than the next business day of the Department. The Director shall notify the insurer of the new independent review organization to which the request for the independent review should be sent. The Director shall also notify the enrollee of the Director's determination regarding the potential conflict of interest and the name and address of the new independent review organization.

(6) Not later than the sixth business day of the insurer after the date on which the insurer received notice from the Director under section (3) of this rule, the insurer shall deliver to the assigned independent review organization the following documents and information considered in making the insurer's final adverse decision, including the following:

(a) Information submitted to the insurer by a provider or the enrollee in support of the request for coverage under the health benefit plan's procedures.

(b) Information used by the health benefit plan during the internal appeal process to determine whether the course or plan of treatment is:

(A) Medically necessary;

(B) Experimental or investigational; or

(C) An active course of treatment for purposes of continuity of care.

(c) A copy of all denial letters issued by the plan concerning the case under review.

(d) A copy of the signed waiver form, or a waiver, authorization or consent that is otherwise permitted under the federal Health Insurance Portability and Accountability Act or other state or federal law, authorizing the insurer to disclose protected health information, including medical records, concerning the enrollee that is pertinent to the independent review.

(e) An index of all submitted documents.

(7) Not later than the second business day of the independent review organization after receiving the material specified in section (6) of this rule, the independent review organization shall deliver to the enrollee the index of all materials that the insurer has submitted to the independent review organization. The insurer shall provide to the enrollee, upon request, all relevant information supplied to the independent review organization that is not confidential or privileged under state or federal law concerning the case under review.

(8) The independent review organization shall notify the enrollee, the provider of the enrollee and the insurer of any additional medical information required to conduct the review after receipt of the documentation under section (7) of this rule. Not later than the fifth business day of such a request, the enrollee or the provider of the enrollee shall submit the additional information or an explanation of why the additional information is not being submitted to the independent review organization. If the enrollee or the provider of the enrollee fails to provide the additional information or the explanation of why additional information is not being submitted within the timeline specified in this subsection, the assigned independent review organization shall make a decision based on the information submitted by the insurer as required by section (6) of this rule. Except as provided in this section,

failure by the insurer to provide the documents and information within the time specified in section (6) of this rule shall not delay the conduct of the independent review.

(9) An independent review organization must provide notice to enrollees and the insurer of the result and basis for the determination as provided in OAR 836-053-1325 not later than the fifth day after the independent review organization makes a determination in a regular, nonexpedited case.

Stat. Auth.: ORS 731.244, 743.858 & 743.862
Stats. Implemented: ORS 743.858 & 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1342
Timelines and Notice for Expedited Decision-Making

(1) When an insurer expedites an enrollee's case under ORS 743.857(4), the insurer shall inform the Director and the independent review organization that the referral is expedited. If information on whether a referral is expedited is not provided to the independent review organization, the independent review organization may presume that the referral is not an expedited review, but the independent review organization may request clarification from the insurer.

(2) An independent review organization shall make its decision in each expedited case within a time period that is appropriate for accommodating the clinical urgency of the particular case, but in any event not exceeding the maximum time period specified in ORS 743.862(3)

(3) In an expedited case, an independent review organization shall immediately provide notice to enrollees and the insurer of the result and basis for the determination as provided in OAR 836-053-1325.

Stat. Auth.: ORS 731.244, 743.858 & 743.862
Stats. Implemented: ORS 743.858 & 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02;

836-053-1345
Quality Assurance Mechanisms

(1) An independent review organization must have a quality assurance program that ensures the timeliness, quality of review and communication of determinations to enrollees and insurers. The program must also ensure the qualifications, impartiality and freedom from conflict of interest of the organization, its staff and medical reviewers. The quality of review of an independent review organization includes the use of appropriate methods to match the case, confidentiality and systematic evaluation of complaints for patterns or trends.

(2) A quality assurance program must include a written plan addressing its scope and objectives, program organization, monitoring and oversight mechanisms, and evaluation and organizational improvement of independent review organization activities. Organizational improvement must include the implementation of action plans to improve or correct identified problems, and communication of the results of action plans to staff and medical reviewers.

(3) An independent review organization shall record complaints in a log. The log shall include for each complaint the nature of the complaint and how it was resolved. The Director may examine both the complaints and the log.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1350
Ongoing Requirements for Independent Review Organizations

(1) An independent review organization shall file an annual statistical report with the Director, on a form specified by the Director, that summarizes reviews conducted. The report shall include, but need not be limited to, volumes, types of cases, compliance with timelines for expedited and nonexpedited cases, determinations, number and nature of complaints and compliance with conflict of interests rules.

(2) An independent review organization shall submit updated information to the Director if at any time there is a material change in the information included in the response of the independent review organization to the Director's request for proposals.

Stat. Auth.: ORS 731.244, 743.858 & 743.862
Stats. Implemented: ORS 743.858 & 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1355
Synopses

(1) The synopses of decisions required to be filed by independent review organizations under ORS 743.862(5) with the Director must meet the requirements of this rule.

(2) Synopses of decisions shall include the following for each decision:

(a) A description of the dispute sought to be reviewed by the independent review organization, including whether the dispute is alleged to concern the determination of medical necessity or experimental or investigational treatment, whether an active course of treatment is occurring for the purpose of determining whether a person is eligible for continuity of care, or whether the dispute concerns some other issue.

(b) A determination by the independent review organization whether the dispute falls within any of the categories of issues that are eligible for independent review.

(c) A determination of the dispute by the independent review organization in favor of the insurer or enrollee.

(3) A synopsis may include a statement describing the illness, condition or other object of medical treatment, subject to section (4) of this rule.

(4) Synopses must exclude all facts and other matters that identify or may identify an enrollee. The facts and other matters include but are not limited to the name or address of an enrollee, the location of the provider office or other place of treatment, and the disease, condition or other treated matter, the disclosure of which may reveal the identity of the enrollee.

Stat. Auth.: ORS 731.244 & 743.862
Stats. Implemented: ORS 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1360
Independent Review Reporting

(1) Each independent review organization shall maintain written records in the aggregate and by insurer on all requests for independent review for which it conducted an independent review for the Director during a calendar year.

(2) Each independent review organization shall submit to the Director, by March 31 of each year for the preceding calendar year, a report in the format specified by the Director. The report shall include the information required by this section in the aggregate, for each insurer, for Oregon independent reviews only. The information to be included in the report as provided in this section is as follows:

(a) The total number of requests for independent review received during the reporting period;

(b) The number of requests for independent review for which the independent review organization has made a final determination and, of those requests, the number that uphold the insurer's final adverse determination;

(c) The average length of time for final determination by the independent review organization of:

(A) Disputes other than expedited disputes; and

(B) Expedited disputes.

(d) A summary of the types of coverages or cases for which an independent review was sought;

(e) The number of requests for which the independent review organization decided that it did not have jurisdiction under ORS 743.857.

(f) The number of independent review cases that were terminated as the result of a reconsideration by the insurer of the insurer's final adverse determination after the receipt of additional information from the enrollee or the enrollee's designated representative; and

(g) Any other information the Director requests or requires.

Stat. Auth.: ORS 731.244, 743.858 & 743.862
Stats. Implemented: ORS 743.858 & 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1365
Fees for Independent Reviews

Fees to be imposed by an independent review organization for its independent review of disputes shall be as determined in the competitive solicitation process, but shall be as low as is feasible in the request for proposal process. Fees shall be separately established for initial jurisdictional determinations by an independent review organization and for determinations that call for a more extended review.

Stat. Auth.: ORS 731.244 & 743.858
Stats. Implemented: ORS 743.858
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

Annual Reporting Requirements

836-053-1400
Format and Instructions for Report Required by Ch. 765, Oregon Laws 2005

(1) A carrier shall submit the information required by section 2(1), chapter 765, Oregon Laws 2005 electronically in the format and according to the directions established by the Director of the Department of Consumer and Business Services and made available on the website of the Insurance Division, and according to the provisions of this rule.

(2) The following terms used in section 2(1)(a), chapter 765, Oregon Laws 2005 have the following meanings for the purpose of the information required thereunder. References in this section to specific schedules and instructions are to schedules and instructions for the NAIC health annual statement blank. The terms are defined as follows:

(a) "Average amount of premiums per member per month" means total earned premiums as reported on the exhibit of premiums, enrollment and utilization divided by the total member months for the required reporting year.

(b) "Carrier's annual report" is the carrier's annual statement submitted as required by ORS 731.574.

(c) "Medical loss ratio" means the total medical claims cost divided by the total premiums earned, both as reported on the exhibit of premiums, enrollment and utilization.

(d) "Percentage change in the average premium per member per month" means the average amount of premiums per member per month for the reporting year less the average premium per member per month for the preceding reporting year divided by the average premium per member per month for the preceding reporting year.

(e) "Total amount of costs for claims" means incurred claims as reported by the carrier on the exhibit of premiums, enrollment and utilization in its annual statement. If the annual statement blank used by a carrier does not include an exhibit of premiums, enrollment and utilization, the carrier shall derive the answer from its records, using the instructions for the exhibit of premiums, enrollment and utilization for reporting the information.

(f) "Total amount of premiums" means earned premium as reported by the carrier on the exhibit of premiums, enrollment and utilization in its annual statement. If the annual statement blank used by a carrier does not include an exhibit of premiums, enrollment and utilization, the carrier shall derive the answer from its records, using the instructions for the exhibit of premiums, enrollment and utilization for reporting the information.

(g) "Total number of members" means total number of members as of December 31 of the reporting year, as reported by the carrier in its annual statement. If the annual statement blank used by a carrier does not include an exhibit of premiums, enrollment and utilization, the carrier shall derive the answer from its records, using the instructions for the exhibit of premiums, enrollment and utilization for reporting the information.

(3) A carrier shall submit the following information by total for all comprehensive hospital and medical products nationwide and by total for all such products in each Oregon market segment:

(a) Number of members.

(b) Number of member months.

(c) Premiums earned.

(d) Medical claims costs.

(e) Medical loss ratio.

(f) Average premium per member per month for the reporting year.

(g) Average premium per member per month for the preceding reporting year.

(h) Percentage change in premium per member per month from the preceding reporting year.

Stat. Auth.: ORS 731.244, Sec. 2, Ch. 765, OL 2005
Stats. Implemented: Sec. 2, 3, 4, Ch. 765, OL 2005
Hist.: ID 7-2006, f. & cert. ef. 4-14-06

836-053-1404
Definitions; noncontracting providers; co-morbidity disorders

(1) As used in ORS 743.556, this rule and OAR 836-053-1405:

(a) "Mental or nervous conditions" means:

(A) All disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for:

(i) Diagnostic codes 317, 318.0, 318.1, 318.2, 319; Mental Retardation;

(ii) Diagnostic codes 315.00, 315.1, 315.2, 315.9; Learning Disorders;

(iii) Diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9; Paraphilias;

(iv) Diagnostic codes 302.85, 302.6, 302.9; Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and

(v) Diagnostic codes V15.81 through V71.09; "V" codes. This exception does not extend to children 5 years of age or younger for diagnostic codes V61.20; Parent-Child Relational Problem through V61.21; Neglect, Physical Abuse, or Sexual Abuse of Child, and V62.82; Bereavement.

(b) "Chemical dependency" means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems.

(c) "Chemical dependency" does not mean an addiction to, or dependency on:

(A) Tobacco;

(B) Tobacco products; or

(C) Foods.

(2) A non-contracting provider must cooperate with a group health insurer's requirements for review of treatment in ORS 743.556 (10) and (11) to the same extent as a contracting provider in order to be eligible for reimbursement.

(3) The exception of a disorder in the definition of "mental or nervous conditions" or "chemical dependency" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

Stat. Auth.: ORS 731.244 & 743.556
Stats. Implemented: ORS 743.556
Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07

836-053-1405
General Requirements for Coverage of Mental or Nervous Conditions and Chemical Dependency

(1) A group health insurance policy issued or renewed in this state shall provide coverage or reimbursement for medically necessary treatment of mental or nervous conditions and chemical dependency, including alcoholism, at the same level as, and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for other medical conditions.

(2) For the purposes of ORS 743.556, the following standards apply in determining whether coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions is provided at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions:

(a) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for medical and surgical services otherwise provided under the health insurance policy.

(b) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services for mental or nervous conditions and chemical depen-

dency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services otherwise provided under the health insurance policy.

(c) Annual or lifetime limits for treatment of mental or nervous conditions and chemical dependency, including alcoholism, may be no less than the annual or lifetime limits for medical and surgical services otherwise provided under the health insurance policy.

(d) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles expenses for prescription drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed for other medical services provided under the health insurance policy.

(e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, must be by the same process as drug selection for formulary status applied for drugs intended to treat other medical conditions, regardless of whether such drugs are intended to treat mental or nervous conditions, chemical dependency, including alcoholism, or other medical conditions.

(3) A group health insurance policy issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical, mental or nervous conditions, and chemical dependency, including alcoholism..

(4) A group health insurer that issues or renews a group health insurance policy in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

(5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical dependency, including alcoholism, may be managed through common methods designed to limit eligible expenses to treatment that is medically necessary only if similar limitations or requirements are imposed on coverage for expenses arising from other medical condition. Common methods include, but are not limited to, selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary.

(6) Coverage of mental or nervous conditions and chemical dependency, including alcoholism, may be limited for in-home services.

(7) Nothing in this rule prevents a group health insurance policy from providing coverage for conditions or disorder excepted under the definition of "mental or nervous condition" in OAR 836-053-1400.

(8) The Director shall review OAR 836-053-1400 and this rule and any other materials within two years of the rules' effective date to determine whether the requirements set forth in the rules are uniformly applied to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

Stat. Auth.: ORS 731.244 & 743.556
Stats. Implemented: ORS 743.556
Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07

DIVISION 54

INSURANCE POLICIES

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 insurance producer 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 within 60 days of the time the named insured makes 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.

Stat. Auth.: ORS 731.244 & 742.502
Stats. Implemented: ORS 742.502(2)
Hist.: ID 5-1994, f. & cert. ef. 5-9-94; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 19-2006, f. & cert. ef. 9-26-06

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 Consumer and Business Services in ORS 731.244, and the specific authority of the Director in ORS 742.400 to require additional information in the claim reports for professional negligence required under ORS 742.400.

(2) The purpose of OAR 836-054-0050 to 836-054-0065 is to carry out the reporting requirements of ORS 742.400, 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 731.244
Stats. Implemented: ORS 742.400(3)
Hist.: ID 8-1988, f. & cert. ef. 4-14-88; ID 10-1998, f. & cert. ef. 7-28-98

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 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 of professional liability policies shall report any claim against an insured for alleged professional negligence to the appropriate licensing board as provided under ORS 742.400.

Stat. Auth.: ORS 731.244

Stats. Implemented: ORS 742.400(3)
Hist.: ID 8-1988, f. & cert. ef. 4-14-88; ID 10-1998, f. & cert. ef. 7-28-98

836-054-0065
Report Content — Professional Liability Claim Information

(1) Except as provided in section (2) of this rule, the report required by ORS 742.400 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 742.400 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: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 742.400(3)
Hist.: ID 8-1988, f. & cert. ef. 4-14-88; ID 10-1998, f. & cert. ef. 7-28-98

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:
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:
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:
Hist.: ID 4-1995, f. 7-21-95, cert. ef. 10-1-95

Mortgage Insurance

836-054-0300
Loan to Value

(1) A mortgage insurer may provide insurance with respect to an obligation that does not exceed, solely or in combination with liens existing at the time the insured loan is made, 105 percent of the fair market value of the securing real property at the time the loan is made if permitted by the insurer's domicile and if the obligation insured is secured by a mortgage, deed of trust or other instrument constituting a first lien or charge.

(2) A mortgage insurer may provide insurance with respect to an obligation that does not exceed, solely or in combination with liens existing at the time the insured loan is made, 110 percent of the fair market value of the securing real property at the time the loan is made if permitted by the insurer's domicile and if the insured obligation is secured by a mortgage, deed of trust or other instrument constituting a junior lien or junior charge. In determining the 110 percent limitation, the full amount of a line of credit to be secured by a junior lien shall be considered the amount of the loan.

(3) This rule is adopted under the authority of ORS 731.244 for the purpose of implementing ORS 742.282(1)(a).

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 742.282
Hist.: ID 4-2001, f. & cert. ef. 4-3-01; ID 22-2002, f.& cert. ef. 11-27-02

DIVISION 58

MOTOR VEHICLE LIABILITY INSURANCE

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 809.409(5).

(3) The excluded person's Oregon driver's license is suspended pursuant to ORS 809.419(3).

Stat. Auth.: ORS 731.244 & 742.450
Stats. Implemented: ORS 742.450(6)(b)
Hist.: ID 6-1993, f. & cert. ef. 8-25-93; ID 19-2006, f. & cert. ef. 9-26-06

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) - 742.450(2) & 742.464
Hist.: ID 6-1993, f. & cert. ef. 8-25-93

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 733.306, 742.003, 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, 2001, and apply as follows:

(a) Except as otherwise provided in this section, on January 1, 2001, 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 January 1, 2001;

(c) Any replacement or amendment of a group credit insurance policy in an attempt to 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 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 October 10, 2000 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, 2001 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 731.244
Stats. Implemented: ORS 742.003, 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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01; ID 13-2000(Temp), f. & cert. ef. 12-21-00 thru 6-9-01; Administrative correction 11-20-01

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) "Credit Health Insurance" means the kind of insurance defined in ORS 743.371 and limited by ORS 743.372.

(3) "Credit Insurance" means credit life insurance or credit health insurance or both.

(4) "Credit Life Insurance" means the kind of insurance defined in ORS 743.371 and limited by ORS 743.372.

(5) "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.

(6) "Indebtedness" means total amount repayable, including principal, interest and finance charges.

(7) "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.

(8) "Underwritten" or "underwriting" refers to the use of medical questions to elicit the existence of high risk medical conditions as described in OAR 836-060-0026 and 836-060-0031 for the purpose of determining insurability, to the extent such conditions were assumed in developing the underwritten prime facie rates.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 742.005, 743.015, 743.371-.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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

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, the creditor must inform each debtor 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 creditor shall give the debtor 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) Claim Standards. The following requirements apply to claims:

(a) All claim payments shall go first to pay the balance of the indebtedness of the insured. Any residual benefit shall be paid to the insured or the designated beneficiary or the estate of the debtor;

(b) All claims are covered upon the earlier of the date of acceptance by the insurer for insurability or 30 days after the date of the application for coverage if not rescinded. Except for falsified state-

ments, no claim may be denied for reason of ineligibility or uninsurability if the coverage is issued and not rescinded before the date of the claim; and

(c) All claims for consumer credit insurance are subject to ORS 746.230 and OAR 836-080-0205 to 836-080-0235.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

(10) 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;

(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; and

(c) A refund of premium that is owing because of early termination of a loan is determined as of the date the loan or coverage is terminated. The creditor shall promptly refund the amount owing the debtor or report a refund due to the insurer. In all cases, the insurer is responsible for a prompt refund. The refund shall be made not later than the 30th day after the loan is terminated.

(11) 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.

(12) Amounts insured. The following types of insurance must provide benefits as follows:

(a) Credit life insurance based on gross coverage must provide benefits not to exceed the amount of indebtedness outstanding;

(b) Credit life insurance based on net coverage must provide benefits not to exceed the amount of indebtedness outstanding less the unearned interest and finance charges;

(c) Credit health insurance must provide benefits not to exceed the amount of outstanding indebtedness inclusive of unearned interest or finance charges for the benefit period unless paid in a lump sum.

(13) Participation. No group policy shall contain a minimum participation percentage.

Stat. Auth.: ORS 731.244
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

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 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 loss ratio of not less than 60 percent.

(2) With the exception of deviations approved under OAR 836-060-0043, the rates established in OAR 836-060-0026 and 836-060-0031, as adjusted periodically pursuant to OAR 836-060-0041, are the prima facie rates and shall be conclusively presumed to satisfy the standard set forth in section (1) of this rule.

(3) Nonstandard Coverage. If an insurer files for approval a form providing coverage different from that described in OAR 836-060-0026 and 836-060-0031, the insurer shall demonstrate to the satisfaction of the Director that the premium rates to be charged for such coverage will develop, or reasonably may be expected to develop, a loss ratio not less than that contemplated for standard coverage, or are actuarially consistent with the rates used for standard coverages.

(4) Prima facie rates are presumed sufficient to cover up to two months of delinquencies.

(5) 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.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 742.003 & 742.005

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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

836-060-0026
Credit Life Insurance Rates

(1) Unless data submitted to the Director under OAR 836-060-0043 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) $.65 per month per $1,000 of outstanding insured indebtedness, if premiums are payable on a monthly outstanding balance basis ($.59 if underwritten);

(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) $.42 per year on credit terms of 63 months or less ($.38 if underwritten); and

(B) On credit terms over 63 months

$$\frac{(n+1)}{20}$$

times $.65 ($.59 if underwritten), 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.

(c) If premiums are payable on a single premium basis and the benefit provided is level term, the prima facie rate is $.76 per $100 ($.68 if underwritten) 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.

(d) The joint coverage rate shall be 165% of the rounded rate for single person coverage;

(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 (2)(e), of this rule, rates shall be actuarially consistent with the rates specified in this section.

(2) The premium rates in section (1) of this rule apply to credit life insurance policies that are issued without underwriting or with underwriting for high risk conditions that have the potential of becoming terminal during the period of coverage, and that are 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) Except as provided in paragraph (B) of this subsection, the effective date of insurance coverage applicable to an indebtedness is the date on which the individual policy or certificate of coverage was first issued; and

(B) An individual policy for an open-end plan or a certificate of coverage under a group policy for an open-end plan may provide that the effective date of coverage of a specific advance or charge, for the amount in excess of the first $3,000 of account balance, is the date of the specific advance or charge;

(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 and may provide that all insurance will terminate upon attainment by the debtor of a specified age not less than 66 years;

(c) 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) Except as provided in paragraph (B) of this subsection, the effective date of insurance coverage applicable to an indebtedness is the date on which the individual policy or certificate of coverage was first issued; and

(B) An individual policy for an open-end plan or a certificate of coverage under a group policy for an open-end plan may provide that the effective date of coverage of a specific advance or charge, for the amount in excess of the first $3,000 of account balance, is the date of the specific advance or charge; and

(d) 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 731.244
Stats. Implemented: ORS 742.003 & 742.005
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

836-060-0027
Credit Life Reserves

(1) For policies or certificates issued prior to January 1, 2001, the minimum reserve standard is the Commissioners 1958 Extended Term Insurance Table and 4.5% interest.

(2) For policies or certificates issued on or after January 1, 2001, the minimum reserve standard is the Male Commissioners 1980 Standard Ordinary Mortality Table and 4.5% interest.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 733.306(8)
Hist.: ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

836-060-0031
Credit Health Insurance Rates

(1) Unless data submitted to the Director under OAR 836-060-0043 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 Tables 1 and 2, if premiums are payable on a single premium basis for the duration of the coverage;

(b) As set forth in Tables 1 and 2, if premiums are payable on a monthly outstanding insured indebtedness basis for a closed-end loan;

(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 benefit plans:

(A) 14-day nonretroactive plan — $1.66–$1.49 if underwritten;

(B) 30-day nonretroactive plan — $1.40–$1.26 if underwritten;

(C) 14-day retroactive plan — $1.89–$1.70 if underwritten;

(D) 30-day retroactive plan — $1.74–$1.57 if underwritten;

(f) For other benefits, except for benefits described in section (2)(g) of this rule, rates shall be actuarially consistent with the rates specified in this section;

(g) 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, and the extension as published in 1970 Volume 1, pp. 332–333. The factors are published in Exhibit 2.

(2) The premium rates in section (1) of this rule shall apply to credit health insurance policies issued without underwriting or with underwriting for conditions with a high potential of resulting in permanent disablement, and 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 diagnosis or treatment within six months preceding the effective date of the debtor's coverage and which caused loss that commences within six months immediately following the effective date of coverage. For purposes of this subsection:

(A) Except as provided in paragraph (B) of this subsection, the effective date of insurance coverage applicable to an indebtedness is the date on which the individual policy or certificate of coverage was first issued; and

(B) An individual policy for an open-end plan or a certificate of coverage under a group policy for an open-end plan may provide that the effective date of coverage of a specific advance or charge, for the amount in excess of the first $3,000 of account balance, is the date of the specific advance or charge;

(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 and may provide that all insurance will terminate upon attainment by the debtor of a specified age not less than 66 years;

(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) 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; and

(h) Shall not contain a requirement of regular physician care unless the care is medically necessary for determination of continued disability.

(3) The rates under section (1)(e) of this rule may be used as a composite rate for a benefit pay-off duration not to exceed 48 months. The percentage of monthly benefit must include accruing interest and charges. For durations greater than 48 months, rates filed must include actuarial development and adjustments consistent with this basis.

[ED. NOTE: Exhibits and Tables referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

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 pro rata unearned gross premium method shall be used for level term credit life insurance or credit health insurance where under 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 commonly referred to as the Rule of Anticipation. A refund of unearned premium used for decreasing term credit life insurance 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 $5 or less need be made.

Stat. Auth.: ORS 731.244
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

836-060-0041
Experience Reports

(1) Each insurer transacting credit insurance in this state shall submit an Oregon-specific Credit Insurance Experience Exhibit to the National Association of Insurance Commissioners (NAIC). If this report is discontinued as an NAIC report, the report must be sent directly to the Director by June 1 of each year.

(2) Notwithstanding section (1) of this rule, each insurer transacting credit insurance that is underwritten shall submit to the Director an Oregon-specific Credit Insurance Experience Exhibit for the underwritten business. The information shall be reported on the NAIC form and submitted by June 1 of each year. An insurer need not comply with this section if the NAIC Credit Insurance Experience Exhibit includes a separate accounting for underwritten business.

(3) The experience reports required by this rule replace all other annual reports to the Director of credit insurance experience. 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.

(4) The Director shall review the loss ratio development every four years and compare it with the standards set forth in OAR 836-060-0021 and the prima facie rates set forth for underwritten and nonunderwritten in OAR 836-060-0026 and 836-060-0031 as adjusted and determine therefrom the statewide loss ratio using no less than three years of experience. The Director shall compare the expected loss ratio with the actual loss ratio for the preceding review period determined from the incurred claims and earned premiums at prima facie rates reported under this rule, and publish the adjusted actual statewide prima facie rates to be used by insurers. If published, the rates are adjusted for the difference between:

(a) Actual claims and expected claims; and

(b) Any other additional premium changes necessary to meet the loss ratio standards of OAR 836-060-0021.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 731.244
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

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) 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.: ORS 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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

836-060-0046
Supervision of Credit Insurance Operations

(1) Once every rate review period established under OAR 836-060-0041(4), each insurer transacting credit insurance in this state shall be responsible for conducting 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. The records shall:

(a) Review and report the creditor's activities according to OAR 836-060-0011(5); and

(b) Verify the prompt and timely payment of claims and accuracy of refunds.

Stat. Auth.: ORS 731.244
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

836-060-0055
Prohibited Transactions

The following insurer practices in connection with the sale or placement of credit insurance, or as an inducement thereto, 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) Practices in connection with the creditor:

(a) 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.

(b) 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.

(c) 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 subsection 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.

(2) Placement of insurance on an account by automatic deduction of premium payments without a signed consent by the insured authorizing such deduction for payments.

Stat. Auth.: ORS 731.244
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; ID 12-2000, f. 11-14-00, cert. ef. 1-1-01

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 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

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 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 insurance producer 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 insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 731
Stats. Implemented: ORS 742.005(2), 742.023(1)(f) & 746.240
Hist.: ID 9-1989, f. & cert. ef. 10-23-89

DIVISION 71

INSURANCE LICENSING

Insurance Producers, Adjusters and Insurance Consultants

836-071-0101
Adjuster and Insurance Consultant License Application; Required Information

(1) In addition to information required under ORS 744.001, an applicant for an adjuster or insurance consultant 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;

(f) The Social Security number of the applicant; and

(g) 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) An applicant for a resident adjuster or insurance consultant license who is or has been licensed as a resident producer, 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.

(3) An applicant for a non-resident adjuster or insurance consultant license who is licensed as a resident producer, 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.

(4) The Director may collect Social Security numbers submitted in applications under this rule and may use a Social Security number of an individual when authorized to do so for the purposes specified in this section. In addition to the governmental uses for which a Social Security number is required in an application under federal and state law, when authorized by the holder of a Social Security number, the Director may use a Social Security number for any of the following purposes:

(a) As an identification number in maintaining records and reporting grades or examination scores;

(b) For licensing purposes; and

(c) For use by other government agencies to carry out their statutory duties.

(5) An applicant may voluntarily allow the Director to use the Social Security number of the applicant, as the Director may request in the application form, for the purposes specified in section (4) of this rule. Refusal to voluntarily allow such use of the Social Security number will not result in the denial of any individual right, benefit or privilege provided by law. The use authorized by an applicant is in addition to uses authorized by state and federal law for which collection of Social Security numbers is mandatory.

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; ID 9-2002, f. & cert. ef. 3-18-02

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 731 & 744
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0108
Limited Class Insurance Licenses

For the purpose of ORS 744.062, the Director establishes the following classifications for limited class insurance licenses, for use on and after July 1, 2005:

(1) Under a "limited class credit insurance" license, the licensee may transact the following classes of insurance when the insurance is offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation:

(a) Credit life insurance. Under this class, an insurance producer may transact credit life insurance as approved under ORS 743.371(1).

(b) Credit health insurance. Under this class an insurance producer may transact credit health insurance as approved under ORS 743.371(2).

(c) Credit unemployment and involuntary unemployment insurance. Under this class an insurance producer may transact approved liability coverage for unemployment.

(d) Credit property insurance. Under this class, an insurance producer may transact insurance against property loss or damage that may result in failure of debtors to pay their obligations to the insured, including but not limited to motor vehicle physical damage insurance. This class does not include mortgage insurance.

(e) Mortgage guarantee insurance. Under this class, an insurance producer may transact only the insurance that is issued by an authorized mortgage insurer under ORS 742.282 to 742.286.

(f) Mortgage life or disability insurance, or mortgage life and disability insurance. Under this class, a lending institution may transact mortgage cancellation insurance as approved under ORS 743.303(1)(b) and (5).

(g) Gap insurance. This class applies to a person described in ORS 731.036(9) who does not qualify for the exemption in ORS 731.036(9) because the person imposes an additional charge to waive the amount described in ORS 731.036(9)(b) pursuant to an agreement to lease or to finance the purchase of a motor vehicle.

(2) Under a "limited class insurance" license, the licensee may transact the following classes of insurance:

(a) Crop insurance. Under this class, an insurance producer may place insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation, including multi-peril crop insurance.

(b) Surety insurance. Under this class an insurance producer may place insurance or a bond that covers obligations to pay the debts of, or answer for the default of another, including faithlessness in a position of public or private trust as approved under ORS 742.350 to 742.376. For the purpose of this limited line license, surety does not include surety bail bonds.

(3) Under a "trip travel insurance" license, the licensee may place insurance for trip cancellation, trip interruption, baggage, accidental death, sickness and accident, disability and personal effects. Trip travel coverage provides reimbursement of expenses resulting from an emergency in connection with travel. The following provisions apply to this limited license:

(a) An insurance producer may transact trip travel insurance that covers the risks of a specific trip and sold in connection with transportation provided by a common carrier, owner of a transportation ticket agency or filed with a city, county or state as a tour business.

(b) The limited license under this subsection may be endorsed for an employee or owner, either of whom is engaged in the sale of transportation tickets.

(c) The individual coverage may not be more than the duration of a specified trip.

(d) The limited license under this subsection is issued for the sale of coverage provided by an insurer holding a certificate of authority for casualty insurance or by an insurer holding a certificate of authority for health insurance when the insurer insures only accidental death, sickness and accident or disability coverages.

Stat. Auth.: ORS 731.244, 744.062
Stats. Implemented: ORS 744.062
Hist.: ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 731 & 744
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0112
Social Security Numbers; Insurance Producer Applications

(1) An applicant for an insurance producer license shall furnish the Social Security number of the applicant as provided in the application form.

(2) The Director may collect Social Security numbers submitted in applications under this rule and may use a Social Security number of an individual when authorized to do so for the purposes specified in this section. In addition to the governmental uses for which a Social Security number is required in an application under federal and state law, when authorized by the holder of a Social Security number, the Director may use a Social Security number for any of the following purposes:

(a) As an identification number in maintaining records and reporting grades or examination scores;

(b) For licensing purposes; and

(c) For use by other government agencies to carry out their statutory duties.

(3) In addition to the governmental uses for which a Social Security number is required in an application under federal and state law, an applicant may voluntarily allow use by the Director of the Social Security number of the applicant, as the Director may request in the application form, for the purposes specified in section (2) of this rule. Refusal to voluntarily allow such use of 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

Stats. Implemented: ORS 744.058 & 744.063
Hist.: ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 731 & 744
Stats. Implemented:
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
Stats. Implemented:
Hist.: ID 6-1992, f. & cert. ef. 3-26-92

836-071-0120
Examination Procedure

(1) To take an examination, an applicant 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; or

(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, 744.058, 744.535, 744.619 & 744.621
Stats. Implemented: ORS 744.001, 744.003, 744.058, 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; ID 9-2002, f. & cert. ef. 3-18-02

836-071-0125
Period for Completion of License Application

An application for a license is invalid if the license for which the application was made has not been granted on or before the last day of the ninth month after the date on which the application was filed with the Director.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.001
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1999, f. 12-13-99, cert. ef. 1-1-00

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 licensee'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
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0130
Adjuster or Insurance Consultant License Renewal

(1) An adjuster or insurance consultant license expires on the last day of the month in which the second anniversary of the initial issuance date occurs. Thereafter, the license shall expire on the second anniversary following each renewal.

(2) An adjuster or insurance consultant 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; and

(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.

(3) The Director may allow an adjuster or insurance consultant licensee not more than 30 days to submit missing information on the application form if the fees have 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.: ORS 731.244 & 744.007
Stats. Implemented: ORS 744.007
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 3-1997, f. 4-7-97, cert. ef. 6-1-97; ID 6-1999, f. 12-13-99, cert. ef. 1-1-00; ID 9-2002, f. & cert. ef. 3-18-02

836-071-0135
Renewal of Expired Adjuster or Insurance Consultant License

The expiration date of an expired license that is renewed under ORS 744.009 shall be the same as the expiration date of the initial license.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.009
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 9-2002, f. & cert. ef. 3-18-02

836-071-0140
License Amendment

An applicant for an amendment to an adjuster or insurance consultant license shall apply in the manner provided for application for the initial license under ORS 744.001.

Stat. Auth.: ORS 731.244, 731.804, 744.001, 744.003, 744.535, 744.619 & 744.621
Stats. Implemented: ORS 744.001, 744.003, 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; ID 9-2002, f. & cert. ef. 3-18-02

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
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90

836-071-0148
Extended License Expiration Date, Active Military Duty and Other Extenuating Circumstances

(1) An individual insurance producer who is unable to comply with license renewal procedures due to military service or another extenuating circumstance such as a long term medical disability may request a waiver from compliance with those procedures as authorized by ORS 744.072, as provided in this rule. The waiver may include an extension of the expiration date of the license as provided in this rule.

(2) An individual insurance producer who is ordered by a branch of the armed forces of the United States into active military duty may obtain an extension of the expiration date of the license for the period of time provided in this section. 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.

(3) The expiration date of the license of an insurance producer who requests extension of the expiration date of the license for an

extenuating circumstance other than being ordered into active military duty under section (2) of this rule may be extended by the Director according to the Director's judgment, as provided in this section. The extended expiration date is established for a license as follows:

(a) By adding the number of days the insurance producer was unable to exercise authority under the insurance producer license to the date on which the insurance producer was once again able to resume duties under the license, if the license would otherwise have expired during the period of the extenuating circumstance; or

(b) By adding the number of days the insurance producer was unable to exercise authority under the insurance producer license to the date on which the insurance producer was once again able to resume duties under the license, if the license would otherwise have expired after the date on which the period of the extenuating circumstance ends.

(4) The extended expiration date established under sections (2) and (3) 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.

(5) The fee, continuing education and other applicable requirements for renewal that would have applied for the normal expiration date of a license of an insurance producer described in section (2) or (3) of this rule apply for the extended expiration date. An insurance producer applying for renewal under this rule shall include documentation with the renewal application as follows:

(a) If the reason for the requested extension is that the insurance producer was called to active duty in the military, the insurance producer shall provide a copy of documentation by the branch of the armed forces in which the insurance producer served that shows the period served on active duty or an affidavit, signed by the applicant, that states the period served on active duty.

(b) If the extension is requested for some other reason, the insurance producer shall provide documentation or other evidence of the extenuating circumstances as specified by the Director.

(6) Sections (2) and (3) of this rule apply 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
Stats. Implemented: ORS 744.072
Hist.: ID 10-1997, f. & cert. ef. 10-8-97; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 licensee. The Oregon surplus lines licensee must also affirm in writing that the Oregon surplus lines licensee 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
Stats. Implemented:
Hist.: ID 1-1992, f. & cert. ef. 1-27-92; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0160
Errors and Omissions Insurance; Reinsurance Intermediary Managers

(1) The amount of insurance for which a reinsurance 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) A reinsurance intermediary manager may obtain insurance required by ORS 744.818, 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 reinsurance 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 reinsurance 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 reinsurance 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 licensee. The Oregon surplus lines licensee must also affirm in writing that the Oregon surplus lines licensee will be the agent for service of process for any action or proceeding involving the reinsurance 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

Training and Examinations

836-071-0180
Insurance Producer Pre-Examination Requirements

(1) An applicant for a license as an insurance producer 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 any 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; or

(c) Completion of a verifiable online self-study program.

(3) Preexamination training shall consist of not less than:

(a) 20 hours in basic principles of property insurance, for authority to transact property insurance;

(b) 20 hours in basic principles of casualty insurance, for authority to transact casualty insurance;

(c) 20 hours in basic principles of personal lines insurance, for authority to transact personal lines insurance;

(d) 30 hours in basic principles of life insurance, for authority to transact life insurance; and

(e) 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:

(a) One hour of training shall consist of not less than 50 minutes of instruction.

(b) Surety is included in the casualty insurance line and marine and transportation insurance may be included in the property insurance line or the casualty insurance line.

(c) The personal lines line is a subcategory of the casualty insurance line. Consequently, a person who obtains training for a license to transact casualty insurance need not obtain separate or additional training to transact personal lines insurance.

(5) Except as authorized in section (2) of this rule for an online self-study program, 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 insurance producer license in this state; and

(b) Obtaining and showing proof of three years of licensure as a resident insurance producer, agent or insurance broker in another state, a province of Canada or Mexico:

(A) If the applicant has been so licensed within two years of the date of application for the insurance producer license in this state; and

(B) If the applicant is not otherwise exempt from taking the examination under ORS 744.067.

(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) Any registered program that fulfills the educational requirement leading to the CFP/Certified Financial Planner certification awarded by the Certified Financial Planner Board of Standards, Inc.: 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 insurance producer must obtain not less than eight hours of training in the Oregon Insurance Code and administrative rules.

(11) The amendments to this rule that were filed in ID 15-2002 with the Secretary of State on June 26, 2002 to become effective on July 1, 2002 are re-adopted with the operative date of July 1, 2002.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.058, 744.064 & 744.067
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94; ID 9-2002, f. & cert. ef. 3-18-02; ID 15-2002, f. 6-26-02, cert. ef. 7-1-02; ID 4-2003(Temp), f. 6-30-03, cert. ef. 7-1-03 thru 12-19-03; ID 8-2003, f. 12-12-03, cert. ef. 12-19-03; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 2-2006, f. & cert. ef. 1-31-06

836-071-0185
Qualification of Agents Selling Variable Life Insurance, Including Annuities

A person shall not solicit, place or procure variable life insurance contracts or policies, including annuities, unless the person has completed to the Director's satisfaction an examination of the National Association of Securities Dealers (NASD) that is Series 6 or Series 7 and is licensed to a securities dealer in Oregon.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.062
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 4-1991, f. & cert. ef. 4-25-91; ID 9-2002, f. & cert. ef. 3-18-02

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 insurance producer 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 includes subject matter equivalent to the examination outline adopted by the Insurance Division.

(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 731.244
Stats. Implemented: ORS 744.072

Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer 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 731 & 744
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

Continuing Education

836-071-0210
Statutory Authority; Purpose

(1) OAR 836-071-0210 to 836-071-0250 are adopted under the authority of ORS 731.244 and 744.072 for the purpose of implementing ORS 744.072, relating to continuing education for insurance producers. The purpose of OAR 836-071-0210 to 836-071-0250 is to establish requirements and standards for the program for licensees.

(2) The purpose of the continuing education program is to promote trustworthy and competent insurance services for the public by requiring a sufficient number of hours for insurance training.

Stat. Auth.: ORS 731.244 & 744.072
Stats. Implemented: ORS 744.072
Hist.: ID 3-1997, f. 4-7-97, cert. ef. 6-1-97; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0215
Continuing Education Requirements for Insurance Producers; Hours; Credit for Experience and Coursework

(1) Each resident insurance producer is responsible for obtaining the credit hours required by this rule by enrolling in courses approved by the Director that serve the insurance producer's professional needs. The following minimum continuing education requirements apply to resident insurance producers as a condition of renewing a license as insurance producer:

(a) For each two year renewal period occurring after issuance of an insurance producer license through the sixth year that an insurance producer holds an insurance producer license, the insurance producer must complete 44 hours of continuing education;

(b) For each two year renewal period occurring after the sixth year that an insurance producer holds an insurance producer license, the insurance producer must complete 24 hours of continuing education;

(c) If an insurance producer has received the designation of Chartered Property and Casualty Underwriter or Chartered Life Underwriter, after issuance of the insurance producer license, the insurance producer must complete 24 hours of continuing education; and

(d) For each two year renewal period occurring after issuance of an insurance producer license, the renewing insurance producer 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 producers.

(2) For the purpose of satisfying minimum continuing education requirements:

(a) A resident insurance producer 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 insurance producer license for three years;

(b) A resident insurance producer previously licensed as an insurance producer in Oregon or in another state may count the period of prior licensing on a year for year basis.

Stat. Auth.: ORS 731.244 & 744.072
Stats. Implemented: ORS 744.072
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; ID 6-1999, f. 12-13-99, cert. ef. 1-1-00; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0220
Continuing Education; Documentation

(1) For the purpose of furnishing evidence of completion of a course for which an insurance producer claims credit, the insurance producer shall submit the documentation applicable to the course as follows:

(a) For a registered course taken for academic credit, an insurance producer 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 insurance producer 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 insurance producer 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 insurance producer 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 insurance producer, 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 insurance producer 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 insurance producer, an insurance producer must comply with the requirements of OAR 836-071-0250.

(2) An insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0225
Continuing Education; Standards for Granting Credit Hours

(1) Subject to the subject matter requirements of OAR 836-071-0230, an insurance producer 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 insurance producer is an instructor of a course if the course meets the continuing education requirements of an insurance producer attending it. Credit may be taken by an insurance producer with respect to a course only once in each renewal period in which the insurance producer 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 insurance producer may take credit for a course only if the insurance producer has successfully completed the course before the insurance producer applies for renewal or reinstatement. For the purpose of taking credit for a course other than one taken through independent study, an insurance producer successfully completes the course if the insurance producer is present for the full approved time and has signed in and out on the attendance register for the course.

(3) An insurance producer may not take continuing education credit for:

(a) Hours devoted to preparation for a course; when the insurance producer 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 insurance producer 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 insurance producer 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 insurance producer 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 insurance producer cannot review the study material while taking the examination and if the examination has safeguards ensuring that the insurance producer 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 insurance producer 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 insurance producer, 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 insurance producer 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 insurance producer passed the examination.

(5) The provider of a course shall issue a certificate of completion of the course to each qualifying insurance producer not later than the 15th day after the date on which an insurance producer 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 insurance producer in writing, when the insurance producer 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 insurance producer population. There is no registration fee. If the person will proctor independent study course examinations for other than the general insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0230
Continuing Education; Course Qualification Guidelines

(1) An insurance producer 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) Office management, client relations or improving the operations of the insurance producer's business, or any combination thereof;

(v) Any other subject matter that the Director determines will enhance the ability of an insurance producer to provide insurance services to the public effectively.

(2) An insurance producer may claim not more than four hours of credit in a renewal period for a course on the subject matter described in section (1)(u) of this rule.

(3) An insurance producer 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, writing or motivational and promotional communication;

(e) A course in personnel management or recruiting;

(f) Any product not available for sale to Oregon consumers;

(g) Securities, other than variable life and variable annuities.

Stat. Auth.: ORS 731.244 & 744.072
Stats. Implemented: ORS 744.072
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; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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's registration number assigned by the Department, the course title and credit hours suggested by the provider for the course, and if known, the date, time and location of meetings of each course for which application is made. 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) In order to ensure that a course is eligible to be registered prior to the date of the first meeting of the course, a registered provider must apply for registration of the course not later than the 60th day preceding the first date.

(3) The registration of a course expires on the last day of the 24th month after the date the course is registered unless the course is renewed prior to the date on which registration expires. The provider must apply for renewal of a course not later than the 21st day prior to the date on which registration expires. If the Director determines that the course materials submitted with the renewal application are sufficiently changed or otherwise so different that the course as a whole should be treated as a new course rather than renewed, the course and its materials shall be reviewed according to the review period established in section (2) of this rule.

(4) 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.

(5) A registered provider shall resubmit a registered course for review and approval whenever the provider substantially changes the content of the course as registered.

(6) A provider shall notify the Director immediately of a cancellation or a change of date, time or location of a scheduled class.

(7) A course registration application that is submitted after the 60th day before the date of the first meeting of the course is subject to approval or disapproval after the date of the first meeting. If the Director approves an application for registration of a course that is submitted after the 60th day before the date of the first meeting of the course and before the tenth day prior to the date of that meeting, and if the provider gives notice of the course meeting as required by OAR 836-071-0247, the provider may grant credit for the course retroactively.

(8) A provider domiciled in another state that is a member of the Midwest Zone Continuing Education Reciprocity Agreement may offer in this state a course that is registered in its domiciliary state if the provider registers the course as provided in this rule. Such a course qualifies for registration if the Director determines that the subject matter of the course is not disqualified for credit under OAR 836-071-0230(2). A course to which this section applies is subject to renewal of its registration and the provider and the course are subject to the other provisions of this rule.

Stat. Auth.: ORS 731.244, 744.119 & Sec. 12, Enrolled SB 268 (2001)
Stats. Implemented: ORS 744.008, 744.119 & Sec. 12, Enrolled SB 268 (2001)
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; ID 19-1998, f. & cert. ef. 12-2-98; ID 10-2001, f. & cert. ef. 9-11-01

836-071-0242
Provider Trade Practices

(1) A registered provider shall not engage in false, misleading or deceptive advertising.

(2) A registered provider must disclose in writing the charges for a course to each insurance producer applying to take the course, prior to enrollment of the insurance producer.

(3) If a registered 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.

(5) 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.

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; ID 19-1998, f. & cert. ef. 12-2-98; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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

836-071-0247
Requirements for Granting Credit; Attendance Records

(1) A registered provider shall provide the Director with the meeting times and places of a registered course not later than the tenth day before the date that the course is given.

(2) A registered provider shall not give credit for a course unless the Director has approved the registration application for the course and the registered provider has given the Director notice of the meeting of the course as provided in section (1) of this rule.

(3) 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.

(4) A 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.

(5) 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.

(6) A course that is registered in this state pursuant to OAR 836-071-0240(8) shall be allocated the times and credits determined pursuant to the Midwest Zone Continuing Education Reciprocity Agreement.

Stat. Auth.: ORS 731.244, 744.119 & Sec. 12, Enrolled SB 268 (2001)
Stats. Implemented: ORS 744.119 & Sec. 12, Enrolled SB 268 (2001)
Hist.: ID 19-1998, f. & cert. ef. 12-2-98; ID 10-2001, f. & cert. ef. 9-11-01

836-071-0250
Credit for Unregistered Courses

(1) An insurance producer 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 insurance producer 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 insurance producer must substantiate to the Direc-

tor's satisfaction that the course meets the requirements of OAR 836-071-0225 and 836-071-0230 and that the insurance producer attended and completed the course. To make the substantiation, the insurance producer 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 insurance producer must substantiate to the Director's satisfaction that the course meets the requirements of OAR 836-071-0225, that the course contributes to the insurance producer's professional competence and will benefit the insurance-buying public and that the insurance producer attended and completed the course. To make the substantiation, the insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

Fees and Disclosure; Incidental Charges

836-071-0260
Fees Charged by Insurance Producers

(1) When an insurance producer or any affiliate of the insurance producer receives any compensation authorized under ORS 735.455, 744.091 or 744.093 from a prospective insured for transacting insurance, neither the insurance producer nor the affiliate may accept or receive any compensation from an insurer or other third party for the placement of insurance for the prospective insured unless the insurance producer, prior to the prospective insured's purchase of insurance, has:

(a) Obtained the prospective insured's documented acknowledgment that the compensation will be received by the insurance producer or affiliate;

(b) Disclosed the amount of compensation from the insurer or other third party for the placement. If the amount of compensation is not known at the time of disclosure, the insurance producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount; and

(c) Disclosed the nature of the work that the insurance producer or affiliate will perform on behalf of the prospective insured.

(2) When an insurance producer or any affiliate of the insurance producer receives any compensation authorized under ORS 735.455, 744.091 or 744.093 from a prospective insured for transacting insurance and receives no compensation from an insurer or other third party for placement of insurance for the prospective insured, the insurance producer or affiliate must obtain the prospective insured's documented acknowledgement that the compensation will be received by the insurance producer and must disclose the nature of the work that the insurance producer or affiliate will perform on behalf of the prospective insured.

(3) A person is not a prospective insured for the purpose of this rule if the person is merely:

(a) A participant or beneficiary of an employee benefit plan; or

(b) Covered by a group or blanket insurance policy or group annuity contract sold, solicited or negotiated by the insurance producer or affiliate.

(4) This rule does not apply to any of the following persons:

(a) An insurance producer when the insurance producer acts only as an intermediary between an insurer and the prospective insured's insurance producer, such as a managing general agent, a wholesale insurance producer under ORS 744.093, a surplus lines licensee when transacting insurance with a producing insurance producer under ORS 735.455 or a sales manager.

(b) An insurance producer with respect to an incidental charge that is received from the prospective insured and is authorized under OAR 836-071-0267.

(c) A reinsurance intermediary.

(5) As used in this rule:

(a) "Affiliate" means a person that controls, is controlled by or is under common control with the insurance producer.

(b) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(c) "Compensation from a prospective insured" does not include any fee or amount collected by or paid to the insurance producer that does not exceed an amount established by the Director.

Stat. Auth.: ORS 731.244, 735.455, 744.091, 744.093
Stats. Implemented: ORS 735.455, 744.091, 744.093
Hist.: ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0263
Fees Charged by Insurance Consultants or Insurance Producers

(1) When an insurance consultant or an affiliate of an insurance consultant receives from a prospective insured any compensation authorized under the Insurance Code or rules adopted thereunder, neither the insurance consultant nor the affiliate may accept or receive any compensation from an insurer or other third party for services provided to the prospective insured in addition to the compensation paid by the prospective insured unless the insurance consultant, prior to the transaction:

(a) Has obtained the prospective insured's documented acknowledgment that the compensation will be received by the insurance consultant or affiliate; and

(b) Disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the insurance consultant shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.

(2) When an insurance producer or an affiliate of an insurance producer receives any compensation otherwise authorized under the Insurance Code or OAR 836-071-0269 to 836-071-0277 from a prospective insured, neither the insurance producer nor the affiliate may accept or receive any compensation from an insurer or other third party for the placement of insurance in the same or related transaction unless the insurance producer, prior to the prospective insured's purchase of insurance, has:

(a) Obtained the prospective insured's documented acknowledgment that the compensation will be received by the insurance producer or affiliate; and

(b) Disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the insurance producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.

(3) A person is not a prospective insured for the purpose of this rule if the person is merely:

(a) A participant or beneficiary of an employee benefit plan; or

(b) Covered by a group or blanket insurance policy or group annuity contract sold, solicited or negotiated by the insurance producer or affiliate.

(4) This rule does not apply to:

(a) An insurance producer with respect to a transaction to which ORS 735.455, 744.091 or 744.093 applies;

(b) An insurance producer when the insurance producer acts only as an intermediary between an insurer and the prospective insured's insurance producer, such as a managing general agent, a wholesale insurance producer under ORS 744.093, a surplus lines licensee when transacting insurance with a producing insurance producer under ORS 735.455 or a sales manager;

(c) An insurance producer with respect to an incidental charge that is received from the prospective insured and is authorized under OAR 836-071-0267; or

(d) A reinsurance intermediary.

(5) As used in this rule:

(a) "Affiliate" means a person that controls, is controlled by or is under common control with the insurance consultant or insurance producer.

(b) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(c) "Compensation from a prospective insured" does not include any fee or amount collected by or paid to the insurance producer that does not exceed an amount established by the Director.

Stat. Auth.: ORS 731.244, 744.077 & 744.650
Stats. Implemented: ORS 737.205, 742.009, 744.077, 744.650, 746.015
Hist.: ID 9-2005(Temp), f. 5-18-05, cert. ef. 8-1-05 thru 1-15-06; ID 13-2005, f. 12-29-05, cert. ef. 1-15-06

836-071-0267
Incidental Charges for Customer Services; Personal, Commercial Lines

(1) This rule establishes incidental charges that an insurance producer may impose for customer services in connection with the transaction of insurance. For the purpose of this rule, personal lines insurance is property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(2) An insurance producer may impose an incidental charge established in this rule on a customer only if the insurance producer has given written notice to the customer that the insurance producer may impose incidental charges authorized by this rule. The notice must disclose all incidental charges that the insurance producer may impose and the service provided for each incidental charge. The insurance producer must give the notice to a customer before providing any service for which an incidental charge may be imposed, but not later than at the time of application or the renewal before the insurance producer commences imposing the incidental charges. The written notice requirement does not apply to the binding or issuance of a policy. At the time an insurance producer charges an incidental charge under this rule, the insurance producer must clearly disclose to the customer the amount of the incidental charge and the service for which the incidental charge is imposed.

(3) An insurance producer may impose an incidental charge for rewriting or reinstating a policy that was cancelled by the insurer because of an action or inaction of the customer, such as nonpayment of premium or failure to renew according to policy terms, as provided in this section. An insurance producer may not impose the incidental charge for the first rewriting or reinstatement of the policy. The incidental charges are as follows:

(a) A charge not to exceed $25 for personal lines insurance.

(b) A charge not to exceed $100 for commercial insurance.

(4) An insurance producer may impose an incidental charge for taking a payment of premium in cash, in an amount not to exceed $10.

(5) An insurance producer may impose an incidental charge as authorized by ORS 30.701 for handling and collecting on a check from a customer that is returned for insufficient funds.

(6) An insurance producer may impose an incidental charge for the actual cost of providing photographic or inspection services to a customer in connection with issuing or amending insurance coverage, but the incidental charge may not exceed:

(a) $7.50 for the services in connection with issuing or amending personal insurance coverage.

(b) $45 for the services in connection with issuing or amending commercial insurance coverage.

(7) An insurance producer may impose an incidental charge for the actual cost of obtaining a motor vehicle report from the Motor Vehicle Division of the Oregon Department of Transportation or from the comparable agency in another state, but the charge may not exceed $4.

(8) An insurance producer may impose an incidental charge not to exceed $5 for preparing a duplicate insurance identification card at the request of a customer, when the customer requests the preparation of the card instead of waiting for the insurance identification card prepared by the insurer.

(9) An insurance producer may impose an incidental charge not to exceed $10 for each endorsement to a personal lines insurance policy that is in addition to the first six other endorsements by the insurance producer to the policy within a six-month period.

(10) An insurance producer may impose an incidental charge not to exceed $5 for obtaining a duplicate SR22 filing on behalf of a customer when the customer has lost or misplaced the original SR22 filing.

(11) An insurance producer may impose an incidental charge not to exceed $5 for each certificate of commercial insurance coverage issued by the insurance producer that is in addition to the first 20 certificates requested by the customer for the commercial insurance policy during a policy period.

Stat. Auth.: ORS 731.244 and 744.077
Stats. Implemented: ORS 744.077
Hist.: ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

Insurance Producer Service Fees

836-071-0269
Purpose and Authority

(1) OAR 836-071-0269 to 836-071-0277 regulate the charging of service fees by insurance producers.

(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 Director of the Department of Consumer and Business Services. 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 Director 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 insurance producer to be either an insurance premium charge or a premium financing charge.

(3) OAR 836-071-0269 to 836-071-0277 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 746.530 (Premium Financing) and ORS 742.009 (relating to necessary information for insureds). Formerly: OAR 836-030-0050

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 737.205, 742.009, 746.015 & 746.405 - 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; Renumbered from 836-030-0050, ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0272
Scope of OAR 836-071-0269 to 836-071-0277; Definitions

(1) OAR 836-071-0269 to 836-071-0277 do not apply to the transaction of life insurance, mortgage insurance, or title insurance.

(2) "Service fee" means a charge made by an insurance producer 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 746.530 (Premium Financing). Formerly: OAR 836-030-0055

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 737.205, 742.009, 746.015 & 746.405 - 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; Renumbered from 836-030-0055, ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0274
Service Fees Prohibited on Personal Lines

Except as provided in OAR 836-071-0267, a service fee may not 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 is considered individual coverage for the purpose of this rule. Formerly: OAR 836-030-0060

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 737.205, 742.009, 746.015, 746.405 - 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; Renumbered from 836-030-0060, ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0277
Service Fees Allowed on Commercial Lines; Conditions

(1) Service fees may be charged with respect to the transaction of insurance that covers other than an individual's person, property, or liability.

(2) Except as authorized in ORS 744.091 and 744.093, a service fee may be charged only in those instances where the insurance producer has provided service additional to what is the usual and customary practice of insurance producers under similar circumstances. The insurance producer must give a written explanation of the charge and the reason for it to the person charged. If OAR 836-071-0260 or 836-071-0263 applies to the transaction in which a service fee is charged under this rule, the insurance producer may include the written explanation with the disclosure required by OAR 836-071-0260 or 836-071-0263 or provide the written explanation separately.

(3) A service fee may not be charged with respect to arranging the financing of premium payments. This does not preclude finance charges by insurance producers on their own accounts, or service charges by premium finance companies, which conform to the provisions of ORS 746.405 to 746.530.

Stat. Auth.: ORS 731.244, 744.077 & 744.650
Stats. Implemented: ORS 737.205, 742.009, 746.015, 746.405 - 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; Renumbered from 836-030-0065, ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 9-2005(Temp), f. 5-18-05, cert. ef. 8-1-05 thru 1-15-06; ID 13-2005, f. 12-29-05, cert. ef. 1-15-06

Regulation Generally

836-071-0280
Permitted and Prohibited Activities of Insurance Personnel Exempt from Insurance Producer License Requirement

For purposes of ORS 744.056(2)(a):

(1) An unlicensed person whose activities are executive, administrative, managerial, clerical or a combination of these and is employed by an insurance producer may engage in any activity described in this section, subject to review by the insurance producer or an insurance producer employed by the insurance producer if review is required under this section, if the unlicensed person engages in the activity under the supervision of the insurance producer and on the premises of the insurance producer's business. The unlicensed person may:

(a) Disclose rates to the insurance-buying public, but only if the rates are reviewed by the insurance producer prior to submission to the insurer;

(b) Fill out an application for insurance if the application is reviewed by the insurance producer 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 whose activities are executive, administrative, managerial, clerical or a combination of these 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 whose activities are executive, administrative, managerial, clerical or a combination of these and is employed by an insurance producer may engage in the following activities only if they are indirectly related to the sale, solicitation or negotiation of insurance:

(a) Binding coverage; or

(b) Interpreting policy coverages.

Stat. Auth.: ORS 731.244 & 744.056
Stats. Implemented: ORS 744.056
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 6-1994, f. & cert. ef. 5-20-94; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0285
Insurance Producer Review of Applications

An insurance producer 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 insurance producer reviewed the application, giving the date of the review.

Stat. Auth.: ORS 731 & 744
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0287
Transaction of Group Life, Health Insurance by Insurance Producer without Appointment

(1) Subject to section (2) of this rule:

(a) An insurance producer licensed to transact life or health insurance, or both such classes, may solicit group insurance authorized under the license of the insurance producer for an insurer with whom the insurance producer does not hold an appointment; and

(b) The insurer may issue proposals based on the solicitation by the insurance producer.

(2) If an insurance producer 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 files the notice of the appointment with the Director as provided in ORS 744.078.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.053 & 744.078
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 15-1996, f. & cert. ef. 11-12-96; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0291
Certificate of Deposit in Lieu of Trust Account

For purposes of ORS 744.084, evidence of a certificate of deposit kept by an insurance producer is satisfactory:

(1) If the evidence is a written statement of verification issued by the institution issuing the certificate to the insurance producer; 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. Formerly: OAR 386-071-0275

Stat. Auth.: ORS 731.244, 744.084
Stats. Implemented: ORS 744.084
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; Renumbered from 836-071-0275, ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0295
Transaction of Insurance by Individual Insurance Producer for Appointed Firm or CorporateInsurance Producer

An individual insurance producer affiliated by employment or contract with a firm or corporate insurance producer that is appointed by an insurer may transact insurance for the insurer without an appointment from the insurer. An individual insurance producer may so transact insurance only with respect to the classes of insurance endorsed on the license of the individual insurance producer. For purposes of this rule, an individual insurance producer is affiliated with a firm or corporate insurance producer if the individual insurance producer under the contract is authorized to transact insurance in the name of the firm or corporate insurance producer.

Stat. Auth.: ORS 731 & 744
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0297
Permitted Transaction of Insurance by Unappointed Insurance Producer

(1) When an insurance producer does not hold an appointment with an insurer, the insurance producer may transact casualty insur-

ance, property insurance or both by placing the insurance with the insurer through a firm or corporate insurance producer appointed by the insurer and:

(a) The appointed insurance producer has a contract with the unappointed insurance producer that specifies the binding authority, if any, and fiduciary responsibility of the unappointed insurance producer, including ownership and payment of the premiums, but does not authorize the unappointed insurance producer to act in the name of the appointed insurance producer; and

(b) The appointed insurance producer obtains at least 90 percent of its premium under contractual agreement with unappointed insurance producers that are not affiliated with the firm or corporate insurance producer.

(2) This rule does not apply to the transaction of insurance by an individual insurance producer affiliated with a firm or corporate insurance producer as provided in OAR 836-071-0295.

Stat. Auth.: ORS 731.244 & 744
Stats. Implemented:
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0300
Requirement of Contract with or Employment of Licensee

A firm or corporate adjuster or insurance consultant 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 731.244
Stats. Implemented: ORS 744.022
Hist.: ID 3-1990, f. & cert. ef. 1-19-90; ID 9-2002, f. & cert. ef. 3-18-02

836-071-0310
Referral Fee from Oregon Medical Insurance Pool

An insurance producer 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 insurance producer 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 731 & 744
Stats. Implemented:
Hist.: ID 14-1990(Temp), f. & cert. ef. 6-29-90; ID 22-1990, f. 12-20-90, cert. ef. 12-26-90; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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
Stats. Implemented:
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
Stats. Implemented:
Hist.: ID 6-1992, f. & cert. ef. 3-26-92

836-071-0321
Terms for OAR 836-071-0323 to 836-071-0346

For purposes of OAR 836-071-0323 to 836-071-0346:

(1) A felony offense involving dishonesty includes but is not limited to any offense constituting or involving theft, burglary, perjury, bribery, forgery, counterfeiting, a false or misleading oral or written statement, deception, fraud, a scheme or artifice to deceive or defraud, a material misrepresentation or the failure to disclose material facts, or any felony the commission of which is determined by the Director to have involved some element of deceit, misrepresentation, untruthfulness or falsification.

(2) A breach of trust includes but is not limited to any offense constituting or involving misuse, misapplication or misappropriation of anything of value held as a fiduciary, including but not limited to a trustee, administrator, executor, conservator, receiver, guardian, agent, employee, partner, officer, director or public servant, or anything of value of any public, private or charitable organization.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428, 744.013, 744.074
Hist.: ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0323
License Applicants and Licensees with Prior Convictions

(1) When the Director considers an application for a license that indicates the applicant has been convicted of a crime or crimes described in ORS 744.113(1)(e) or 744.074(1)(f), the Director shall determine whether the crime or any of the crimes is an offense under 18 U.S.C. sec. 1033 or a felony offense involving dishonesty or breach of trust that is subject to 18 U.S.C. sec. 1033.

(2) An applicant for a license who has been convicted by final judgment of an offense under 18 U.S.C. sec. 1033 or of any felony offense involving dishonesty or breach of trust does not qualify for the license unless:

(a) The Director has reviewed the entire application of the applicant and has determined that the applicant qualifies for the license; and

(b) The Director issues a written consent as provided in this rule.

(3) An applicant for a license to whom subsection (2) of this rule applies must apply to the Director for a consent as provided in OAR 836-071-0326.

(4) A licensee who has ever been convicted of an offense described in section (1) of this rule must apply to the Director for a consent as provided in OAR 836-071-0326. The licensee may not retain the license unless the Director issues a written consent as provided in this rule.

(5) A licensee who, while licensed, is convicted of an offense described in section (1) of this rule must apply to the Director for a consent as provided in OAR 836-071-0326 not later than the 30th day after the date of the final judgment. The licensee may not retain the license unless the Director issues a written consent as provided in this rule.

(6) A license applicant or licensee who is appointed or expects to be appointed by more than one insurer need submit only one consent application under OAR 836-071-0326, but the application and related letters, statements and other information must relate to the insurer with whom the license applicant or licensee has or will have the most substantial ongoing business relationship.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428, 744.013 & 744.074
Hist. : ID 9-2000, f. & cert. ef 10-24-00; ID 9-2002, f. & cert. ef. 3-18-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0326
Application by Person under OAR 836-071-0323

(1) A person to whom OAR 836-071-0323 applies must submit a consent application on a form provided by the Director.

(2) A person shall submit with the application the following:

(a) A letter from the president of the insurer, or designee of the president, for whom the person acts or will act, that the president or designee is aware of the offense or offenses to which the consent application applies and that the president or designee attests to the character of the person. The letter should describe the person's character traits as they relate to the employment, position or activities for which written consent is sought and the duties and responsibilities thereof.

(b) At least five letters or other forms of statement addressed to the Director, attesting to the character and reputation of the person, in addition to the letter required in subsection (a) of this section. The statement as to character should indicate the length of time the writer has known the person and should describe the person's character traits as they relate to the employment, position or activities for which writ-

ten consent is sought and the duties and responsibilities thereof. The statement as to reputation must attest to the person's reputation in the person's community, circle of business or social acquaintances.

(3) Each letter or statement required in section (2) of this rule should indicate that it has been submitted in compliance with these procedures and that the person has informed the writer of the factual basis of the application being filed with the Director and the purpose thereof. In evaluating letters or statements from relatives by blood or marriage, prospective employers or insurance related business activities, or persons serving in any capacity with the insurer, its employees or agents, the Director may take into account the personal and business interests of those persons.

(4) A person shall also submit with the application under this rule a current credit report from a credit bureau. A credit report is current if it was issued within 30 days after the date of the application.

(5) A person shall submit information in addition to that required in this rule as the Director determines to be appropriate for the proper consideration and disposition of the consent application under this rule.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428, 744.013
Hist.: ID 9-2000, f. & cert. ef. 10-24-00; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0328
Unlicensed Individuals with Prior Convictions Who are Engaged or Participate in Business of Insurance

(1) When the Director considers an application of an individual who applies to the Director under ORS 731.428 for written consent to engage or participate in the business of insurance, other than a licensee to whom OAR 836-071-0323 applies, the Director shall determine whether the crime or any of the crimes is an offense under 18 U.S.C. sec. 1033 or a felony offense involving dishonesty or breach of trust that is subject to 18 U.S.C. sec. 1033. Individuals to whom this section applies includes any applicant for employment in the business of insurance in Oregon and any current unlicensed individual engaged or participating in the insurance business in Oregon who has ever been convicted of an offense described in this section.

(2) An applicant for written consent under this section who has been convicted by final judgment of an offense under 18 U.S.C. sec. 1033 or of any felony offense involving dishonesty or breach of trust does not qualify for the written consent unless:

(a) The Director has reviewed the entire application of the applicant and has determined that the applicant qualifies for the written consent; and

(b) The Director issues a written consent as provided in this rule.

(3) An applicant to whom this rule applies must submit a consent application on a form provided by the Director.

(4) An individual currently engaged or participating in the insurance business in Oregon and is not required to be licensed to do so may not continue to engage or participate in the business of insurance in Oregon unless the Director issues a written consent as provided in this rule.

(5) An unlicensed individual who, while engaged or participating in the insurance business in Oregon and is not required to be licensed to do so, is convicted of an offense described in section (1) of this rule must submit a consent application under this rule not later than the 30th day after the date of the final judgment. The individual may not engage or participate in the insurance business in Oregon unless the Director issues a written consent as provided in this rule.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428
Hist.: ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0331
Director's Procedures, Application for Consent

When the Director has received a complete license application and the consent application required in OAR 836-071-0326, or has received the consent application required in OAR 836-071-0326, in the case of a current licensee or an applicant for a license, or required in OAR 836-071-0328, in the case of an unlicensed person engaged or participating in the business of insurance, and the person has otherwise complied with all applicable requirements:

(1) The Director shall determine whether the crime or any crimes committed by the person and described in the application are subject to ORS 670.280, if a license or license application is involved.

(2) The Director shall notify all state members of the National Association of Insurance Commissioners that an application for written consent has been filed, and shall include with the notice a statement including the name, address, Social Security number (if submitted with the application) and types of insurance actions to be conducted by the applicant, and a request that any insurance commissioner with relevant knowledge regarding the fitness of the applicant respond immediately. The Director shall allow at least 30 days from the date on which the notice was sent, for comment.

(3) The Director may conduct an investigation of the person. The Director may use data bases of the National Association of Insurance Commissioners, including but not necessarily limited to the Regulatory Information Retrieval system, the Producer Database, the Complaint Database and the Special Activities Database.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428, 744.013
Hist.: ID 9-2000, f. & cert. ef. 10-24-00; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0336
Factors to be Considered by the Director

The Director shall consider at least the following factors when deliberating upon a consent application :

(1) The legitimate interest of the Director or the insurer for whom the activities would be performed in protecting property and the safety and welfare of specific individuals, businesses or the general public.

(2) Whether the applicant or someone on the applicant's behalf has made a materially false or misleading statement or omission in the application process.

(3) The nature of the circumstances surrounding, and the seriousness of, the offense or offenses.

(4) Whether the applicant has been charged with, indicted or convicted of multiple criminal offenses.

(5) What evidence exists of the applicant's rehabilitation, including good conduct in prison, on probation or on parole; good conduct in the community; counseling or psychiatric treatment received; acquisition of additional academic or vocational schooling; successful participation in correctional work-release programs; and the recommendation of persons who have or have had the applicant under their supervision (for example, letters of recommendation from prosecutors, law enforcement or correctional officers who have prosecuted, arrested or had custodial responsibility for the applicant, and letters of recommendation from the sheriff or chief of police in the community in which the applicant resides or has resided).

(6) Whether all members of the National Association of Insurance Commissioners were notified in a timely manner of the applicant's request and any relevant information regarding the fitness of the applicant received from members of the National Association of Insurance Commissioners.

(7) Whether licensing the applicant or issuing the person a written consent to engage in the business of insurance would be consistent with the public interest, with federal and state law, with applicable court orders and with the determination that the applicant is trustworthy to conduct the business of insurance.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428, 744.013
Hist.: ID 9-2000, f. & cert. ef. 10-24-00; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0341
Issuance of Written Consent

A written consent to engage in the business of insurance issued by the Director must include the following:

(1) A reference to 18 U.S.C. Section 1033(e)(2).

(2) A statement that the written consent is conditioned on the truth and veracity of the facts disclosed by the applicant in the application for the consent.

(3) A statement that the written consent is conditioned on the applicant remaining in the approved position with its associated insurance activities in which the applicant is not considered to be a risk or threat to insurance consumers or insurers.

(4) Any specific restrictions imposed by the Director as conditions of the written consent.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.013
Hist.: ID 9-2000, f. & cert. ef. 10-24-00

836-071-0346
Denial of Consent

(1) If the Director determines that a written consent to engage in the business of insurance should be denied to an applicant, the Director shall issue the denial in writing and shall notify the applicant of rights of review of the Director's determination.

(2) If the Director determines that the crime committed by the applicant is not one to which 18 U.S.C. Section 1033 applies, the Director shall so inform the applicant at the time of granting or denying the license application or, in response to a consent application.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 731.428, 744.013
Hist.: ID 9-2000, f. & cert. ef. 10-24-00; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-071-0351
Subsequent Conviction of Person Previously Granted Written Consent

A person to whom the Director has given a written consent to engage in the business of insurance shall notify the Director immediately if subsequently convicted of a crime. If the Director determines that the person has been convicted of an offense under 18 U.S.C. Section 1033 or any felony involving dishonesty or breach of trust making the person subject once again to the prohibitions in 18 U.S.C. Section 1033, the Director shall notify the person in writing by certified mail, return receipt requested, that the written consent previously issued has been withdrawn and that engaging in the business of insurance again violates 18 U.S.C. Section 1033.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 744.013
Hist.: ID 9-2000, f. & cert. ef. 10-24-00

Limited License, Rental Companies

836-071-0355
Limited License Application, Rental Companies; Required Information

(1) On and after October 1, 2000, a rental company must hold a limited license in order to transact insurance as authorized by ORS 744.854. An applicant for a limited license as a rental company as authorized by ORS 744.854 shall apply for a limited license to the Director of the Department of Consumer and Business Services on a form established by the Director. The applicant shall include the following information in the application:

(a) The applicant's corporate, firm or other business entity name, the business address and telephone number of the principal place of business and the business address and telephone number of each additional location at which the applicant will transact business under the license;

(b) All assumed business names and other names under which the applicant will engage in business under the license;

(c) The names of all officers and directors or partners, or the sole proprietor or the owners if the applicant is other than a corporation or a partnership, and the name of the executive designated as the statewide filing officer as required by ORS 744.856;

(d) Whether any of the following has occurred with respect to an officer or director of the applicant, or a partner, or the sole proprietor or any of the owners if the applicant is other than a corporation or a partnership:

(A) Conviction of or indictment for a crime, including a felony involving dishonesty or a breach of trust to which 18 U.S.C. sec. 1033 applies;

(B) A judgment entered against the officer, director, partner, sole proprietor or owner if the applicant is other than a corporation or a partnership, for fraud;

(C) A claim of indebtedness by an insurer or agent, and the details of any such indebtedness; or

(D) Refusal, revocation or suspension of any license to act in any occupational or professional capacity in this or any other state;

(e) All states and provinces of Canada in which the applicant or an officer, director or partner of the applicant, or a sole proprietor or owner if the applicant is other than a corporation or a partnership, 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;

(f) Whether any firm or corporation of which an officer, director or partner of the applicant, or the sole proprietor or an owner if the applicant is other than a corporation or a partnership, is or has been an officer, director, partner, sole proprietor or owner has ever filed for bankruptcy or been adjudged a bankrupt; and

(g) Any other information requested by the Director in the license application form.

(2) The applicant shall include with the application the following:

(a) The course of study to be used by the applicant for the training program for employees concerning the kinds of coverage offered under the license;

(b) A certification by the applicant that all employees to be involved in the sale or offer of coverage to members of the public have completed or will complete the training program prior to conducting the sales or offers; and

(c) A certification by the applicant that all employees to be involved in the sale or offer of coverage to members of the public will receive continuing education on a regular basis concerning the topics covered in the training program.

(d) A copy of the insurance sales material to be made available to renters of vehicles through the licensee.

(3) Each application shall be accompanied by a $200 fee.

(4) During the review of an application, the Director may require any other information that the Director determines will assist consideration of the application.

Stat. Auth.: ORS 731.244, 731.804, 744.852 & 744.858
Stats. Implemented: ORS 731.804, 744.852, 744.856 & 744.858
Hist.: ID 8-2000, f. & cert. ef. 7-24-00

836-071-0360
License Renewal

(1) A limited license expires on the last day of the month in which the second anniversary of the initial issuance date occurs. Thereafter, the limited license shall expire on the second anniversary following each renewal.

(2) A limited licensee applying for renewal must submit the following, as applicable:

(a) 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) A copy of the insurance sales material made available to renters of vehicles through the limited licensee.

(c) A renewal fee of $200.

(3) The Director may allow a limited licensee not more than 30 days to submit missing information on the application form if the fees, course of study and certifications have 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 limited license.

(5) An expired license may be renewed according to the requirements and procedures in ORS 744.009, except that the person renewing an expired license must pay $50 instead of twice the amount of the renewal fee.

Stat. Auth.: ORS 731.804 & 744.858
Stats. Implemented: ORS 731.804 & 744.856
Hist.: ID 8-2000, f. & cert. ef. 7-24-00

836-071-0370
List of Employees Selling Coverage; Continuing Education

(1) A limited licensee shall maintain at all times a current list of all employees who are authorized by the limited licensee to offer and sell the insurance coverage for the limited licensee. The limited licensee must provide the list to the Director upon request and the list must otherwise be available and accessible to the Director at all reasonable hours at the principal place of business of the licensee in this state.

(2) For the purpose of complying with the education filing and certification requirements of ORS 744.856, not later than March 1 of each year, a limited licensee shall:

(a) File the syllabus for the training program with the Director; and

(b) Certify to the Director that all employees involved in the sale or offer of coverage to members of the public have completed or will complete the training program prior to conducting such sales or offers and will receive continuing education on a regular basis concerning the topics covered in the training program.

(3) For the purpose of the requirement in ORS 744.856 that employees of a limited licensee shall receive continuing education on a regular basis, a "regular basis" is at least once every 12 months.

Stat. Auth.: ORS 744.858
Stats. Implemented: ORS 744.856
Hist.: ID 8-2000, f. & cert. ef. 7-24-00

836-071-0380
Course of Training for Training Program and for Continuing Education

A limited licensee must include at least the following information in the training program for new employees who will be offering the insurance coverage and in the continuing education program for current employees offering the insurance coverage, as required by ORS 744.856:

(1) Materials for the purpose of facilitating employee understanding of the insurance coverages offered by the licensee.

(2) That renters of vehicles through the licensee are not required to purchase the coverage offered through the licensee as a condition of renting a vehicle.

(3) That renters must be informed that coverage offered by the licensee may duplicate existing coverage of the renter and that the renter should consult with the renter's insurance agent if the renter has any question about existing coverage.

(4) Claims procedures.

(5) The identity of the insurer of the coverage offered by the licensee.

(6) That employees of the licensee are not authorized to evaluate a renter's existing coverages.

Stat. Auth.: ORS 744.858
Stats. Implemented: ORS 744.856
Hist.: ID 8-2000, f. & cert. ef. 7-24-00

836-071-0390
Statewide Filing Officer

(1) Each limited licensee must appoint as the statewide filing officer of the licensee an executive or manager of the licensee who is located in this state. The statewide filing officer shall serve as the in-state representative and contact person for the limited licensee.

(2) The limited licensee shall notify the Director in writing of any change in the appointment.

Stat. Auth.: ORS 744.858
Stats. Implemented: ORS 744.852 & 744.856
Hist.: ID 8-2000, f. & cert. ef. 7-24-00

836-071-0400
Applicable Insurance Code Statutes

(1) Provisions of the Insurance Code that apply to the limited licensing program established by ORS 744.850 to 744.858 include but are not limited to the following: ORS 744.007(6), 744.013, 744.014, 744.016, 744.018, 744.024, 744.028, 744.033, and 744.037.

(2) A limited licensee is not subject to ORS 744.225 and 744.227 and are not otherwise required to treat moneys paid by renters for insurance in a fiduciary capacity or to hold the moneys in a separate trust account.

Stat. Auth.: ORS 744.858
Stats. Implemented: ORS 744.856 & 744.858
Hist.: ID 8-2000, f. & cert. ef. 7-24-00

Surplus Lines

836-071-0500
Licensing and Filing Requirements

(1) This rule establishes requirements that a nonresident surplus lines licensee or a nonresident insurance producer not licensed in this state must satisfy in connection with placement of a surplus lines insurance policy on a risk with exposures located both in this state and outside this state and in connection with filing requirements following such a placement. Establishment of such requirements is authorized under ORS 735.410 with respect to placement and under ORS 735.425 with respect to filing.

(2) A person who is licensed as a resident agent or producer in another state must be licensed in this state as a nonresident surplus lines insurance licensee in order to place in this state a surplus lines insurance policy on a risk with exposures located both in this state and outside this state.

(3) When a nonresident surplus lines licensee transacts surplus lines insurance in this state on a risk with exposures located both in this state and outside this state, the nonresident surplus lines licensee shall comply with the placement requirements in ORS 735.410(1) and the filing requirements in ORS 735.425(1) and (2).

(4) When a nonresident surplus lines licensee or a nonresident insurance producer not licensed in this state transacts surplus lines insurance outside this state on a risk with exposures located both in this state and outside this state, the agent or producer shall file with the Surplus Lines Association of Oregon a report on the Oregon portion of the transaction, disclosing the policy information and Oregon allocation.

Stat. Auth.: ORS 731.244, 735.410 & 735.425
Stats. Implemented: ORS 735.410 & 735.425
Hist.: ID 6-2002, f. & cert. ef. 2-6-02

DIVISION 74

INSURANCE DIVISION TRUST ACCOUNTS

836-074-0005
Statutory Authority; Effective Date

OAR 836-074-0005 to 836-074-0050 are adopted under the general rulemaking authority of the Director of the Department of Consumer and Business Services under ORS 731.244 for the purpose of carrying out ORS 744.083.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.225
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 19-2006, f. & cert. ef. 9-26-06

836-074-0010
Definitions

As used in OAR 836-074-0005 to 836-074-0050:

(1) "Insurance producer includes any person who is licensed by the Department as a resident insurance producer.

(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 731
Stats. Implemented: ORS 744.225
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 insurance producer who is exclusively a salaried employee of an insurer.

(2) An insurance producer who sells only industrial life insurance, as that term is defined in ORS 731.166.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0020
Premium Funds Trust Account

(1) Except as otherwise provided in OAR 836-074-0025, an insurance producer shall deposit in one or more premium funds trust accounts all premium funds received by the insurance producer under the insurance producer's license. Each trust account must be located in this state unless the Director gives written permission to the insurance producer to keep the account in another state. In applying for permission, the insurance producer must give written justification for keeping the account outside this state;

(2) An insurance producer 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 insurance producer 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 insurance producer on or under any policy of insurance are received in the fiduciary capacity of the insurance producer.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0025
Deposit and Payment of Funds

An insurance producer shall deposit and pay premium funds received as provided in this rule. When deposit is required, the insurance producer shall deposit the funds not later than the seventh day after they are received. When a payment is owed to an insured, the insurance producer 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 insurance producer'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 insurance producer, the insurance producer shall deposit the equivalent of the credit in money into the account.

(2) When an insurance producer receives a payment of premium funds in the form of an instrument, such as a check, made payable to an insurer, another insurance producer, a surplus line licensee or a premium finance company, the insurance producer 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 insurance producer receives a payment of premium funds in the form of cash or an instrument requiring endorsement by the insurance producer, the insurance producer shall deposit the premium funds in the trust account or endorse and forward the instrument to the insurer, another insurance producer, the surplus lines licensee or the premium finance company that is entitled to the premium funds received. An insurance producer:

(a) Need not deposit premium funds that are paid in cash if the insurance producer does not maintain a premium trust account because the insurance producer does not engage in transactions for which a trust account must be established, and if the insurance producer complies with all of the following requirements:

(A) Upon receiving the cash, the insurance producer 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 insurance producer 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 insurance producer 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 insurance producer in writing. Such other procedures must:

(A) Recognize that the insurance producer is receiving premiums directly on behalf of the insurer;

(B) Direct the insurance producer to give adequate receipts on behalf of the insurer;

(C) Require deposit of the proceeds into the account of the insurer.

(4) An insurance producer may remove gross commissions from the trust account and pay them to the operating account of the insurance producer.

(5) An insurance producer 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 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0030
Advancing Return Premiums

An insurance producer may advance return premiums from funds of the insurance producer other than from a trust account of the insurance producer, in anticipation of receiving a credit for the return premium from the insurer. When the insurance producer credits the return premium to the trust account, the insurance producer may transfer the advanced credit out of the trust account.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0035
Other Permissible Funds

(1) An insurance producer 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 the insurance producer 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 insurance producer 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 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0040
Interest on Trust Funds

Unless an insurance producer and the insurer agree to the contrary, interest earned in a premium funds trust account may be retained by the insurance producer and:

(1) Used to offset bank charges; or

(2) Removed to the operating account of the insurance producer.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0045
Accounting Records; Inspection

(1) An insurance producer shall establish and maintain records and an appropriate accounting system for all premium funds received by the insurance producer as provided in this rule.

(2) Unless otherwise authorized by the Director, an insurance producer shall establish and maintain the records and accounting system in this state. An insurance producer may establish the records and system in another state if the Director gives written permission to the insurance producer to do so. In applying for permission, the insurance producer must give written justification for keeping the records and system outside this state.

(3) An insurance producer shall make the records available in this state for inspection by the Director during regular business hours upon demand.

(4) An insurance producer 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.

(5) An insurance producer 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 insurance producer shall make a description of the system available for review by the Director.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer, when the trust account or accounting records are located outside this state.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producers of the insurer, if the requirements are more restrictive than the provisions of OAR 836-074-0005 to 836-074-0050.

Stat. Auth.: ORS 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-074-0050
Single Account for Affiliated Persons

(1) An insurance producer 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 insurance producer 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 731
Stats. Implemented: ORS 744.083
Hist.: ID 9-1987, f. 12-22-87, cert. ef. 1-1-88; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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, insurance producer 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, except as provided in subsection (d) of this section;

(d) If the applicant is a corporation that is newly formed for the purpose of transacting business as a third party administrator, the financial statements or reports of each incorporator, shareholder and officer for the two most recent years, a current balance sheet for the corporation and such information as the Director may require in order to review the current financial condition of the applicant;

(e) 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;

(f) Evidence that the applicant has a fiduciary account established in a federally or state-insured financial institution. An applicant that is an insurance producer licensed under ORS chapter 744 need not comply with this subsection if the applicant is in compliance withers 744.225 with respect to the premiums, charges and return premiums referred to in ORS 744.730;

(g) Evidence of insurance coverage required by ORS 744.726;

(h) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an insurance producer 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 producer must provide proof that it has a license as an insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 19-2006, f. & cert. ef. 9-26-06

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: Publications referenced are available from the agency.]
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 licensee who also affirms in writing that the Oregon surplus lines licensee 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

DIVISION 80

TRADE PRACTICES

Replacement of Life Insurance and Annuities

836-080-0001
Statutory Authority; Purpose; Applicability

(1) OAR 836-080-0001 to 836-080-0043 are adopted pursuant to the general rulemaking authority of the Director of the Department of Consumer and Business Services in ORS 731.244 and the specific authority in ORS 746.085(1), for the purpose of implementing ORS 746.085 and 746.240.

(2) The purpose of OAR 836-080-0001 to 836-080-0043 is to protect the insurance-buying public in insurance transactions involving the replacement of life insurance or annuities by:

(a) Regulating the activities of insurers and insurance producers with respect to the replacement of existing life insurance and annuities.

(b) Protecting the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. OAR 836-080-0001 to 836-080-0043 are intended to:

(A) Assure that a purchaser receives information with which a decision can be made in the purchaser's own best interest;

(B) Reduce the opportunity for misrepresentation and incomplete disclosure; and

(C) Establish penalties for failure to comply with requirements of OAR 836-080-0001 to 836-080-0043.

(3) In OAR 836-080-0001 to 836-080-0043 and the appendices thereto, for purposes of consistency with the Life Insurance and Annuities Replacement Model Regulation of the National Association of Insurance Commissioners dated July 2000, an annuity is referred to as a contract and a life insurance policy is referred to as a policy, and they are subject to OAR 836-080-0001 to 836-080-0043 on the basis of that terminology.

(4) Unless otherwise specifically included, OAR 836-080-0001 to 836-080-0043 do not apply to transactions involving:

(a) Credit life insurance;

(b) Group life insurance or group annuities, when there is no direct solicitation of individuals by an insurance producer. Direct solicitation does not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation are subject to the provisions of OAR 836-080-0039;

(c) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Director;

(d) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same insurer;

(e)(A) Policies or contracts used to fund any of the following:

(i) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(ii) A plan described by Section 401(a), 401(k) or 403(b) of the Internal Revenue Code, when the plan, for purposes of ERISA, is established or maintained by an employer;

(iii) A governmental or church plan defined in Section 414 of the Internal Revenue Code, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(B) Notwithstanding paragraph (A) of this subsection, OAR 836-080-0001 to 836-080-0043 apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and when the insurer has been notified that plan participants may choose from among two or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation does not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(f) When new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(g) Existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed;

(h) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of OAR 836-080-0001 to 836-080-0043; or

(i) Structured settlements.

(5) Registered contracts are exempt from the requirements of OAR 836-080-0029(1)(b) and 836-080-0034(2) with respect to the provision of illustrations or policy summaries, but premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

Stat. Auth.: ORS 731.244 & 746.085
Stats. Implemented: ORS 746.085 & 746.240
Hist.: IC 8-1984, f. 10-26-84, ef. 12-1-84; ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-080-0005
Definitions

(1) "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

(2) "Existing insurer" means the insurer whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement."

(3) "Existing policy" means an individual life insurance policy or annuity policy in force, including a policy under a binding or conditional receipt or a policy that is within an unconditional refund period.

(4) "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same insurer within four months before or 13 months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in OAR 836-080-0022(1)(e).

(5) "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in OAR 836-051-0500 to 836-051-0600.

(6) "Policy summary" has the following meanings:

(a) For policies or contracts other than universal life policies, the term means a written statement regarding a policy or contract that shall contain to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan.

(b) For universal life policies, the term means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; 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); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

(7) "Registered Contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

(8) "Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing insurance producer, or to the proposing insurer if there is no insurance producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(a) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer 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) Used in a financed purchase.

(9) "Replacing Insurer" means the insurer that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or that is a financed purchase.

(10) "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the insurer or insurance producer and used in the presentation to the policyholder or contract owner related to the policy or contract purchased.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.085
Hist.: IC 39, f. 12-4-67, ef. 3-1-68; IC 8-1984, f. 10-26-84, ef. 12-1-84; ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-080-0014
Duties of Agent

(1) An insurance producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the insurance producer as to whether the applicant has existing policies or contracts and, at the option of the insurer, as to whether the applicant is replacing any of the existing policies or contracts. If the first question is asked alone and the answer is "no," or if both questions are asked and the answer to the optional question is "no," the insurance producer's duties with respect to replacement are complete, except as provided in section (2) of this section.

(2) If the applicant answered "yes" to the question whether the applicant has existing coverage referred to in section (1) of this rule, and the question is asked alone, or if both questions are asked and the answer is "yes" to both, the insurance producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A to this rule or other substantially similar form approved by the Director. Approval is not required, however, when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced. The notice shall be signed by both the applicant and the insurance producer attesting that the notice has been read aloud by the insurance producer or that the applicant did not wish the notice to be read aloud (in which case the insurance producer need not have read the notice aloud) and left with the applicant.

(3) The notice under section (2) of this rule shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction an insurance producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. Electronically presented sales material shall be provided to the policy or contract owner in printed form not later than at the time of policy or contract delivery.

(5) Except as provided in OAR 836-080-0029(3), in connection with a replacement transaction an insurance producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this rule, a statement identifying any preprinted or electronically presented insurer-approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 746.085
Stats. Implemented: ORS 746.085 & 746.240
Hist.: ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-080-0022
Duties of Insurers that Use Agents Insurance Producers

Each insurer that uses an insurance producer shall:

(1) Maintain a system of supervision and control to insure compliance with the requirements of OAR 836-080-0001 to 836-080-0043. The system shall do at least the following:

(a) Inform its insurance producers of the requirements of OAR 836-080-0001 to 836-080-0043 and incorporate the requirements of OAR 836-080-0001 to 836-080-0043 into all relevant insurance producer training manuals prepared by the insurer;

(b) Provide to each insurance producer a written statement of the insurer's position with respect to the acceptability of replacements, providing guidance to its insurance producer as to the appropriateness of these transactions;

(c) Include a system for reviewing the appropriateness of each replacement transaction that the insurance producer does not indicate is in accord with subsection (b) of this section;

(d) Include procedures that confirm the requirements of OAR 836-080-0001 to 836-080-0043 have been met; and

(e) Include procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or insurance producer. Compliance with OAR 836-080-0001 to 836-080-0043 may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters or programs of internal monitoring;

(2) Have the capacity to monitor each insurance producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, such records for and make such records available to, the Director. The capacity to monitor shall include the ability to produce records for the following with respect to each insurance producer:

(a) Life replacements, including financed purchases, as a percentage of the insurance producer's total annual sales for life insurance;

(b) Number of lapses of policies by the insurance producer as a percentage of the agent's total annual sales for life insurance;

(c) Annuity contract replacements as a percentage of the insurance producer's total annual annuity contract sales;

(d) Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the insurer's monitoring system as required by subsection (1)(e) of this section; and

(e) Replacements, indexed by replacing insurance producer and existing insurer;

(3) Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the insurance producer as to whether the applicant has existing policies or contracts;

(4) Require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in **Appendix A** to this rule, unless the notice is not required under OAR 836-080-0014(1) and (2);

(5) When the applicant has existing policies or contracts, be able to produce copies of any sales material required by OAR 836-080-0014(5), the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the insurance producer's and applicant's signed statements with respect to financing and replacement for at least five years after the termination or expiration of the proposed policy or contract;

(6) Ascertain that the sales material and illustrations required by OAR 836-080-0014(5) meet the requirements of OAR 836-080-0001 to 836-080-0043 and are complete and accurate for the proposed policy or contract;

(7) If an application does not meet the requirements of OAR 836-080-0001 to 836-080-0043, notify the insurance producer and applicant and fulfill the outstanding requirements; and

(8) Maintain records in paper, photograph, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.085 & 746.240
Hist.: IC 8-1984, f. 10-26-84, ef. 12-1-84; ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 19-2006, f. & cert. ef. 9-26-06

836-080-0029
Duties of Replacing Insurers that Use Agents

(1) When a replacement is involved in the transaction, the replacing insurer shall:

(a) Verify that the required forms are received and are in compliance with OAR 836-080-0001 to 836-080-0043;

(b) Notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five business days of a request from an existing insurer;

(c) Be able to produce copies of the notification regarding replacement required in OAR 836-080-0014(2), indexed by insurance producer, for at least five years or until the next regular examination by the insurance department of the insurer's state of domicile, whichever is later; and

(d) Provide to the policyholder or contract owner notice of the right to return the policy or contract within 30 days of the delivery of the policy or contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract. Notice required in this subsection may be included in **Appendix A** or **C** to this rule.

(2) In a transaction in which the replacing insurer and the existing insurer are the same or are subsidiaries or affiliates under common ownership or control, the replacing insurer shall allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to a financed purchase the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

(3) If an insurer prohibits the use of sales material other than that approved by the insurer, as an alternative to the requirements made of an insurer pursuant to OAR 836-080-0014(5), the insurer may:

(a) Require with each application a statement signed by the insurance producer that:

(A) Represents that the insurance producer used only insurer-approved sales material;

(B) States that copies of all sales material were left with the applicant in accordance with OAR 836-080-0014(4); and

(b) Within ten days of the issuance of the policy or contract:

(A) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the insurance producer has represented that copies of all sales material have been left with the applicant in accordance with OAR 836-080-0014(4);

(B) Provide the applicant with a toll-free number to contact insurer personnel involved in the compliance function if the insurer cannot give the applicant the notice required in paragraph (A) of this subsection; and

(C) Stress the importance of retaining copies of the sales material for future reference.

(4) An insurer to whom section (3) of this rule applies shall maintain the ability to produce from the policy file a copy of the letter or other verification sent to an applicant under section (3) of this rule for at least five years after the termination or expiration of the policy or contract.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.085 & 746.240
Hist.: ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-080-0034
Duties of the Existing Insurer

When a replacement is involved in a transaction, the existing insurer shall:

(1) Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later.

(2) Send a letter to the policyholder or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five business days of receipt of the request from the policy or contract owner.

(3) Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice advising the policyholder that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policyholder. In the case of consecutive automatic premium loans, the insurer is required to send the notice only at the time of the first loan.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.085 & 746.240
Hist.: ID 5-2001, f. 4-16-01, cert. ef. 11-1-01

836-080-0039
Duties of Insurers with Respect to Direct Response Solicitations

(1) In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement in **Appendix B** to this rule, or other substantially similar form approved by the Director.

(2) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(a) Provide to the applicant or prospective applicant with the policy or contract a notice, as described in **Appendix C** to this rule, or other substantially similar form approved by the Director. In these instances the insurer may delete the references to the insurance producer, including the insurance producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the Director. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this subsection. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this section; and

(b) Comply with the requirements of OAR 836-080-0029(1)(b), if the applicant furnishes the names of the existing insurers, and the requirements of OAR 836-080-0029(1)(c) and (d), and (2).

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.085 & 746.240
Hist.: ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-080-0043
Violations and Penalties

(1) Any failure to comply with OAR 836-080-0001 to 836-080-0043 shall be considered an unfair trade practice for purposes of ORS 746.240. Examples of violations include:

(a) Any deceptive or misleading information set forth in sales material;

(b) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(c) The intentional incorrect recording of an answer;

(d) Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(e) Advising a policyholder or contract owner to write directly to the insurer in such a way as to attempt to obscure the identity of the replacing insurance producer or insurer.

(2) Policyholders and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policyholders or contract owners of the same insurance producer shall be deemed prima facie evidence of the insurance producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the insurance producer's intent to violate OAR 836-080-0001 to 836-080-0043.

(3) When it is determined that the requirements of OAR 836-080-0001 to 836-080-0043 have not been met, the replacing insurer shall provide to the policyholder or contract owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements in **Appendix A** or **C** to this rule.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.085 & 746.240
Hist.: ID 5-2001, f. 4-16-01, cert. ef. 11-1-01; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 731
Stats. Implemented: ORS 746.015(1)
Hist.: IC 61, f. 12-2-74, ef. 1-1-75

Payment of Health Insurance Claims (Sampling Method)

836-080-0080
Definition, Claims Handling Services; Claims Procedures and Information

(1) As used in sections 2 and 3, chapter 747, Oregon Laws 2001, "clean claim" means a claim under a health benefit plan that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

(2) For purposes of section 2(1), chapter 747, Oregon Laws 2001, an insurer is considered to have received a claim when the claim is received by the insurer itself or when the claim is received by a representative of the insurer that performs claims handling on the sole behalf of the insurer, whichever receipt date is earlier. A representative may include but is not limited to a third party administrator, a claims service or a pricing service. When an insurer uses such a representative, then the insurer shall include for purposes of section 2(1), chapter 747, Oregon Laws 2001, the days in which a claim is in the control of the representative, including the date on which the representative received the claim.

(3) For the purpose of communicating the information necessary for claim form completion as required by section 2(3), chapter 747, Oregon Laws 2001, an insurer shall include any specific description of standard supporting documentation, information and data routinely required to be submitted with a claim form. Compliance with the standard transaction requirements established under the federal **Health Insurance Portability and Accountability Act** at 45 **CFR parts 160** and **162** shall be considered to be compliance with this section.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & Sec. 2, Ch. 747, OL 2001
Stats. Implemented: Sec. 2, Ch. 747, OL 2001
Hist.: ID 1-2002, f. & cert. ef. 1-15-02

836-080-0085
Annual Report; Sampling

(1) Each insurer shall report to the Director annually on its compliance with section 2, chapter 747, Oregon Laws 2001 (Enrolled Senate Bill 894), governing claims received by an insurer from a provider on behalf of an enrollee, according to the requirements of this rule.

(2) Not later than March 1 of each year, each insurer shall submit the following to the Director:

(a) A count of all claims for which final disposition has been made by the insurer during the immediately preceding calendar year.

(b) A count of all claims included in the count in subsection (a) of this section that were each finally disposed of later than the 30th day after the date on which the insurer received the claim.

(c) A data file that includes a population list with respect to the claims described in subsection (b) of this section, in the form and manner specified by the Director.

(3) The Director shall select a number of sample files from each insurer's data file submitted under section (2) of this rule, using a methodology determined by the Director to provide a representative and statistically valid sampling of the insurer's insured population and shall deliver to the insurer the file numbers and the format in which the information required under section (4) of this rule shall be captured and submitted to the Director.

(4) Each insurer shall examine each sample selected under section (3) of this rule against its records to determine information requested by the Director. The information shall include but not be limited to the following:

(a) The date on which the claim was received;

(b) The date on which the insurer requested additional information on the claim;

(c) The date on which the insurer received the additional information;

(d) The date on which the insurer paid or denied the claim.

(e) Whether interest was owed or paid on the claim under section 3, chapter 747, Oregon Laws 2001, or whether the insurer was not required to pay interest as provided in section 3(2), chapter 747, Oregon Laws 2001.

(f) Whether the claim was paid or denied. For the purpose of this subsection, a claim that is paid in part and denied in part shall be treated as a paid claim.

(5) Not later than the 60th day after the date on which an insurer receives the selection of sample files from the Director under section (3) of this rule, the insurer shall submit to the Director a report of its data determined under section (4) of this rule in the format prescribed by the Director.

(6) For the purpose of the annual report that is due for calendar year 2002, an insurer shall sample and count only those claims that were submitted to an insurer on or after January 1, 2002 and on or before December 31, 2002.

Stat. Auth.: ORS 731.244 & Sec. 2 & 3, Ch. 747, OL 2001
Stats. Implemented: Sec. 2 & 3, Ch. 747, OL 2001
Hist.: ID 1-2002, f. & cert. ef. 1-15-02

Suitability

836-080-0090
Suitability in the Sale of life Insurance and Annuities

A person may not recommend to a consumer the purchase, sale or replacement of a life insurance policy or annuity, or any rider, endorsement or amendment to the policy or annuity, without reasonable grounds to believe that the recommendation or transaction is not unsuitable for the consumer based upon reasonable inquiry concerning the consumer's insurance objectives, financial situation and needs, age and other relevant information known by the person. For the purpose of this rule, when a person recommends a group life insurance policy or annuity, "consumer" refers to the intended group policyholder.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.100, 746.110 & 746.240
Hist.: ID 6-2004, f. 8-26-04, cert. ef. 1-1-05

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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 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 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 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 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 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.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 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 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 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 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, and Applicability

(1) OAR 836-080-0205 to 836-080-0250 are adopted by the Director of the Department of Consumer and Business Services pursuant to general rulemaking authority in ORS 731.244, to aid in the proper effectuation of ORS 746.230.

(2) The purpose of OAR 836-080-0205 to 836-080-0250 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) OAR 836-080-0205 to 836-080-0250:

(a) Apply with respect to all insurance except fidelity and surety bonds and title insurance;

(b) Apply to workers' compensation insurance only as provided in OAR 836-080-0250; and

(c) Are not exclusive, and the Director may also consider other acts not herein specified to be violations of ORS 746.230.

(4) OAR 836-080-0205 to 836-080-0250 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; ID 20-1998, f. 12-2-98, cert. ef. 2-1-99

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 any first party claimant and any third party claimant, the designated legal representative of any such claimants and any 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 that 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, that 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 731.244
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; ID 20-1998, f. 12-2-98, cert. ef. 2-1-99

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 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 731
Stats. Implemented: ORS 746.230(1)(a), 746.230(f), 746.230(j) & 746.230(m)
Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80

836-080-0225
Required Claim Communication Practices

An insurer shall:

(1) Not later than the 30th day after receipt of notification of claim, acknowledge the notification or pay the claim. An appropriate and dated notation of the acknowledgment shall be included in the insurer's claim file.

(2) Not later than the 21st day after receipt of an inquiry from the Director about a claim, furnish the Director with an adequate response.

(3) Make an appropriate reply, not later than the 30th day after 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 not later than the 30th day after receipt of notification of a claim constitutes compliance with section (1) of this rule.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.230
Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; ID 3-1998, f. & cert. ef. 2-10-98

836-080-0230
Standard for Prompt Claim Investigation

An insurer shall complete its claim investigation not later than the 45th day after its receipt of notification of claim, unless the investigation cannot reasonably be completed within that time.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.230
Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; ID 3-1998, f. & cert. ef. 2-10-98

836-080-0235
Standards for Prompt and Fair Settlements — Generally

(1) An insurer shall, not later than the 30th day 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 made on a health insurance policy and the claim involves a coordination of benefits issue to which OAR 836-020-0700 to 836-020-0765 apply, the time allowed in OAR 836-020-0740 to an insurer for applying a coordination of benefit provision shall be added to the time period provided in section (1) of this rule.

(3) 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.

(4) 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 not later than the 30th day 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.

(5) 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.

(6) 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.

(7) 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 731.244
Stats. Implemented: ORS 746.230(1) & 746.240
Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; ID 3-1998, f. & cert. ef. 2-10-98; ID 19-2006, f. & cert. ef. 9-26-06

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 another comparable automobile or one of like kind and quality, the insurer shall adjust and settle the claim as provided in this rule.

(2) The insurer may elect to offer a replacement automobile that is at least comparable to the insured automobile. A replacement automobile is at least comparable if it is the same make, is of the same or a newer year, is of a similar body style, has similar options and mileage as the insured automobile, is in as good or better overall condition and is available for inspection within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to the transfer of evidence of ownership of the automobile at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(3) The insurer may elect to make a cash settlement, less any deductible provided in the policy, but including all applicable taxes, license fees and other fees incident to transfer of ownership of another comparable automobile. When an insurer makes a cash settlement, if the insured so requests, the insurer shall furnish the insured copies of the information used by the insurer for the purpose of determining the amount of the cash settlement. If the information includes documentation of a specific and comparable automobile that the insurer intends to rely upon to preclude reopening the claim file under section (4) of this rule, the insurer shall prominently disclose that intention. The value of the automobile for purposes of a cash settlement may be based upon one of the following standards:

(a) A valuation obtained from a computerized database source that produces statistically valid and fair market values for automobiles, on the basis of the following criteria:

(A) The source shall produce values for at least 85 percent of all makes and models of private passenger automobiles for the last 15 model years;

(B) The source shall rely upon values of vehicles that are currently available or were available within the last 90 days from the date of loss for all vehicles and shall apply appropriate standards of comparability; and

(C) For all vehicles of five model years or less of age, the values must be derived primarily from verifiable data or inventory from licensed dealers;

(D) The source shall monitor the average retail price of private passenger automobiles when there is insufficient data or inventory from licensed dealers to ensure statistically valid market area values;

(E) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area; and

(F) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters, such as time and area, to assure statistical validity.

(b) The actual cost to purchase the automobile identified by the insurer as a replacement automobile that is at least comparable to the insured automobile as determined pursuant to section (2) of this rule, including all applicable taxes, license fees and other fees incident to purchase of the automobile other than any deductible provided in the policy; or

(c) An alternative that deviates from the methods described in subsections (a) and (b) of this section and is allowable under the policy, as long as documentation in the claim file supports the deviation and gives particulars of the pre-loss condition of the automobile. Any deductions from the cost, including deduction for salvage if the salvage is retained by the claimant, must be measurable, discernible, itemized and specified as to dollar amount and must be appropriate in amount. The basis for such a settlement must be fully explained in writing, supplied to the claimant and maintained in the claim file.

(4) If the insured notifies the insurer within 35 days of the receipt of the claim draft that the insured cannot purchase an automobile for the market value as determined in section (3) of this rule, the insurer shall reopen its claim file and the following procedures shall apply:

(a) The insurer may locate an automobile that is at least comparable to the insured automobile as determined pursuant to section (2) of this rule, and that is currently available for the market value determined by the insurer at the time of settlement;

(b) The insurer may either pay the insured the difference between the market value before applicable deductions and the cost of the comparable automobile of like kind and quality that the insured has located, or negotiate and effect the purchase of the automobile for the insured;

(c) The insurer may elect to offer a replacement automobile in accordance with the provisions set forth in section (2) of this rule; or

(d) The insurer may conclude the loss settlement in the manner provided in the appraisal section of the insurance policy in force at the time of the loss.

(5) The right of the insured to have a claim reopened under section (4) of this rule applies only to first party claims of the insured under the policy. The insurer is not required to take action under section (4) of this rule if its documentation to the insured at the time of settlement includes written notification of the availability and location of a specified automobile that is at least comparable to the insured automobile as determined pursuant to section (2) of this rule, that could have been purchased for the market value determined by the insurer before applicable deductions. The documentation shall include the vehicle identification number or another specific vehicle identifier.

(6) When 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.

(7) 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.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.230, 746.240 & 746.280
Hist.: IC 2-1980, f. 5-8-80, ef. 6-1-80; IC 8-1986, f. & ef. 12-30-86; ID 20-1998, f. 12-2-98, cert. ef. 2-1-99; ID 2-2001(Temp), f. & cert. ef. 3-15-01 thru 9-7-01; Administrative correction 11-20-01; ID 12-2002, f. & cert. ef. 5-10-02

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

Use of Insurance Scores and Credit History

836-080-0425
Applicability; Definitions

(1) OAR 836-080-0425 to 836-080-0440 apply to personal insurance as defined in ORS 746.600.

(2) "Application" means an action by a prospective insured that, if accepted by the insurer, would establish a contract of insurance.

(3) "Consumer," "consumer reporting agency," "credit history" and "insurance score" have the meanings given those terms in ORS 746.600.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.015 & 746.240
Hist.: ID 25-2002, f. 12-17-02, cert. ef. 6-1-03; ID 7-2004, f. & cert. ef. 10-5-04

836-080-0430
Disclosure of Use of Credit History or Insurance Scores

(1) Before an insurer or its insurance producer may obtain the credit history or insurance score of a consumer in response to a request by the consumer relating to insurance coverage, the insurer or insurance producer shall notify the consumer that the insurer or insurance producer will check the credit history or insurance score of the consumer. The notice may be oral, in writing or in the same medium as the medium in which communication between the consumer and the insurer or insurance producer is conducted.

(2) An insurance producer need provide only one notice under section (1) of this rule to a consumer for the inquiry or inquiries that the insurance producer makes to one or more insurers in response to the request by the consumer.

(3) An insurer who uses credit histories or insurance scores for underwriting or rating coverage shall instruct each of its insurance producer that before an insurance producer may obtain a consumer's credit history or insurance score, the insurance producer must notify the consumer that the consumer's credit history or insurance score of the consumer will be checked.

(4) An insurer that uses the credit history or insurance score of a consumer when considering the consumer's application for insurance must notify the consumer during the application process that the consumer may request a written statement describing its use of credit histories or insurance scores. The notice to the consumer may be either in writing or in the same medium as the medium in which the application is made. The statement must address the following items:

(a) Why the insurer uses credit history or insurance scores.

(b) How the insurer uses credit histories or insurance scores.

(c) What kinds of credit information are used by the insurer.

(d) Whether a consumer's lack of credit history will affect the insurer's consideration of an application.

(e) Where the consumer may go with questions.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.015, 746.240, 746.661 & 746.663
Hist.: ID 25-2002, f. 12-17-02, cert. ef. 6-1-03; ID 7-2004, f. & cert. ef. 10-5-04; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 11-2005(Temp), f. & cert. ef. 9-15-05 thru 3-6-06; ID 4-2006, f. 3-9-06, cert. ef. 3-10-06

836-080-0435
Policies Governing Credit Histories and Insurance Scores

Each insurer that uses credit histories or insurance scores in the rating or underwriting, or both, of prospective applicants, applicants or policyholders for personal insurance shall establish a written policy that includes at least the following:

(1) An explanation of credit histories or insurance scores, or an explanation of both if the insurer uses both, and the insurer's standards governing their use.

(2) Rating and underwriting protocols, rules and instructions relating to credit histories or insurance scores. The protocols, rules and

instructions shall include an explanation of the insurer's consideration and treatment, for underwriting purposes and for rating purposes, of:

(a) A consumer for whom the insurer or provider of credit scoring information has found no credit records (a "no hit"), and whether the insurer may make exceptions.

(b) A consumer for whom the insurer or provider of credit history or insurance score information has found a credit record but insufficient credit activity for creating a credit score (a "no score"), and whether the insurer may make exceptions.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.015 & 746.240
Hist.: ID 25-2002, f. 12-17-02, cert. ef. 6-1-03; ID 7-2004, f. & cert. ef. 10-5-04

836-080-0436
Absence of or Inability to Determine Credit History; Relation to Risk to Insurer

An insurer may use the category of absence of a credit history ("no hit") or the category of inability to determine a consumer's credit history ("no score") under ORS 746.661(1)(c) according to the separate risk profiles for the two categories, and any relevant subcategories, demonstrated by actuarial data that the insurer has submitted to the Director of the Department of Consumer and Business Services.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.650
Hist.: ID 7-2004, f. & cert. ef. 10-5-04

836-080-0438
Definition of Adverse Underwriting Decision; Notice

(1) For the purpose of the notice required by ORS 746.650(5), an adverse underwriting decision as defined in ORS 746.600(1)(a)(G)(iii) occurs when an insurer accepting an application for insurance would have given the consumer a lower rate if the consumer's credit history or the credit factors in the consumer's insurance score were more favorable.

(2) An insurer shall include in a notice of adverse underwriting decision required by ORS 746.650(5) an explanation of the consumer's right to request, no more than once annually, that the insurer rerate the consumer, and of potential negative consequences of rerating, if any.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.600 & 746.650
Hist.: ID 7-2004, f. & cert. ef. 10-5-04; ID 11-2005(Temp), f. & cert. ef. 9-15-05 thru 3-6-06; ID 4-2006, f. 3-9-06, cert. ef. 3-10-06

836-080-0440
Unfair Insurance Trade Practice

Violation of any provision of OAR 836-080-0425 to 836-080-0440 is an unfair trade practice for purposes of ORS 746.240.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240
Hist.: ID 25-2002, f. 12-17-02, cert. ef. 6-1-03

Privacy of Personal Information (ORS 746.600 to 746.690)

836-080-0501
Authority; Rule of Construction; Applicability

(1) OAR 836-080-0501 to 836-080-0551 are adopted under the authority of ORS 731.244 and 746.620 for the purpose of implementing ORS 746.600, 746.620, 746.630 and 746.665.

(2) The examples in OAR 836-080-0501 to 836-080-0551 are not exclusive. Compliance with an example in OAR 836-080-0501 to 836-080-0551 constitutes compliance with the statute to which the example applies.

(3) OAR 836-080-0501 to 836-080-0551 have the same scope of applicability as ORS 746.600, 746.620, 746.630 and 746.665, applying to insurance activities of a licensee and not to noninsurance activities.

(4) The applicability of the exemptions in ORS 746.665(1)(b) and (c) includes but is not limited to a licensee's transactions described in ORS 746.665(1)(b) and (c) with a reinsurer or with an insurer with respect to stop loss or excess loss insurance.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stat. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02; ID 11-2006, f. & cert. ef. 6-26-06; ID 19-2006, f. & cert. ef. 9-26-06

836-080-0506
Definitions and Examples

The following definitions and examples of definitions apply to the following terms as they are defined or used in ORS 746.600 and used in ORS 746.620, 746.630 and 746.665 or as they are defined or used in OAR 836-080-0501 to 836-080-0551:

(1) "Clear and conspicuous" means that a notice under ORS 746.620 or a disclosure authorization form under ORS 746.630 is reasonably understandable and designed to call attention to the nature and significance of the information in the notice or disclosure authorization form. The following are applicable examples:

(a) Examples of "reasonably understandable." A licensee makes its notice or disclosure authorization form reasonably understandable if it:

(A) Presents the information in the notice or disclosure authorization form in clear, concise sentences, paragraphs and sections;

(B) Uses short explanatory sentences or bullet lists whenever possible;

(C) Uses definite, concrete, everyday words and active voice whenever possible;

(D) Avoids multiple negatives;

(E) Avoids legal and highly technical business terminology whenever possible; and

(F) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice or disclosure authorization form to call attention to the nature and significance of the information in it if the licensee:

(A) Uses a plain-language heading to call attention to the notice or disclosure authorization form;

(B) Uses a typeface and type size that are easy to read;

(C) Provides wide margins and ample line spacing;

(D) Uses boldface or italics for key words; and

(E) Uses distinctive type size, style and graphic devices, such as shading or sidebars, when a form combines the licensee's notice or disclosure authorization form with other information.

(c) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensures that other elements on the web site, such as text, graphics, hyperlinks or sound, do not distract attention from the notice, and the licensee either:

(A) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(B) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

(2) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(3) The following examples apply to the term "consumer" as it is defined in the definition of "individual" in ORS 746.600 and as it is used in ORS 746.620, 746.630 and 746.665:

(a) An individual who provides personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if the licensee discloses personal information about the individual to a nonaffiliated third party other than as permitted under ORS 746.665(1)(a) to (j) or (m) to (q), and:

(A) The individual is a beneficiary of a life insurance policy underwritten by the licensee;

(B) The individual is a claimant under an insurance policy issued by the licensee;

(C) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(D) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy.

(e) If the licensee provides the initial, annual and revised notices under ORS 746.620 to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder, and if the licensee does not disclose personal information about such an individual to a nonaffiliated third party other than as permitted under ORS 746.665(1)(a) to (j) and (m) to (q), an individual is not the consumer of the licensee solely because the individual is:

(A) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary; or

(B) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(f) Individuals described in paragraphs (A) and (B) of subsection (e) of this section are consumers of a licensee if the licensee does not meet all of the conditions of subsection (e) of this section. The individuals are not customers for purposes of ORS 746.600, 746.620, 746.630 or 746.665 solely because of their status described in paragraphs (A) and (B) of subsection (e) of this section.

(4) The following examples that indicate whether a continuing relationship exists apply to the term "customer" as it is defined in the definition of "individual" in ORS 746.600:

(a) A consumer has a continuing relationship with a licensee if:

(A) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(B) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(A) The consumer applies for insurance but does not purchase the insurance;

(B) The licensee sells the consumer airline travel insurance in an isolated transaction;

(C) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(D) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee.

(E) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(F) The customer's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than for annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials.

(G) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(H) For the purposes of this rule, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(5) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 (12 USC 1843(k)). "Financial institution" does not include:

(a) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 USC 1 et seq.).

(b) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 USC 2001 et seq.); or

(c) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales, including sales of servicing rights or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(6) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 USC 1843(k)). The term includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

(7) The term "licensee" as defined in ORS 746.600 also includes an unauthorized insurer that accepts business placed through a licensed surplus lines agent in this state, but only with regard to the surplus lines placements placed pursuant to ORS 735.400 to 735.495.

(8) The term "nonaffiliated third party" as defined in ORS 746.600 also includes any company that is an affiliate solely because of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act (12 USC 1843(k)(4)(H) and (I)).

(9) "Personal financial information" is the category of personal information that does not include medical record information but includes any of the following information:

(a) Information that a consumer provides to a licensee to obtain an insurance product or service from the licensee.

(b) Information about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer.

(c) Information that the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to the consumer.

(d) Any list, description or other grouping of consumers, and publicly available information pertaining to those consumers, that is derived using any personal financial information that is not publicly available.

(10) The definition of "personal information" in ORS 746.600 provides that "'Personal information' does not include information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law." For purposes of this exemption:

(a) A licensee has a reasonable basis to believe the information is lawfully made available to the general public if the licensee has taken steps to determine:

(A) That the information is of the type that is available to the general public; and

(B) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(b) The following are examples:

(A) Government records. Information in government records that is not "personal information" includes information in government real estate records and security interest filings.

(B) Widely distributed media. Information from widely distributed media that is not "personal information" includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(C) Reasonable basis examples:

(i) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(ii) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book

or the consumer has informed the licensee that the telephone number is not unlisted.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0511
Application of Notice Requirements

(1) A licensee is not subject to the requirements stated in ORS 746.620 if the licensee is an employee or other representative of another licensee who is the principal in the relationship and the principal otherwise complies with the requirements of ORS 746.620, 746.630 and 746.665, and:

(a) If the licensee is an insurance producer, the licensee acts in accordance with the requirements of ORS 746.620(8); and

(b) If the licensee is other than an insurance producer, the licensee does not disclose any personal information to any person other than to the principal or its affiliate as provided in ORS 746.665(1)(a) to (j) or (m) to (q), or under ORS 746.665(1)(L) in connection with an audit.

(2) A surplus lines licensee or surplus lines insurer is deemed to be in compliance with ORS 746.620 if:

(a) The licensee or insurer does not disclose personal information of a consumer or a customer to nonaffiliated third parties for any purpose, except as permitted by ORS 746.665(1)(a) to (j) and (L) to (q); and

(b) The licensee or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE
WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-080-0516
Initial Notice to Consumers

(1) A licensee shall provide an initial notice as provided in ORS 746.620(1) and also subsequently when further information is collected in connection with a renewal or reinstatement of an insurance policy.

(2) A licensee is not required to provide an initial notice to a consumer for purposes of ORS 746.620 if any of the following circumstances applies:

(a) If the licensee does not disclose any personal information about the consumer to any nonaffiliated third party other than as authorized by ORS 746.665(1)(a) to (j) or (m) to (q) and the licensee does not have a customer relationship with the consumer.

(b) If the licensee has a customer relationship with the consumer and the consumer consents to the licensee's searching for insurance coverage to replace existing coverage or to perform another insurance service for the consumer, and if disclosure of personal information of the consumer meets the conditions specified in ORS 746.665(1)(c)(B).

(c) If a notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

(3) For the purpose of the notice requirement of ORS 746.620(1), pursuant to which a licensee shall provide notice of information practices to a consumer who becomes a customer of the licensee not later than the date that the licensee establishes a continuing relationship with the consumer, a continuing relationship between a licensee and consumer is established when the consumer, as shown in the following examples:

(a) Becomes a policyholder of a licensee that is an insurer, when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an agent, obtains insurance through that licensee; or

(b) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

(4) When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, either of the following provisions may apply to a licensee regarding the initial notice requirements of ORS 746.620:

(a) The licensee may provide a revised policy notice as provided in OAR 836-080-0531; or

(b) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under ORS 746.620.

(5) A licensee may provide the initial notice required by ORS 746.620 within a reasonable time after the licensee establishes a customer relationship if establishing the customer relationship is not at the customer's election or if providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time. The following are examples of exceptions for purposes of this section:

(a) Not at the customer's election: Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) Substantial delay of a customer's transaction: Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(c) No substantial delay of a customer's transaction: Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a website.

(6) When a licensee is required to deliver an initial privacy notice by ORS 746.620, the licensee shall deliver it according to OAR 836-080-0536. If the licensee uses an abbreviated notice according to ORS 746.620, the licensee may deliver the privacy notice as provided in OAR 836-080-0519(8).

(7) A licensee that uses a standard privacy notice to comply with the requirements of the federal Gramm-Leach-Bliley Act of 1999 and its implementing regulations for its business as a financial institution or that uses such a standard privacy notice for its insurance business in two or more states may comply with the initial privacy notice requirement by using either of the following options:

(a) By using the standard privacy notice and another supplementary privacy notice that includes the elements required by ORS 746.620 and OAR 836-080-0519 that are not contained in the standard privacy notice. The supplementary privacy notice must prominently and clearly state that any rights an individual may have as described in that notice are not abridged or limited by the standard privacy notice that the individual may receive separately.

(b) By using a single Oregon-specific privacy notice that complies in its entirety with ORS 746.620.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0519
Information to be Included in Initial Privacy Notice

(1) This rule implements the requirement of the initial notice under ORS 746.620, describes the contents of the initial notice and provides examples of categories of information required in the notice.

(2) The following are examples of categories of personal information collected by a licensee. A licensee satisfies the requirement of categorizing the personal information it collects if the licensee categorizes it according to the source of the information, including, for example:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from an insurance support organization.

(3) The following are examples of categories of personal information disclosed by a licensee:

(a) A licensee satisfies the requirement of categorizing personal information it discloses if the licensee categorizes the information according to source, as described in section (2) of this rule, as applicable, and provides a few examples to illustrate the types of information in each category. These may include:

(A) Information from the consumer, including application information such as assets and income and identifying information such as name, address and social security number;

(B) Transaction information, such as information about balances, payment history and parties to the transaction; and

(C) Information from consumer reporting agencies, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee may disclose all of the personal information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of personal information that the licensee discloses.

(4) The following are examples for describing categories of affiliated and nonaffiliated third parties to which a licensee discloses information:

(a) A licensee satisfies the requirement of categorizing the affiliates and nonaffiliated third parties to which the licensee discloses personal information about consumers if the licensee identifies the types of business in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee may also categorize the affiliates and nonaffiliated third parties to which it discloses personal information about consumers using more detailed categories.

(5) A privacy notice shall include an explanation of the consumer's right under ORS 746.665(1)(k) to opt out of the disclosure of personal information to nonaffiliated third parties, including the method by which the consumer may exercise that right at that time. The following are examples of disclosures under the exception for joint marketers under ORS 746.665(1)(k). If a licensee discloses personal information under the exception in ORS 746.665(1)(k) to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the applicable disclosure requirement of this rule if the licensee:

(a) Lists the categories of personal information it discloses, using the same categories and examples the licensee used to meet the requirements of section (1) of this rule.

(b) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(6) If a licensee does not disclose personal information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under ORS 746.665(1)(a) to (k) and (m) to (q), and under ORS 746.665(1)(L) in connection with an audit, the licensee may simply state that fact, in addition to the information it is required to provide under ORS 746.620(3)(a), (h), (i) and (j) and (4).

(7) A licensee describes its policies and practices relating to protection of the confidentiality and security of personal information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(8) An abbreviated notice authorized by ORS 746.620(5) must include in full the elements of the notice required by the federal Gramm-Leach-Bliley Act of 1999 for the purpose of compliance with that law and shall also include the information referred to in section (5) of this rule and in ORS 746.620(5). The licensee shall deliver its abbreviated notice according to OAR 836-080-0536. The licensee is not required to deliver its privacy notice with its abbreviated notice. The licensee instead may provide the consumer a reasonable means to obtain its privacy notice as described in OAR 836-080-0536(9). If a consumer who receives the licensee's abbreviated notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to OAR 836-080-0536.

(9) A licensee's initial privacy notice may include any of the following:

(a) Categories of personal information that the licensee reserves the right to disclose in the future but does not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, personal information.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0523
Annual Notice

(1) The personal information to which a licensee must refer in the annual notice need include only personal financial information. A licensee provides the notice annually if it defines the 12-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

(2) Termination of customer relationship: A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship. The following are examples in which a continuing relationship no longer exists:

(a) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains services with or through the licensee.

(b) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than to provide annual privacy notices, material required by law or regulation or promotional materials.

(c) For the purpose of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(d) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement purposes, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

(3) When a licensee is required by this rule to deliver an annual privacy notice, the licensee shall deliver it according to OAR 836-080-0536.

(4) An insurer issuing a title insurance policy is not required to give the annual notice required by ORS 746.620(2) to the policyholder.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0526
Information to be Included in Annual Notice

(1) This rule implements the requirement of the annual notice under ORS 746.620, describes the contents of the annual notice and provides examples of categories of information required in the annual notice.

(2) The following are examples of categories of personal financial information collected by a licensee. A licensee satisfies the requirement of categorizing the personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from an insurance support organization.

(3) The following are examples of categories of personal financial information disclosed by a licensee:

(a) A licensee satisfies the requirement of categorizing personal financial information it discloses if the licensee categorizes the information according to source, as described in section (2) of this rule, as applicable, and provides a few examples to illustrate the types of information in each category. These may include:

(A) Information from the consumer, including application information such as assets and income and identifying information such as name, address and social security number;

(B) Transaction information, such as information about balances, payment history and parties to the transaction; and

(C) Information from consumer reporting agencies, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee may disclose all of the personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of personal financial information that the licensee discloses.

(4) The following are examples for describing categories of affiliated and nonaffiliated third parties to which a licensee discloses information:

(a) A licensee satisfies the requirement of categorizing the affiliates and nonaffiliated third parties to which the licensee discloses personal financial information about consumers if the licensee identifies the types of business in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee may also categorize the affiliates and nonaffiliated third parties to which it discloses personal financial information about consumers using more detailed categories.

(5) An annual notice shall include an explanation of the consumer's right under ORS 746.665(1)(k) to opt out of the disclosure of personal financial information to nonaffiliated third parties, including the method by which the consumer may exercise the right at that time. An annual notice that contains such an explanation satisfies the requirement of ORS 746.620(3)(f). If a licensee discloses personal financial information under the exception in ORS 746.665(1)(k) to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the applicable disclosure requirement of this rule if the licensee:

(a) Lists the categories of personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of section (1) of this rule.

(b) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(6) If a licensee does not disclose personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under ORS 746.665(1)(a) to (j) and (m) to (q), and under ORS 746.665(1)(L) in connection with an audit, the licensee may state that fact, in addition to the information it is required to provide under ORS 746.620(3)(a), (h) and (i), and (4).

(7) A licensee describes its policies and practices relating to protection of the confidentiality and security of personal financial information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(8) A licensee's notice may include any of the following:

(a) Categories of personal financial information that the licensee reserves the right to disclose in the future but does not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, personal financial information.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0531
Revised Privacy Notices

(1) Except as otherwise authorized in OAR 836-080-0501 to 836-080-0551, a licensee shall not, directly or through an affiliate, disclose any personal financial information about a consumer to a nonaffiliated third party under ORS 746.665(1)(k) other than as described in the initial notice that the licensee provided to the consumer under ORS 746.620 and OAR 836-080-0501 to 836-080-0551, unless:

(a) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(b) The licensee has given the consumer a reasonable opportunity, before the licensee discloses personal financial information to the nonaffiliated third party, to opt out of the disclosure; and

(c) The consumer does not opt out.

(2) Except as otherwise allowed by ORS 746.665(1)(a) to (j) and (m) to (q), a licensee shall provide a revised notice to the consumer under section (1) of this rule before the licensee, for example:

(a) Discloses a new category of personal financial information to a nonaffiliated third party;

(b) Discloses personal financial information to a new category of nonaffiliated third party; or

(c) Discloses personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to indicate that the former customer does not want disclosure.

(3) A revised privacy notice under this rule shall be delivered according to OAR 836-080-0536.

(4) The prohibition in section (1) of this rule and the requirements of section (2) of this rule do not apply with respect to a revision of an initial notice, the sole purpose of which is to incorporate a notice of a disclosure of personal information for which authorization is not required by ORS 746.665.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0536
Delivery

(1) A licensee shall provide any notices required by ORS 746.620 and OAR 836-080-0501 to 836-080-0551 so that each consumer can be reasonably expected to receive actual notice in writing or, if the consumer agrees, electronically.

(2) The following are examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(a) Hand-delivers a printed copy of the notice to the consumer;

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(3) The following are examples of unreasonable expectations of actual notice. A licensee may not reasonably expect that a consumer will receive actual notice of its privacy policies and practices if the licensee:

(a) Posts only a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(b) Sends the notice by electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(4) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(a) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(b) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(5) A licensee may not provide any notice required by ORS 746.620 and OAR 836-080-0501 to 836-080-0551 solely by orally explaining the notice, either in person or over the telephone.

(6) For customers only, a licensee shall provide the initial notice, annual notice and revised notice required by ORS 746.620 and OAR 836-080-0501 to 836-080-0551 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically. The following are examples of retention and accessibility of notices. A licensee provides a privacy notice to a customer so that the customer can retain it or obtain it later if the licensee:

(a) Hand-delivers a printed copy of the notice to the customer;

(b) Mails a printed copy of the notice to the last known address of the customer; or

(c) Makes its current privacy notice available on a web site or a link to another web site for the customer who obtains an insurance product or services electronically and agrees to receive the notice at the web site.

(7) A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of another financial institution.

(8) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements by providing one notice to those consumers jointly.

(9) A licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice for the purpose of OAR 836-080-0519(8) if the licensee:

(A) Provides a toll-free telephone number that the consumer may call to request the notice; or

(B) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand and provides a copy to the consumer immediately upon request.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0541
Opt in Notice; Form of Opt Out Notice to Consumers and Opt Out Methods for Purpose of ORS 746.665(1)(k)

(1) Form of opt in notice. The form of the disclosure authorization (the opt in form) is governed by ORS 746.630, and is used with respect to disclosures of personal information that do not meet one or more of the conditions specified in ORS 746.665(1).

(2) Form of opt out notice. Sections (2) to (10) of this rule govern the form of and requirements applicable to an opt out notice when the notice is required by ORS 746.665(1)(k). If a licensee is required to provide an opt out notice by ORS 746.665(1)(k), the licensee shall accurately explain the right to opt out under that provision. The notice shall state:

(a) That the licensee discloses or reserves the right to disclose personal financial information about its consumer to a nonaffiliated third party;

(b) That the consumer has the right to opt out of that disclosure; and

(c) A reasonable means by which the consumer may exercise the opt out right.

(3) The following are examples for purposes of section (2) of this rule:

(a) Adequate opt out notice. A licensee provides adequate notice that the consumer may opt out of the disclosure of personal financial information to a nonaffiliated third party if the licensee:

(A) Identifies all of the categories of personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information as permitted by ORS 746.665(1)(k), and states that the consumer may opt out of the disclosure of that information; and

(B) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(b) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(A) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(B) Includes a reply form together with the opt out notice;

(C) Provides an electronic means to opt out, such as a form that can be sent by electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(D) Provides a toll-free telephone number that the consumers may call to opt out.

(c) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(A) The only means of opting out is for the consumer to write the consumer's own letter to exercise that opt out right; or

(B) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(d) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

(4) Same form as initial notice permitted. A licensee may provide the opt out notice for purposes of ORS 746.665(1)(k) together with or on the same written or electronic form as the initial notice the licensee provides in accordance with OAR 836-080-0516.

(5) Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with OAR 836-080-0516, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(6) The following governs joint relationships:

(a) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer as explained in subsection (e) of this section.

(b) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(A) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(B) Permit each joint consumer to opt out separately.

(c) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(d) A licensee may not require all joint consumers to opt out before the licensee implements any opt out direction.

(e) The following is an example for purposes of this section. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but the licensee shall explain in the opt out notice of notice of the licensee which opt out policy the licensee will follow:

(A) Send a single opt out notice to John's address, but the licensee shall except an opt out direction from either John or Mary.

(B) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(C) Permit John and Mary to make different opt out directions. If the licensee does no:

(i) The licensee shall permit John and Mary to opt out for each other;

(ii) If both opt out, the licensee shall permit both of them to notify the licensee in a single response, such as on a form or through a telephone call; and

(iii) If John opts out and Mary does not, the licensee may disclose personal financial information only about Mary but not about John, and not about John and Mary jointly.

(7) Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives the direction.

(8) Continuing right to opt out. A consumer may exercise the right to opt out at any time.

(9) The duration of a consumer's opt out direction is governed as follows:

(a) A consumer's direction to opt out under this rule is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(b) When a customer relationship terminates, the customer's opt out direction continues to apply to the personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(10) Delivery. When a licensee is required to deliver an opt out notice by this rule, the licensee shall deliver it according to OAR 836-080-0536.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0546
Limits on Sharing Account Number Information for Marketing Purposes

(1) General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

(2) Exceptions. Section (1) of this rule does not apply if a licensee discloses a policy number or similar form of access number or access code:

(a) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to dir3eectly initiate charges to the account;

(b) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(c) To a participant in an affinity or similar program when the participants in the program are identified to the customer when the customer enters into the program.

(3) The following are examples for purposes of this rule:(a) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(b) Policy or transaction account. For the purpose of this rule, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

(4) Violation of this section is an unfair trade practice for purposes of ORS 746.240.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

836-080-0551
Authorization Request Delivery

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of a notice under ORS 746.620 if the request and the authorization form are clear and conspicuous.

Stat. Auth.: ORS 731.244, 746.600 & 746.620
Stats. Implemented: ORS 746.600, 746.620, 746.630 & 746.665
Hist.: ID 8-2002, f. & cert. ef. 2-15-02

Privacy of Health Insurance-Related Information

Generally

836-080-0600
Authority; Rule of Construction; Applicability

(1) OAR 836-080-0600 to 836-080-0700 are adopted under the authority of ORS 731.244 and 746.608, for the purpose of implementing ORS 746.600 and 746.607 with respect to licensees transacting health insurance.

(2) The examples in OAR 836-080-0600 to 836-080-0700 are not exclusive. Compliance with an example in OAR 836-080-0600 to 836-080-0700 constitutes compliance with the rule to which the example applies.

(3) OAR 836-080-0600 to 836-080-0700 apply to health insurance activities of a licensee and not to noninsurance activities.

(4) The applicability of the exemptions in OAR 836-080-0670(1)(a) and (b) includes but is not limited to a licensee's transactions described in OAR 836-080-0670(1)(a) and (b) with a reinsurer or with an insurer with respect to stop loss or excess loss insurance.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0610
Definitions and Examples

The following definitions and examples of definitions apply to the following terms as they are defined or used in OAR 836-080-0600 to 836-080-0700:

(1) "Clear and conspicuous" means that a notice under OAR 836-080-0615 or 836-080-0620 or a disclosure authorization form under OAR 836-080-0665 is reasonably understandable and designed to call attention to the nature and significance of the information in the notice or disclosure authorization form. The following are applicable examples:

(a) Examples of "reasonably understandable." A licensee makes its notice or disclosure authorization form reasonably understandable if it:

(A) Presents the information in the notice or disclosure authorization form in clear, concise sentences, paragraphs and sections;

(B) Uses short explanatory sentences or bullet lists whenever possible;

(C) Uses definite, concrete, everyday words and active voice whenever possible;

(D) Avoids multiple negatives;

(E) Avoids legal and highly technical business terminology whenever possible; and

(F) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice or disclosure authorization form to call attention to the nature and significance of the information in it if the licensee:

(A) Uses a plain-language heading to call attention to the notice or disclosure authorization form;

(B) Uses a typeface and type size that are easy to read;

(C) Provides wide margins and ample line spacing;

(D) Uses boldface or italics for key words; and

(E) Uses distinctive type size, style and graphic devices, such as shading or sidebars, when a form combines the licensee's notice or disclosure authorization form with other information.

(c) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensures that other elements on the web site, such as

text, graphics, hyperlinks or sound, do not distract attention from the notice, and the licensee either:

(A) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(B) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

(2) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(3) The following examples apply to the term "consumer" as it is defined in ORS 746.600 and used in OAR 836-080-0600 to 836-080-0700:

(a) An individual who provides personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to a health insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for health insurance prior to the inception of health insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if the licensee discloses personal information about the individual to a nonaffiliated third party other than as permitted under OAR 836-080-0670 or 836-080-0675 and the individual is a claimant under a health insurance policy issued by the licensee.

(e) If the licensee provides the initial, annual and revised notices under OAR 836-080-0615 or 836-080-0620 to the plan sponsor or group or blanket insurance policyholder, and if the licensee does not disclose personal information about such an individual to a nonaffiliated third party other than as permitted under OAR 836-080-0670 or 836-080-0675, an individual is not the consumer of the licensee solely because the individual is:

(A) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary; or

(B) Covered under a group or blanket health insurance policy issued by the licensee.

(f) Individuals described in paragraphs (A) and (B) of subsection (e) of this section are consumers of a licensee if the licensee does not meet all of the conditions of subsection (e) of this section. The individuals are not customers for purposes of ORS 746.600 or this rule, or OAR 836-080-0615, 836-080-0620, 836-080-0665, 836-080-0670 or 836-080-0675, solely because of their status described in paragraphs (A) and (B) of subsection (e) of this section.

(4) The following examples that indicate whether a continuing relationship exists apply to the term "customer" as it is defined in ORS 746.600 and used in OAR 836-080-0600 to 836-080-0700:

(a) A consumer has a continuing relationship with a licensee if:

(A) The consumer is a current policyholder of a health insurance product issued by or through the licensee; or

(B) The consumer obtains financial, investment or economic advisory services relating to a health insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(A) The consumer applies for health insurance but does not purchase the health insurance;

(B) The individual is no longer a current policyholder of a health insurance product or no longer obtains health insurance services with or through the licensee;

(C) The consumer is a beneficiary or claimant under a health insurance policy and has submitted a claim under a health insurance policy choosing a settlement option involving an ongoing relationship with the licensee.

(D) The consumer is a beneficiary or a claimant under a health insurance policy and has submitted a claim under that policy choosing a lump sum settlement option;

(E) The customer's health insurance policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than for annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials.

(F) The individual is an insured under a health insurance policy, but is not the policyholder or owner of the insurance policy; or

(G) For the purposes of this rule, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(5) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 (12 USC 1843(k)). "Financial institution" does not include:

(a) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 USC 1 et seq.).

(b) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 USC 2001 et seq.); or

(c) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales, including sales of servicing rights or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(6) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 USC 1843(k)). The term includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

(7) The term "nonaffiliated third party" as defined in ORS 746.600 also includes any company that is an affiliate solely because of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act (12 USC 1843(k)(4)(H) and (I)).

(8) "Personal financial information" is the category of personal information that includes any of the following information:

(a) Information that a consumer provides to a licensee to obtain a health insurance product or service from the licensee.

(b) Information about a consumer resulting from a transaction involving a health insurance product or service between a licensee and a consumer.

(c) Information that the licensee otherwise obtains about a consumer in connection with providing a health insurance product or service to the consumer.

(d) Any list, description or other grouping of consumers, and publicly available information pertaining to those consumers, that is derived using any personal financial information that is not publicly available.

(9) For purposes of the part of the definition of "personal information" in ORS 746.600 that provides that "'Personal information' does not include information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law":

(a) A licensee has a reasonable basis to believe the information is lawfully made available to the general public if the licensee has taken steps to determine:

(A) That the information is of the type that is available to the general public; and

(B) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(b) The following are examples:

(A) Government records. Information in government records that is not "personal information" includes information in government real estate records and security interest filings.

(B) Widely distributed media. Information from widely distributed media that is not "personal information" includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(C) Reasonable basis example: A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed the licensee that the telephone number is not unlisted.

(10) Statutory definitions of terms used in OAR 836-080-0600 to 836-080-0700, including but not limited to "insurance producer," "insurance support organization" and "privileged information," are found in ORS 746.600.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

Notice of Information Practices

836-080-0615
Personal Information Notice

(1) This rule governs the notice to be given by a licensee to an individual that informs the individual about a licensee's treatment of personal information concerning the individual when the licensee and the individual are engaging in a transaction of health insurance. A licensee shall provide a clear and conspicuous notice of information practices to individuals in connection with a transaction of health insurance under the circumstances and at the times as follows:

(a) In the case of an application for health insurance, a notice shall be provided no later than:

(A) At the time of delivery of the health insurance policy or certificate, when personal information is collected only from the applicant or from public records; or

(B) At the time the collection of personal information is initiated, when personal information is collected from a source other than the applicant or public records.

(b) In the case of a health insurance policy renewal, a notice shall be provided no later than the policy renewal date, except that a notice shall not be required in connection with a policy renewal if:

(A) Personal information is collected only from the policyholder or from public records; or

(B) A notice meeting the requirements of this rule has been given within the previous 24 months.

(c) In the case of a policy reinstatement or change in health insurance benefits by an insurer, a notice shall be provided no later than the time a request for the policy reinstatement or change in insurance benefits is received by the insurer, except that a notice shall not be required if personal information is collected only from the policyholder or from public records.

(2) The notice required by section (1) of this rule shall be in writing or, if the individual agrees, in an electronic format and shall include all of the following items:

(a) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage.

(b) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect the information.

(c) The types of disclosures identified in OAR 836-080-0670 or 836-080-0675 and the circumstances under which the disclosures may be made without prior authorization. The only circumstances that need be described, however, are those that occur with such frequency as to indicate a general business practice.

(d) A description of the rights established under OAR 836-080-0695 and 836-080-0700 and the manner in which the rights may be exercised.

(e) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(3) In lieu of the notice required in section (2) of this rule, an insurer or insurance producer may provide an abbreviated notice in writing or, if the individual agrees, in electronic format, informing the individual that:

(a) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(b) Personal information collected under subsection (a) of this section as well as other personal or privileged information subsequently collected by the licensee may be disclosed in certain circumstances to third parties without authorization;

(c) A right of access and correction exists with respect to all personal information collected; and

(d) The notice required in section (2) of this rule will be furnished to the individual upon request.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0620
Notice of Personal Financial Information Practices

(1) This rule governs the notice to be given by a licensee to an individual, in fulfillment of requirements of the federal Gramm-Leach-Bliley Act (P.L. 106-102), that informs the individual about the licensee's treatment of personal financial information concerning the individual in the course of the ongoing financial relationship between the licensee and the individual, in connection with a health insurance policy. A licensee shall provide a clear and conspicuous notice of its personal financial information practices to individuals under the circumstances and at the times as follows:

(a) Except as provided in this subsection, to a consumer who becomes a customer of the licensee, not later than the date that the licensee establishes a continuing relationship under which the licensee provides one or more health insurance products or services to the consumer that are to be used primarily for personal, family or household purposes. A licensee may provide the notice within a reasonable time after the date the licensee establishes a customer relationship if:

(A) Establishing the customer relationship is not at the customer's election; or

(B) Providing notice not later than the date that the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(b) To a consumer before any personal financial information about that individual is disclosed to a nonaffiliate of the licensee, if the disclosure is made other than as permitted under OAR 836-080-0665, 836-080-0670 or 836-080-0675.

(2) A licensee shall provide a clear and conspicuous notice to a customer that accurately reflects the privacy policies and practices of the licensee not less than once in any period of 12 consecutive months during which the relationship described in section (1)(a) of this rule exists. A licensee may define the period of 12 consecutive months, but the licensee must apply the period to the customer on a consistent basis.

(3) The notice required by sections (1) and (2) of this rule shall be in writing, except that the notice may be provided in electronic form if the recipient agrees. In addition to any other information the licensee wishes to provide, the notice shall include the following items of information that apply to the licensee and to the individuals to whom the licensee sends the notice:

(a) The policy and practices of the licensee with respect to disclosing personal financial information to nonaffiliated parties other than agents of the licensee, including the categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided pursuant to OAR 836-080-0675, and the policies and practices with respect to disclosing personal financial information of persons who have ceased to be customers of the licensees.

(b) The categories of personal financial information that the licensee collects.

(c) The policies the licensee maintains to protect the confidentiality and security of personal financial information.

(4) A licensee that does not disclose personal financial information about customers or former customers to affiliates or nonaffiliates except as authorized in OAR 836-080-0670 or 836-080-0675, and does not wish to reserve the right to do so may satisfy the requirements

of this rule by providing a customer a notice that so states and that also includes:

(a) The information described in section (3)(b) and (c) of this rule; and

(b) A statement that the licensee makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(5) Before a licensee discloses personal financial information to a nonaffiliated third party other than as described in the notice required in section (1) of this rule, the licensee shall send a revised notice that accurately describes its information collection and disclosure practices. The revised notice must comply with the requirements of section (3) of this rule.

(6) For purposes of this rule and OAR 836-080-0670 and 836-080-0675, an individual is not the consumer of a licensee solely because the individual is covered under a group life or health insurance policy issued by the licensee or is a participant or beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary, if:

(a) The licensee provides to the policyholder the initial, annual and revised notices under this rule; and

(b) The licensee does not disclose to a nonaffiliated third party personal information about the individual other than as permitted by OAR 836-080-0675.

(7) When an individual becomes a consumer of a licensee under section (6) of this rule, then this rule and OAR 836-080-0670 and 836-080-0675 apply to the licensee with respect to the individual.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0625
Alternative Procedures

A licensee may satisfy the notice requirements of OAR 836-080-0615 and 836-080-0620 by either of the following alternative means:

(1) By providing separate notices or a single notice combining the requirements of both rules.

(2) By providing a single notice if two or more individuals jointly obtain or apply for an insurance product.

(3) The obligations imposed by OAR 836-080-0615 and by 836-080-0620 upon a licensee may be satisfied, either together or separately, by another licensee or another financial institution or agent authorized to act on its behalf. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions.

(4) Except as otherwise prohibited or limited by the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191):

(a) A licensee may include any notice required pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) with a notice provided under OAR 836-080-0615 or 836-080-0620 or under an alternative means allowed in section (1) of this rule.

(b) Notice obligations imposed by the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) upon a licensee may be satisfied together with the obligations imposed by OAR 836-080-0615 and by 836-080-0620 upon the licensee as provided in section (2) of this rule.

(5) An insurance producer is not subject to the requirements of OAR 836-080-0615 or 836-080-0620 when the insurer on whose behalf the insurance producer acts otherwise complies with the same requirements and the insurance producer does not disclose any personal information to any person other than the insurer or its affiliate, or as otherwise authorized by law.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0630
Application of Notice Requirements

A licensee is not subject to the requirements stated in OAR 836-080-0615 or 836-080-0620 if the licensee is an employee or other representative of another licensee who is the principal in the relationship and the principal otherwise complies with the requirements of OAR 836-080-0615, 836-080-0620, 836-080-0625, 836-080-0665, 836-080-0670 and 836-080-0675 and:

(1) If the licensee is an insurance producer, the licensee acts in accordance with the requirements of OAR 836-080-0625(4); and

(2) If the licensee is other than an insurance producer, the licensee does not disclose any personal information to any person other than to the principal or its affiliate as provided in OAR 836-080-0670 or 836-080-0675.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0635
Initial Notice to Consumers

(1) A licensee shall provide an initial notice as provided in OAR 836-080-0620(1) and also subsequently when further personal financial information is collected in connection with a renewal or reinstatement of a health insurance policy.

(2) A licensee is not required to provide an initial notice to a consumer for purposes of OAR 836-080-0620 if any of the following circumstances applies:

(a) If the licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party other than as authorized by OAR 836-080-0670 and 836-080-0675 and the licensee does not have a customer relationship with the consumer.

(b) If the licensee has a customer relationship with the consumer and the consumer consents to the licensee's searching for health insurance coverage to replace existing coverage or to perform another health insurance service for the consumer, and if disclosure of personal financial information of the consumer meets the conditions specified in OAR 836-080-0670.

(c) If a notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

(3) For the purpose of the notice requirement of OAR 836-080-0620, pursuant to which a licensee shall provide notice of personal financial information practices to a consumer who becomes a customer of the licensee not later than the date that the licensee establishes a continuing relationship with the consumer, a continuing relationship between a licensee and consumer is established when the consumer, as shown in the following examples:

(a) Becomes a health insurance policyholder of a licensee that is an insurer, when the insurer delivers a health insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer, obtains health insurance through that licensee; or

(b) Agrees to obtain financial, economic or investment advisory services relating to health insurance products or services for a fee from the licensee.

(4) When an existing customer obtains a new health insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, either of the following provisions may apply to a licensee regarding the initial notice requirements of OAR 836-080-0620 and:

(a) The licensee may provide a revised policy notice as provided in OAR 836-080-0655; or

(b) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new health insurance product or service, the licensee does not need to provide a new privacy notice under OAR 836-080-0620.

(5) A licensee may provide the initial notice required by OAR 836-080-0620 within a reasonable time after the licensee establishes a customer relationship if establishing the customer relationship is not at the customer's election or if providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time. The following are examples of exceptions for purposes of this section:

(a) Not at the customer's election: Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's health insurance policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) Substantial delay of a customer's transaction: Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the

licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the health insurance product or service.

(c) No substantial delay of a customer's transaction: Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a website.

(6) When a licensee is required to deliver an initial privacy notice by OAR 836-080-0620, the licensee shall deliver it according to OAR 836-080-0660. If the licensee uses an abbreviated notice according to OAR 836-080-0620, the licensee may deliver the privacy notice as provided in OAR 836-080-0640(8).

(7) A licensee that uses a standard privacy notice to comply with the requirements of the federal Gramm-Leach-Bliley Act of 1999 and its implementing regulations for its business as a financial institution or that uses such a standard privacy notice for its health insurance business in two or more states may comply with the initial privacy notice requirement by using either of the following options:

(a) By using the standard privacy notice and another supplementary privacy notice that includes the elements required by OAR 836-080-0615, 836-080-0620 and 836-080-0650 that are not contained in the standard privacy notice. The supplementary privacy notice must prominently and clearly state that any rights an individual may have as described in that notice are not abridged or limited by the standard privacy notice that the individual may receive separately.

(b) By using a single Oregon-specific privacy notice that complies in its entirety with OAR 836-080-0615 and 836-080-0620, if allowed under federal law.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0640
Information to Be Included in Initial Privacy Notice

(1) This rule implements the requirement of the initial notice under OAR 836-080-0620, describes the contents of the initial notice and provides examples of categories of information required in the notice.

(2) The following are examples of categories of nonpublic personal financial information collected by a licensee. A licensee satisfies the requirement of categorizing the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, including, for example:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from an insurance support organization.

(3) The following are examples of categories of nonpublic personal financial information disclosed by a licensee:

(a) A licensee satisfies the requirement of categorizing nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in section (2) of this rule, as applicable, and provides a few examples to illustrate the types of information in each category. These may include:

(A) Information from the consumer, including application information such as assets and income and identifying information such as name, address and social security number;

(B) Transaction information, such as information about balances, payment history and parties to the transaction; and

(C) Information from consumer reporting agencies, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal financial information that the licensee discloses.

(4) The following are examples for describing categories of affiliated and nonaffiliated third parties to which a licensee discloses nonpublic personal financial information:

(a) A licensee satisfies the requirement of categorizing the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of business in which the affiliates and nonaffiliated third parties engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee may also categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

(5) A privacy notice shall include an explanation of the consumer's right under OAR 836-080-0675 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the method by which the consumer may exercise that right at that time. The following are examples of disclosures under the exception for joint marketers under OAR 836-080-0675. If a licensee discloses nonpublic personal financial information under the exception in OAR 836-080-0675 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the applicable disclosure requirement of this rule if the licensee:

(a) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of section (1) of this rule.

(b) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(6) If a licensee does not disclose nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under OAR 836-080-0670 and 836-080-0675, the licensee may simply state that fact, in addition to the information it is required to provide under OAR 836-080-0615(3) (a), (h), (i) and (j) and (4).

(7) A licensee describes its policies and practices relating to protection of the confidentiality and security of personal information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(8) An abbreviated notice authorized by OAR 836-080-0615(3) must include in full the elements of the notice required by the federal Gramm-Leach-Bliley Act of 1999 for the purpose of compliance with that law and shall also include the information referred to in section (5) of this rule and in OAR 836-080-0615(3). The licensee shall deliver its abbreviated notice according to OAR 836-080-0660. The licensee is not required to deliver its privacy notice with its abbreviated notice. The licensee instead may provide the consumer a reasonable means to obtain its privacy notice as described in OAR 836-080-0660. If a consumer who receives the licensee's abbreviated notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to OAR 836-080-0660.

(9) A licensee's initial privacy notice may include any of the following:

(a) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future but does not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

Stat. Auth.: ORS 731.244 & 746.608

Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0645
Annual Notice

(1) The personal information to which a licensee must refer in the annual notice need include only personal financial information. A licensee provides the notice annually if it defines the 12-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

(2) Termination of customer relationship: A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship. The following are examples in which a continuing relationship no longer exists:

(a) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains services with or through the licensee.

(b) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than to provide annual privacy notices, material required by law or regulation or promotional materials.

(c) A licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(3) When a licensee is required by this rule to deliver an annual privacy notice, the licensee shall deliver it according to OAR 836-080-0660.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0650
Information to Be Included in Annual Notice

(1) This rule implements the requirement of the annual notice under OAR 836-080-0645, describes the contents of the annual notice and provides examples of categories of nonpublic personal financial information required in the annual notice.

(2) The following are examples of categories of nonpublic personal financial information collected by a licensee. A licensee satisfies the requirement of categorizing the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from an insurance support organization.

(3) The following are examples of categories of nonpublic personal financial information disclosed by a licensee:

(a) A licensee satisfies the requirement of categorizing nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in section (2) of this rule, as applicable, and provides a few examples to illustrate the types of information in each category. These may include:

(A) Information from the consumer, including application information such as assets and income and identifying information such as name, address and social security number;

(B) Transaction information, such as information about balances, payment history and parties to the transaction; and

(C) Information from consumer reporting agencies, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee may disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal financial information that the licensee discloses.

(4) The following are examples for describing categories of affiliated and nonaffiliated third parties to which a licensee discloses information:

(a) A licensee satisfies the requirement of categorizing the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of business in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee may also categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

(5) An annual notice shall include an explanation of the consumer's right under OAR 836-080-0675 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the method by which the consumer may exercise the right at that time. An annual notice that contains such an explanation satisfies the requirement of OAR 836-080-0615. If a licensee discloses nonpublic personal financial information under the exception in OAR 836-080-0675 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the applicable disclosure requirement of this rule if the licensee:

(a) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of section (1) of this rule.

(b) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(6) If a licensee does not disclose nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under OAR 836-080-0670(1), the licensee may state that fact, in addition to the information it is required to provide under OAR 836-080-0615(4).

(7) A licensee describes its policies and practices relating to protection of the confidentiality and security of nonpublic personal financial information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(8) A licensee's notice may include any of the following:

(a) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future but does not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0655
Revised Privacy Notices

(1) Except as otherwise authorized in OAR 836-080-0600 to 836-080-0700, a licensee shall not, directly or through an affiliate, disclose any personal financial information about a consumer to a nonaffiliated third party under OAR 836-080-0675 other than as described in the

initial notice that the licensee provided to the consumer under OAR 836-080-0620, unless:

(a) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(b) The licensee has given the consumer a reasonable opportunity, before the licensee discloses personal financial information to the nonaffiliated third party, to opt out of the disclosure; and

(c) The consumer does not opt out.

(2) Except as otherwise allowed by OAR 836-080-0670, a licensee shall provide a revised notice to the consumer under section (1) of this rule before the licensee, for example:

(a) Discloses a new category of personal financial information to a nonaffiliated third party;

(b) Discloses personal financial information to a new category of nonaffiliated third party; or

(c) Discloses personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to indicate that the former customer does not want disclosure.

(3) A revised privacy notice under this rule shall be delivered according to OAR 836-080-0660.

(4) The prohibition in section (1) of this rule and the requirements of section (2) of this rule do not apply with respect to a revision of an initial notice, the sole purpose of which is to incorporate a notice of a disclosure of personal information for which authorization is not required by OAR 836-080-0670 or 836-080-0675.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0660
Delivery

(1) A licensee shall provide any notices required by OAR 836-080-0600 to 836-080-0700 so that each consumer can be reasonably expected to receive actual notice in writing or, if the consumer agrees, electronically.

(2) The following are examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(a) Hand-delivers a printed copy of the notice to the consumer;

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(3) The following are examples of unreasonable expectations of actual notice. A licensee may not reasonably expect that a consumer will receive actual notice of its privacy policies and practices if the licensee:

(a) Posts only a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(b) Sends the notice by electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(4) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(a) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(b) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(5) For customers only, a licensee shall provide the initial notice, annual notice and revised notice required by OAR 836-080-0600 to 836-080-0700 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically. The following are examples of retention and accessibility of notices. A licensee provides a privacy notice to a customer so that the customer can retain it or obtain it later if the licensee:

(a) Hand-delivers a printed copy of the notice to the customer;

(b) Mails a printed copy of the notice to the last known address of the customer; or

(c) Makes its current privacy notice available on a web site or a link to another web site for the customer who obtains an insurance product or services electronically and agrees to receive the notice at the web site.

(6) If two or more consumers jointly obtain a health insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements by providing one notice to those consumers jointly.

(7) A licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice for the purpose of OAR 836-080-0640(8) if the licensee:

(a) Provides a toll-free telephone number that the consumer may call to request the notice; or

(b) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand and provides a copy to the consumer immediately upon request.

(8) A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of another financial institution.

(9) A licensee may not provide any notice required by OAR 836-080-0600 to 836-080-0700 solely by orally explaining the notice, either in person or over the telephone.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

Disclosure of Personal, Privileged Information

836-080-0665
Authorization

(1) Except as provided in OAR 836-080-0670 and 836-080-0675, a licensee or insurance-support organization may not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is with the written authorization of the individual, and:

(a) If the authorization is submitted by another licensee or insurance-support organization, the authorization meets the requirements of this rule; or

(b) If the authorization is submitted by a person other than a licensee or insurance-support organization, the authorization is:

(A) Dated;

(B) Signed by the individual; and

(C) Obtained one year or less prior to the date a disclosure is sought pursuant to this subsection.

(2) A licensee or insurance-support organization may not use as its disclosure authorization form in connection with health insurance transactions a form or statement that authorizes the disclosure of personal or privileged information about an individual to the licensee or insurance-support organization unless the form or statement is clear and conspicuous, and contains all of the following:

(a) The identity of the individual who is the subject of the personal information.

(b) A general description of the categories of personal information to be disclosed.

(c) The signature of the individual who is the subject of the personal information or the individual who is legally empowered to grant authority and the date signed.

(3) An authorization may not remain valid for more than 24 months.

(4) An individual who is the subject of personal information may revoke an authorization provided pursuant to this rule at any time, subject to the rights of any individual who acted in reliance on the authorization prior to notice of the revocation.

(5) A licensee shall retain the authorization of an individual or a copy thereof in the record of the individual who is the subject of the personal information.

(6) This rule does not authorize the disclosure of personal or privileged information that is also individually identifiable health information when disclosure of the individually identifiable health information is prohibited or is otherwise regulated under the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

(7) A licensee is not required to comply with this rule with respect to a disclosure of personal information for which the licensee has obtained an authorization under the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0670
Authorization Exemptions

(1) A licensee or insurance-support organization may disclose personal or privileged information about an individual collected or received in connection with a health insurance transaction without obtaining the written authorization required by OAR 836-080-0665 if the disclosure meets one or more of the following conditions, in which a disclosure:

(a) Is reasonably necessary to enable a person other than the licensee or insurance support organization to:

(A) Perform a business, professional or insurance function for the disclosing licensee or insurance-support organization and the person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(i) Would otherwise be permitted by this rule if made by a licensee or insurance-support organization; or

(ii) Is reasonably necessary for the person to perform its function for the disclosing licensee or insurance-support organization.

(B) Provide information to the disclosing licensee or insurance-support organization for the purpose of:

(i) Determining an individual's eligibility for a health insurance benefit or payment; or

(ii) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with a health insurance transaction.

(b) Is to a licensee, insurance-support organization or self-insurer, if the information disclosed is limited to that which is reasonably necessary:

(A) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction; or

(B) For either the disclosing or receiving licensee or insurance-support organization to perform its function in connection with an insurance transaction involving the individual.

(c) Is to a medical care institution or medical professional and discloses only such information as is reasonably necessary to accomplish one or more of the following purposes:

(A) Verifying insurance coverage or benefits.

(B) Informing an individual of a medical problem of the individual, of which the individual may not be aware.

(C) Conducting an operations or services audit.

(d) Is required or authorized for compliance with federal, state or local laws, rules or other applicable legal requirements.

(e) Is required for compliance with a properly authorized civil, criminal or regulatory investigation or a subpoena or summons by a federal, state or local authority.

(f) Is required for response to judicial process or a government regulatory authority having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law.

(g) Is required for protection of the confidentiality or security of a licensee's records pertaining to the individual, service, product or transaction.

(h) Is required for institutional risk control or for resolving disputes or inquiries relating to the individual.

(i) Is to a person holding a legal or beneficial interest relating to the individual.

(j) Is to a person acting in a fiduciary or representative capacity on behalf of the individual.

(k) Is to provide information to an insurance rate advisory organization, a guaranty fund or agency, an agency that is rating a licensee, a person that is assessing the licensee's compliance with industry standards, or the licensee's attorneys, accountants and auditors.

(l) Is allowed or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.) to law enforcement agencies, but only to the extent that disclosure is specifically allowed or required, including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. (Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and transactions) and 12 U.S.C. Chapter 21 (Financial recordkeeping), a state insurance authority, and the federal Trade Commission), a self-regulatory organization or for an investigation on a matter related to public safety, or is otherwise specifically permitted or required by law.

(m) Meets any of the following conditions:

(A) It is necessary to effect, administer or enforce a transaction that an individual requests or authorizes, in that the disclosure is required or is a usual, appropriate or acceptable method of handling the transaction. The condition in this subparagraph has the meaning given in section 509 of the federal Gramm-Leach-Bliley Act (P.L. 106-102).

(B) It is in connection with treatment, payment or health care operations.

(C) It is in connection with servicing or processing an insurance product or service that an individual requests or authorizes.

(D) It is in connection with maintaining or servicing an individual's account with the licensee, a proposed or actual securitization, secondary market sale or similar transaction related a transaction of the individual.

(n) Is made for the purpose of conducting actuarial or research studies, if:

(A) No individual may be identified in any resulting actuarial or research report;

(B) Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and

(C) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by a licensee or insurance-support organization.

(o) Is to a party or a representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the licensee or insurance-support organization.

(p) Is to an affiliate whose only use of the information will be in connection with an audit of the licensee.

(q) Is to a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) or from a consumer report prepared by a consumer reporting agency.

(r) Is to a group policyholder for the purpose of reporting claims experience or conducting an audit of the licensee's operations or services, and the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

(s) Is to a licensee for purposes related to replacement of a group benefit plan, a group health plan or a group welfare plan.

(t) Is to a professional peer review organization for the purpose of reviewing the service or conduct of a medical care institution or medical professional.

(u) Is to a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable.

(v) Is to a policyholder or certificate holder, or an agent or other representative thereof, for the purpose of providing information regarding the status of a health insurance transaction.

(2) A licensee may disclose personal or privileged information to an affiliate in connection with the marketing of a financial product or service if the affiliate agrees not to disclose the information for any other purpose or to an unaffiliated persons except as authorized in section (1) of this rule. If a disclosure under this section is made for marketing a product or service other than the product or service of the disclosing licensee, individually identifiable health information may not be disclosed without the authorization required by OAR 836-080-0665.

(3) A licensee may disclose personal or privileged information to a nonaffiliated third party whose only use of the information will be pursuant to a joint marketing agreement for marketing of a product or service. As used in this subsection, "joint marketing agreement"

means a formal written contract pursuant to which an insurer jointly offers, endorses or sponsors a financial product or service with a financial institution. Information that may be disclosed under this subsection does not include individually identifiable health information, privileged information or personal information relating to an individual's character, personal habits, mode of living or general reputation, or any classification derived from such information, except as authorized in section (1) of this rule.

(4) A licensee or insurance support organization shall not disclose an access number or access code for an individual's policy or transaction account, whether directly or through an affiliate, to any nonaffiliate for use in telemarketing, direct mail marketing or other marketing through electronic mail to an individual, other than to a consumer reporting agency. This section does not apply if a licensee or insurance support organization discloses an access number or access code:

(a) To its service provider solely in order to perform marketing for its own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(b) To an insurance producer solely in order to perform marketing for its own products or services; or

(c) To a participant in an affinity or similar program where the participants in the program are identified to the individual when the individual enters into the program. An access number or access code does not include a number or code in an encrypted form, as long as the licensee or insurance support organization does not provide the recipient with a means to decode the number or code. For purposes of this subsection, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

(5) Personal or privileged information may be acquired by a group practice prepayment health care service contractor from providers that contract with the health care service contractor and may be transferred among providers that contract with the health care service contractor for the purpose of administering plans offered by the health care service contractor. The information may not be disclosed otherwise by the health care service contractor except in accordance with OAR 836-080-0670 or 836-080-0675.

(6) This rule does not authorize the disclosure of personal or privileged information that is also individually identifiable health information when disclosure of the individually identifiable health information is prohibited or is otherwise regulated under the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0675
Disclosure Without Authorization

Unless disclosure is otherwise permitted pursuant to OAR 836-080-0665 or 836-080-0670, a licensee may disclose personal financial information about an individual to a nonaffiliated third party without obtaining the written authorization required by OAR 836-080-0665 only if all of the following conditions are met:

(1) The nonaffiliated third party's only use of the information will be in connection with the marketing of a product or service.

(2) No information relating to an individual's character, personal habits, mode of living or general reputation may be disclosed, and no classification derived from such information may be disclosed.

(3) Prior to disclosure, the individual must have been given the notice described in OAR 836-080-0620 and, at the same time, an opportunity to decide whether to allow disclosure of the information by means of a clear and conspicuous notice that provides the following:

(a) That the licensee discloses or reserves the right to disclose personal financial information about the individual to a nonaffiliated third party;

(b) That the individual has the right to opt out of that disclosure; and

(c) A reasonable means by which the individual may exercise the opt out right.

(4) Disclosure of personal financial information that is also individually identifiable health information is not prohibited or otherwise regulated under the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0680
Opt in Notice; Form of Opt Out Notice to Consumers and Opt Out Methods for Purpose of OAR 836-080-0675

(1) Form of opt in notice. The form of the disclosure authorization (the opt in form) is governed by OAR 836-080-0665 and is used with respect to disclosures of personal information that do not meet one or more of the conditions specified in OAR 836-080-0670 or 836-080-0675.

(2) Form of opt out notice. Sections (2) to (10) of this rule govern the form of and requirements applicable to an opt out notice when the notice is required by OAR 836-080-0675. If a licensee is required to provide an opt out notice by OAR 836-080-0675, the licensee shall accurately explain the right to opt out under that provision. The notice shall state:

(a) That the licensee discloses or reserves the right to disclose personal financial information about its consumer to a nonaffiliated third party;

(b) That the consumer has the right to opt out of that disclosure; and

(c) A reasonable means by which the consumer may exercise the opt out right.

(3) The following are examples for purposes of section (2) of this rule:

(a) Adequate opt out notice. A licensee provides adequate notice that the consumer may opt out of the disclosure of personal financial information to a nonaffiliated third party if the licensee:

(A) Identifies all of the categories of personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information as permitted by OAR 836-080-0675, and states that the consumer may opt out of the disclosure of that information; and

(B) Identifies the health insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(b) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(A) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(B) Includes a reply form together with the opt out notice;

(C) Provides an electronic means to opt out, such as a form that can be sent by electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(D) Provides a toll-free telephone number that the consumers may call to opt out.

(c) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(A) The only means of opting out is for the consumer to write the consumer's own letter to exercise that opt out right; or

(B) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(d) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

(4) Same form as initial notice permitted. A licensee may provide the opt out notice for purposes of OAR 836-080-0675 together with or on the same written or electronic form as the initial notice the licensee provides in accordance with OAR 836-080-0636.

(5) Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with OAR 836-080-0636, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(6) The following provisions of this section govern joint relationships:

(a) If two or more consumers jointly obtain a health insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the

licensee will treat an opt out direction by a joint consumer as explained in subsection (e) of this section.

(b) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(A) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(B) Permit each joint consumer to opt out separately.

(c) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(d) A licensee may not require all joint consumers to opt out before the licensee implements any opt out direction.

(e) The following is an example for purposes of this section. If John and Mary are both named policyholders on a health insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but the licensee shall explain in the opt out notice of notice of the licensee which opt out policy the licensee will follow:

(A) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(B) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(C) Permit John and Mary to make different opt out directions. If the licensee does so:

(i) The licensee shall permit John and Mary to opt out for each other;

(ii) If both opt out, the licensee shall permit both of them to notify the licensee in a single response, such as on a form or through a telephone call; and

(iii) If John opts out and Mary does not, the licensee may disclose personal financial information only about Mary but not about John, and not about John and Mary jointly.

(7) Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives the direction.

(8) Continuing right to opt out. A consumer may exercise the right to opt out at any time.

(9) The duration of a consumer's opt out direction is governed as follows:

(a) A consumer's direction to opt out under this rule is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(b) When a customer relationship terminates, the customer's opt out direction continues to apply to the personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(10) Delivery. When a licensee is required to deliver an opt out notice by this rule, the licensee shall deliver it according to OAR 836-080-0660.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0685
Limits on Sharing Account Number Information for Marketing Purposes

(1) General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, other than to a consumer reporting agency, disclose a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

(2) Exceptions. Section (1) of this rule does not apply if a licensee discloses a policy number or similar form of access number or access code:

(a) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(b) To a licensee who is an insurance producer solely in order to perform marketing for the licensee's own products or services; or

(c) To a participant in an affinity or similar program when the participants in the program are identified to the customer when the customer enters into the program.

(3) The following are examples for purposes of this rule:

(a) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(b) Policy or transaction account. For the purpose of this rule, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

(4) Violation of this section is an unfair trade practice for purposes of ORS 746.240.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600, 746.240 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0690
Authorization Request Delivery

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of a notice under OAR 836-080-0615, 836-080-0620 or 836-080-0625 if the request and the authorization form are clear and conspicuous.

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0695
Access to Recorded Personal Information

(1) If an individual or personal representative of an individual, after proper identification, submits a written request to an insurer, insurance producer or insurance-support organization for access to recorded personal information about the individual that is reasonably described by the individual and reasonably locatable and retrievable by the insurer, insurance producer or insurance-support organization, the insurer, insurance producer or insurance-support organization within 30 business days from the date the request is received shall:

(a) Inform the individual of the nature and substance of the recorded personal information in writing, by telephone or by other oral communication, whichever the insurer, insurance producer or insurance-support organization prefers;

(b) Permit access to inspect or obtain a copy of the individual's personal financial information or protected health information that is maintained in a designated record set about the individual; and

(c) Provide the individual with a summary of the procedures by which the individual may request correction, amendment or deletion of recorded personal information.

(2) Any personal information provided pursuant to this section must identify the source of the information if the source is an institutional source.

(3) If an individual requests individually identifiable health information supplied by a health care provider, the insurer, insurance producer or insurance-support organization shall provide the information, including the identity of the health care provider either directly to the individual or to a health care provider designated by the individual and licensed to provide health care with respect to the condition to which the information relates, whichever the insurer, insurance producer or insurance-support organization prefers. If the insurer, insurance producer or insurance-support organization elects to disclose the information to a health care provider designated by the individual, the insurer, insurance producer or insurance-support organization shall notify the individual, at the time of the disclosure, that the insurer, insurance producer or insurance-support organization has provided the information to the health care provider.

(4) Except for personal information provided under ORS 746.650, an insurer, insurance producer or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to an individual.

(5) The obligations imposed by this rule upon an insurer or insurance producer may be satisfied by another insurer or insurance producer authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request

under this rule, an insurer, insurance producer or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

(6) The rights granted to individuals by this rule shall extend to all natural persons to the extent information about them is collected and maintained by an insurer, insurance producer or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this section does not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or a civil or criminal proceeding involving them.

(7) This rule does not authorize the disclosure of individually identifiable health information when the disclosure is prohibited or is otherwise regulated under the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

(8) For purposes of this rule, the term ' insurance-support organization' does not include 'consumer reporting agency.'

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

836-080-0700
Correction, Amendment or Deletion of Recorded Personal Information

(1) Within 30 business days from the date of receipt of a written request from an individual to correct, amend or delete any recorded personal information about the individual within its possession, an insurer, insurance producer or insurance-support organization shall either:

(a) Correct, amend or delete the portion of the recorded personal information in dispute; or

(b) Notify the individual of:

(A) Its refusal to make the correction, amendment or deletion;

(B) The reasons for the refusal; and

(C) The individual's right to file a statement as provided in subsection (3) of this section.

(2) If the insurer, insurance producer or insurance-support organization corrects, amends or deletes recorded personal information in accordance with section (1) of this rule, the insurer, insurance producer or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment or fact of deletion to:

(a) Each person specifically designated by the individual who may have, within the preceding two years, received the recorded personal information;

(b) Each insurance-support organization whose primary source of personal information is insurers, if the insurance-support organization has systematically received recorded personal information from the insurer within the preceding seven years. However, the correction, amendment or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and

(c) Each insurance-support organization that furnished the recorded personal information that has been corrected, amended or deleted.

(3) Whenever an individual disagrees with an insurer's, insurance producer's or insurance-support organization's refusal to correct, amend or delete recorded personal information, the individual shall be permitted to file with the insurer, insurance producer or insurance-support organization:

(a) A concise statement setting forth what the individual thinks is the correct, relevant or fair information; and

(b) A concise statement of the reasons why the individual disagrees with the insurer's, insurance producer's or insurance-support organization's refusal to correct, amend or delete recorded personal information.

(4) In the event an individual files either or both of the statements described in section (3) of this rule, the insurer, insurance producer or insurance-support organization shall:

(a) File the statements with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statements and have access to them;

(b) In any subsequent disclosure by the insurer, insurance producer or insurance-support organization of the recorded personal information that is the subject of the disagreement, clearly identify the matter or matters in dispute and provide the individual's statements along with the recorded personal information being disclosed; and

(c) Furnish the statements to the persons and in the manner specified in section (2) of this rule.

(5) The rights granted to individuals by this rule extends to all natural persons to the extent information about them is collected and maintained by an insurer, insurance producer or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this rule does not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or a civil or criminal proceeding involving them.

(6) For purposes of this rule, the term "insurance-support organization" does not include "consumer reporting agency."

Stat. Auth.: ORS 731.244 & 746.608
Stats. Implemented: ORS 746.600 & 746.607
Hist.: ID 4-2005, f. & cert. ef. 4-1-05

DIVISION 81

TRADE PRACTICES — GENERAL PROVISIONS

836-081-0005
Statutory Authority; Purpose; Definitions

(1) OAR 836-081-0005 and 836-081-0010 are adopted by the Director of the Department of Consumer and Business Services pursuant to the general rulemaking authority in ORS 731.244.

(2) OAR 836-081-0005 and 836-081-0010 identify particular practices that make an unfair discrimination in the availability of insurance, in violation of ORS 746.015. OAR 836-081-0005 and 836-081-0010 do not limit the Director's authority to determine that other practices relating to insurance availability are unfairly discriminatory.

(3) OAR 836-081-0005 and 836-081-0010 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 746nfair discrimination in the application of rates is prohibited.

(4) OAR 836-081-0005 and 836-081-0010 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.

(5) For the purpose of OAR 836-081-0005 and 836-081-0010:

(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 731 & 746
Stats. Implemented: ORS 746.015(1)
Hist.: IC 2-1978, f. 5-22-78, ef. 6-1-78; ID 19-2006, f. & cert. ef. 9-26-06

836-081-0010
Unfair Discrimination — Insurance Other than Life or Health Insurance

(1) An insurer decision on the availability of insurance for an individual, other than life or health insurance, that is based on any of the following characteristics is considered to be 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 the lack is in violation of law.

(2) An insurer may use a combination of the characteristics described in paragraphs (h) to (j) of section (1) of this rule as a basis for a decision under section (1) of this rule only if the combination significantly increases the degree of hazard.

Stat. Auth.: ORS 731 & 746
Stats. Implemented: ORS 746.015(1)
Hist.: IC 2-1978, f. 5-22-78, ef. 6-1-78; ID 19-2006, f. & cert. ef. 9-26-06

Unfair Discrimination on the Basis of Blindness or Partial Blindness

836-081-0020
Statutory Authority; Purpose; Applicability

(1) OAR 836-081-0020 and 836-081-0030 are adopted pursuant to the general rulemaking authority of the Director of the Department of Consumer and Business Services 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 blind or partially blind members of the insurance-buying public from unfair discrimination by insurers by identifying specific acts or practices that are prohibited by ORS 746.015(2) when an insurer engages in one or more of them 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 731
Stats. Implemented: ORS 746.015(2)
Hist.: IC 1-1985, f. & ef. 2-1-85;ID 19-2006, f. & cert. ef. 9-26-06

836-081-0030
Unfair Discrimination Acts or Practices

(1) The following acts and practices constitute unfair discrimination between individuals of the same class when an insurer engages in one or more of them solely because of blindness or partial blindness of an individual:

(a) Refusing to insure, or refusing to continue to insure, the individual; or

(b) Limiting the amount, extent or kind of coverage available to the individual or

(c) Charging the individual a different rate for the same coverage.

(2) For purposes of section (1) of this rule:

(a) 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.

(b) 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 eyesight.

(c) 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 731
Stats. Implemented: ORS 746.015(2)
Hist.: IC 1-1985, f. & ef. 2-1-85; ID 19-2006, f. & cert. ef. 9-26-06

Standards for Safeguarding Customer Information

836-081-0101
Purpose, Policy, Authority and Effective Date

(1) OAR 836-081-0101 to 836-081-0126 are adopted by the Director of the Department of Consumer and Business Services under the authority of ORS 731.244 for the purpose of implementing:

(a) ORS 746.240, relating to trade practices found by the Director to be an unfair or deceptive act or practice in the transaction of insurance that is injurious to the insurance-buying public; and

(b) ORS 746.670, relating to the Director's authority to examine and investigate into the affairs of an insurer, agent or insurance support organization in order to determine whether any of those entities is violating or has violated any provision of ORS 746.600 to 746.690, governing the use and disclosure of insurance information.

(2) OAR 836-081-0101 to 836-081-0126 establish standards for developing and implementing administrative, technical and physical safeguards to protect the security, confidentiality and integrity of customer information, pursuant to Sections 501, 505(b), and 507 of the Gramm-Leach-Bliley Act, codified at 15 U.S.C. 6801, 6805(b) and 6807, as follows:

(a) Section 501(a) provides that it is the policy of the Congress that each financial institution has an affirmative and continuing obligation to respect the privacy of its customers and to protect the security and confidentiality of those customers' nonpublic personal information. Section 501(b) requires the state insurance regulatory authorities to establish appropriate standards relating to administrative, technical and physical safeguards:

(A) To ensure the security and confidentiality of customer records and information;

(B) To protect against any anticipated threats or hazards to the security or integrity of such records; and

(C) To protect against unauthorized access to or use of records or information that could result in substantial harm or inconvenience to a customer.

(b) Section 503(a)(3) requires each financial institution to develop policies for protecting the nonpublic personal information of consumers, and to make those policies available in written form.

(c) Section 505(b)(2) calls on state insurance regulatory authorities to implement the standards prescribed under Section 501(b) by regulation with respect to persons engaged in providing insurance.

(d) Section 507 provides, among other things, that a state regulation may afford persons greater privacy protections than those provided by subtitle A of Title V of the Gramm-Leach-Bliley Act. The safeguards established pursuant to OAR 836-081-0101 to 836-081-0126 apply to nonpublic personal information, including financial information and health information.

(3) Each licensee shall establish and implement an information security program, including appropriate policies and systems pursuant to OAR 836-081-0101 to 836-081-0126.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240 & 746.670
Hist.: ID 2-2003, f. & cert. ef. 3-17-03; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

836-081-0106
Definitions

For purposes of OAR 836-081-0101 to 836-081-0126, the following definitions apply:

(1) "Customer" means a customer of the licensee as the term "customer" is defined in ORS 746.600(10).

(2) "Customer information" means personal information as defined in ORS 746.600 about a customer, whether in paper, electronic or other form, that is maintained by or on behalf of the licensee.

(3) "Customer information systems" means the electronic or physical methods used to access, collect, store, use, transmit, protect or dispose of customer information.

(4) "Licensee" means a licensee as that term is defined in ORS 746.600, except that "licensee" does not include a purchasing group or an unauthorized insurer in regard to surplus lines business conducted pursuant to ORS 735.400 to 735.495.

(5) "Service provider" means a person that maintains, processes or otherwise is permitted access to customer information through its provision of services directly to the licensee.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240 & 746.670
Hist.: ID 2-2003, f. & cert. ef. 3-17-03

836-081-0111
Information Security Program

(1) Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information. The administrative, technical and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

(2) If a licensee is domiciled in another jurisdiction or subject to the primary jurisdiction of a different functional regulator, and the statutes and rules administered by its domiciliary regulator or primary functional regulator establish standards for protecting the security of

consumer information that are substantially similar to those established by OAR 836-081-0101 to 836-081-0126, then good faith compliance with those standards to the satisfaction of the licensee's primary regulator shall constitute compliance with OAR 836-081-0101 to 836-081-0126.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240 & 746.670
Hist.: ID 2-2003, f. & cert. ef. 3-17-03

836-081-0116
Objectives of Information Security Program

A licensee's information security program shall be designed to:

(1) Ensure the security and confidentiality of customer information;

(2) Protect against any anticipated threats or hazards to the security or integrity of the information; and

(3) Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240 & 746.670
Hist.: ID 2-2003, f. & cert. ef. 3-17-03

836-081-0121
Examples of Methods of Development and Implementation

The actions and procedures described in this rule are examples of methods of implementation of the requirements of OAR 836-081-0111 and 836-081-0116. These examples are nonexclusive illustrations of actions and procedures that licensees may follow to implement OAR 836-081-0111 and 836-081-0116. The examples are as follows:

(1) Assessing risk. The licensee:

(a) Identifies reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration or destruction of customer information or customer information systems;

(b) Assesses the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and

(c) Assesses the sufficiency of policies, procedures, customer information systems and other safeguards in place to control risks.

(2) Managing and controlling risk. The licensee:

(a) Designs its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;

(b) Trains staff, as appropriate, to implement the licensee's information security program; and

(c) Regularly tests or otherwise regularly monitors the key controls, systems and procedures of the information security program. The frequency and nature of these tests or other monitoring practices are determined by the licensee's risk assessment.

(3) Overseeing service provider arrangements. The licensee:

(a) Exercises appropriate due diligence in selecting its service providers; and

(b) Requires its service providers to implement appropriate measures designed to meet the objectives of this regulation, and, where indicated by the licensee's risk assessment, takes appropriate steps to confirm that its service providers have satisfied these obligations.

(4) Adjusting the program. The licensee monitors, evaluates and adjusts, as appropriate, the information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to customer information systems.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240 & 746.670
Hist.: ID 2-2003, f. & cert. ef. 3-17-03

836-081-0126
Unfair Insurance Trade Practice

Violation of any provision of OAR 836-081-0101 to 836-081-0126 is an unfair trade practice for purposes of ORS 746.240.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.240
Hist.: ID 2-2003, f. & cert. ef. 3-17-03

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 731, 742 & 746
Stats. Implemented: ORS 742.005(3) - 742.005(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 731, 742 & 746
Stats. Implemented: ORS 742.005(3) - 742.005(4) & 746.0015(1)
Hist.: ID 13-1990, f. 6-12-90, cert. ef. 7-1-90

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 insurance producers 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 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 insurance producer 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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
Long-term 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 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 insurance producer, 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 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 insurance producer 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 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 insurance producer, 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 insurance producer 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 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; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

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 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 731 & 742
Stats. Implemented: ORS 742.702
Hist.: ID 8-1990, f. & cert. ef. 5-4-90

Practices Injurious to Public or Free Competition

836-085-0201
Statutory Authority; Purpose; Applicability

(1) OAR 836-085-0201 to 836-085-0230 are adopted pursuant to the specific authority of 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 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.

Stat. Auth.: ORS 731 & 737
Stats. Implemented: ORS 737.322(2) & 746.240
Hist.: ID 3-1988, f. & cert. ef. 1-20-88; ID 6-2005, f. & cert. ef. 4-7-05

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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 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 or produced by an insurer that produces its individual employer experience rating modification factors pursuant to OAR 836-042-0015 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 or produced by an insurer that produces its individual employer experience rating modification factors pursuant to OAR 836-042-0015 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 or subsequent anniversary rating date of the policy. However, the insurer shall provide written notice of the inapplicable experience rating modification to the employer.

(4) Notwithstanding sections (1), (2), and (3) of this rule, any employer experience rating modification factors received by the insurer from the rating organization or produced by an insurer that produces its individual employer experience rating modification factors pursuant to OAR 836-042-0015 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 Division 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 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; ID 19-1997(Temp), f. 12-23-97, cert. ef. 1-1-98 thru 6-22-98; ID 9-1998, f. & cert. ef. 7-28-98

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 Admin-

istrator 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 731 & 737
Stats. Implemented: ORS 737.322(2) & 746.240
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 836-042-0045 constitutes an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 731 & 737
Stats. Implemented: ORS 737.322(2) & 746.240
Hist.: ID 3-1988, f. & cert. ef. 1-20-88; ID 6-2005, f. & cert. ef. 4-7-05

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 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

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, or 646.267(6).

(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 contract 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; ID 18-2006, f. & cert. ef. 9-8-06

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) A registrant or applicant that maintains a net worth or shareholders' equity of at least $100,000,000 but who is not required to file a Form 10-K with the Securities and Exchange Commission may file a copy of the obligor's most recently audited annual financial statements to satisfy the requirement of ORS 646.267(5)(a), instead of the Form 10-K, Form 20-F or Form 40-F of its parent company or the filing described in section (3) of this rule. A registrant or applicant that substitutes an audited annual financial statement for a Form 10-K shall file a copy of its most recent audited annual financial statement annually with the director. The copy of the annual financial statements filed under this section shall be considered to be signed by a person who was authorized by the registrant or applicant to sign the agreement.

(9) 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.

(10) If a registrant goes out of business or if the registration of a registrant expires or is suspended or revoked:

(a) 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.

(b) A registrant that is qualified under section (8) of this rule continues to be responsible for all obligations of the registrant that are still outstanding.

(11) 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.

(12) A registrant or applicant that is qualified under section (8) of this rule shall 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; ID 21-2002f. & cert. ef. 10-30-02

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

Collision Damage Waiver Notice

836-200-0100
Notice, Collision Damage Waivers

For purposes of ORS 646.859, which provides that an auto rental agency offering collision damage waivers shall post a sign approved by the Department, the Department shall consider a sign approved if the sign meets the following requirements:

(1) The sign must state the following in bold type that is at least 1.25 inches high:

OUR CONTRACTS OFFER OPTIONAL COLLISION DAMAGE WAIVERS
AT AN ADDITIONAL COST.

(2) The sign must be posted in the place of business of the auto rental agency in a location that is conspicuous to the public.

Stat. Auth.: ORS 705.135
Stats. Implemented: ORS 646.859
Hist.: IF 8-1989, f. 11-6-89, cert. ef. 12-11-89; Renumbered from 440-010-0001, ID 17-2006, f. & cert. ef. 8-11-06