CALIFORNIA INSURANCE CODE

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INSURANCE CODE
SECTION 1-48

1. This act shall be known as the Insurance Code.

2. The provisions of this code in so far as they are substantially the same as existing statutory provisions relating to the same

subject matter shall be construed as restatements and continuations thereof, and not as new enactments.

3. All persons who, at the time this code goes into effect, hold office under any of the acts repealed by this code, which offices are continued by this code, continue to hold the same according to the former tenure thereof.

4. No action or proceeding commenced before this code takes effect, and no right accrued, is affected by the provisions of this code, but all procedure thereafter taken therein shall conform to the provisions of this code so far as possible.

5. Unless the context otherwise requires, the general provisions hereinafter set forth shall govern the construction of this code.

6. Division, part, chapter, article, and section headings contained herein shall not be deemed to govern, limit, modify or in any manner affect the scope, meaning, or intent of the provisions of any division, part, chapter, article, or section hereof.

7. Whenever, by the provisions of this code, a power is granted to a public officer or a duty imposed upon such an officer, the power may be exercised or the duty performed by a deputy of the officer or by a person authorized pursuant to law by the officer, unless it is expressly otherwise provided.

8. Writing includes any form of recorded message capable of comprehension by ordinary visual means. Whenever any notice, report, statement or record is required or authorized by this code, it shall be made in writing in the English language unless it is otherwise expressly provided.

9. Whenever any reference is made to any portion of this code or of any other law of this State, such reference shall apply to all amendments and additions thereto now or hereafter made.

10. "Section" means a section of this code unless some other statute is specifically mentioned and "subdivision" or "subsection" means a subdivision or subsection of the section in which that term occurs unless some other section is expressly mentioned.

11. The present tense includes the past and future tenses; and the future, the present.

12. The masculine gender includes the feminine and neuter.

13. The singular number includes the plural, and the plural the singular.

14. "County" includes "city and county."

15. "City" includes "city and county."

16. As used in this code the word "shall" is mandatory and the word "may" is permissive, unless otherwise apparent from the context.

17. "Oath" includes affirmation.

18. "Signature" or "subscription" includes mark when the signer or subscriber can not write, such signer's or subscriber's name being written near the mark by a witness who writes his own name near the signer's or subscriber's name; but a signature or subscription by mark can be acknowledged or can serve as a signature or subscription to a sworn statement only when two witnesses so sign their own names thereto.

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

20. "Commissioner" means the Insurance Commissioner of this State.

20.5. Whenever in this code the terms "State Industrial AccidentCommission" or "Industrial Accident Commission" or "commission,"relating to the said "State Industrial Accident Commission" or thesaid "Industrial Accident Commission," appear, said terms shall mean"Division of Industrial Accidents," including "administrative director" of said division or "appeals board," or both, as thecontext may require.

21. "Division," and "department," in reference to the government ofthis state, mean the Department of Insurance of this state.

21.5. (a) "Administrative law bureau" or "administrative hearing bureau" means the unit within the Department of Insurance that provides administrative hearings.

(b) An administrative law judge appointed by the commissioner

pursuant to civil service rules shall be employed within the administrative law bureau and shall not be supervised directly by the commissioner or supervised directly or indirectly by an employee in the legal branch of the department.

22. Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.

23. The person who undertakes to indemnify another by insurance is the insurer, and the person indemnified is the insured.

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

25. "Nonadmitted," in relation to a person, means not entitled to transact insurance business in this State, whether by reason of failure to comply with conditions precedent thereto, or by reason of inability so to comply.

26. "Domestic" means organized under the laws of this State, whether or not admitted.

27. "Foreign" means not organized under the laws of this State, whether or not admitted.

28. "State" means the State of California, unless applied to the different parts of the United States. In the latter case, it includes the District of Columbia, the commonwealths and the territories.

29. "Mortgage" includes a trust deed, "mortgagor" includes a trustor under such trust deed, "mortgagee" includes a beneficiary under such trust deed, or a trustee exercising powers or performing duties granted to or imposed upon him thereunder, and "lien" in respect to real or personal property includes a charge or incumbrance arising out of a trust deed.

30. "Resident" means residing in this State, "nonresident" means not residing in this State.

31. "Insurance agent" means a person authorized, by and on behalf of an insurer, to transact all classes of insurance other than life insurance.

An insurance agent is also authorized to transact 24-hour care coverage, as defined in Section 1749.02.

32. A life agent means an insurance agent authorized, by and on behalf of a life, disability or life and disability insurer, to transact life, disability or life and disability insurance.

A life agent may be authorized to transact 24-hour care coverage, as defined in Section 1749.02, pursuant to the requirements of subdivision (b) of Section 1749 or subdivision (h) of Section 1749.3.

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

33. "Insurance broker" means a person who, for compensation and on behalf of another person, transacts insurance other than life with, but not on behalf of, an insurer.

33.5. "Fire and casualty broker-agent" means a person licensed pursuant to Section 1625.

34. "Insurance solicitor" means a natural person employed to aid a fire and casualty broker-agent acting as an insurance agent or insurance broker in transacting insurance other than life.

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

(a) Solicitation.

(b) Negotiations preliminary to execution.

(c) Execution of a contract of insurance.

(d) Transaction of matters subsequent to execution of the contract and arising out of it.

36. "Paid-in capital" or "capital paid-in" means:

(a) In the case of a foreign mutual insurer not issuing or having outstanding capital stock, the value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks as provided by law. Such foreign mutual insurer shall not be admitted, however, unless its paid-in capital is composed of available cash assets amounting to at least two hundred thousand dollars ($200,000.00).

(b) In the case of a foreign joint stock and mutual insurer, its paid-in capital computed, according to its desire, pursuant to the provisions of subdivision (a) or subdivision (c) of this section. If computed pursuant to the provisions of subdivision (a), its admission is subject to the qualification therein expressed.

(c) In the case of all other insurers, the lower of the following amounts:

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

(2) The aggregate par value of its issued shares of stock,

including treasury shares.

For the purpose of computing paid-in capital or capital paid-in, shares of stock are not taken as liabilities.

37. Provisions of this code relating to a particular class of insurance or a particular type of insurer prevail over provisions relating to insurance in general or insurers in general.

38. Unless expressly otherwise provided, any notice required to be given to any person by any provision of this code may be given by mailing notice, postage prepaid, addressed to the person to be notified, at his residence or principal place of business in this State. The affidavit of the person who mails the notice, stating the facts of such mailing, is prima facie evidence that the notice was thus mailed.

39. If any provision of this code, or the application thereof to any person or circumstance, is held invalid, the remainder of the code, or the application of such provision to other persons or circumstances, shall not be affected thereby.

40. The existence of insurers formed prior to the date this code takes effect shall not be affected by the enactment of this code nor by any repeal of the laws under which they were formed, but such insurers shall thereafter operate under the provisions of this code.

41. All insurance in this State is governed by the provisions of this code.

42. The designation of insurance coverage as "group" in any code or law of this State other than this code does not authorize its

representation as a group coverage or as a group policy, certificate or contract by any person licensed or certificated by the commissioner unless the policy providing the coverage is defined as group insurance by a specific provision of this code or of the laws of the state in which the policy, certificate or contract is issued. This section shall apply only to life, disability and workmen's compensation insurance.

44. Any person who willfully and knowingly makes, circulates, or transmits to another any false written or printed statement for the purpose of damaging the financial condition or stability of any insurance company doing business in this state is guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000).

45. (a) "Electronic funds transfer" means any transfer of funds, other than a transaction originated by check, draft, or similar paper instrument, that is initiated through an electronic terminal, telephonic instrument, or computer or magnetic tape, so as to order, instruct, or authorize a financial institution to debit or credit an account. Electronic funds transfer shall be accomplished by an automated clearinghouse debit, an automated clearinghouse credit, a Federal Reserve Wire Transfer (Fedwire), or an international funds transfer, at the option of the insurer.

(b) For purposes of this section:

(1) "Automated clearinghouse" means any federal reserve bank, or an organization established by agreement with the National Automated Clearing House Association, that operates as a clearinghouse for transmitting or receiving entries between banks or bank accounts and that authorizes an electronic transfer of funds between those banks or bank accounts.

(2) "Automated clearinghouse debit" means a transaction in which any department of the state, through its designated depository bank, originates an automated clearinghouse transaction debiting the taxpayer's bank account and crediting the state's bank account for the amount of tax. Banking costs incurred for the automated clearinghouse debit transaction by the taxpayer shall be paid by the state.

(3) "Automated clearinghouse credit" means an automated clearinghouse transaction in which the taxpayer, through its own bank, originates an entry crediting the state's bank account and

debiting its own bank account. Banking costs incurred by the state for the automated clearinghouse credit transaction may be charged to the taxpayer.

(4) "Fedwire" means any transaction originated by the taxpayer and utilizing the national electronic payment system to transfer funds through federal reserve banks, pursuant to which the taxpayer debits its own bank account and credits the state's bank account. Electronic funds transfers may be made by Fedwire only if prior approval is obtained from the department and the taxpayer is unable, for reasonable cause, to make payments pursuant to paragraph (2) or (3). Banking costs charged to the taxpayer and to the state may be charged to the taxpayer.

(5) "International funds transfer" means any transaction originated by the taxpayer and utilizing "SWIFT," the international electronic payment system to transfer funds in which the taxpayer debits its own bank account, and credits the funds to a United States bank that credits the state's bank account. Banking costs charged to the taxpayer and to the state may be charged to the taxpayer.

46. The Legislature hereby declares its intent that the term "workmen's compensation" shall hereafter also be known as "workers' compensation." In furtherance of this policy it is the desire of the Legislature that references to the term "workmen's compensation" in this code be changed to "workers' compensation" when such code sections are being amended for any purpose. This act is declaratory and not amendatory of existing law.

47. "Surplus line broker" means a person licensed under Section 1765 and authorized to do business under Chapter 6 (commencing with Section 1760) of Part 2 of Division 1.

48. A "surplus line broker certificate" means a certificate issued by a surplus line broker to an insurance purchaser as evidence of the placement of insurance with an eligible nonadmitted insurer in accordance with the requirements of Sections 1764, 1764.1, and 1764.2.

INSURANCE CODE
SECTION 100-124

100. Insurance in this state is divided into the following classes:

(1) Life
(2) Fire
(3) Marine
(4) Title
(5) Surety
(6) Disability
(7) Plate glass
(8) Liability
(9) Workmen's compensation
(10) Common carrier liability
(11) Boiler and machinery
(12) Burglary
(13) Credit
(14) Sprinkler
(15) Team and vehicle
(16) Automobile
(17) Mortgage
(18) Aircraft
(19) Mortgage guaranty
(19.5) Insolvency
(19.6) Legal insurance
(20) Miscellaneous

101. Life insurance includes insurance upon the lives of persons or appertaining thereto, and the granting, purchasing, or disposing of annuities.

102. Fire insurance includes:

(a) Insurance against loss by fire, lightning, windstorm, tornado, or earthquake.

(b) Insurance against loss of, or destruction of, or damage to, any of the following property, when such insurance includes loss thereof by fire and excludes coverage of property while in the custody of, or possession of, or being transported by, any carrier

for hire or in the mail:

1. Accounts, books, maps, manuscripts, indexes and other valuable papers, documents and records incidental to the business or profession or activity in which the insured is engaged, resulting from any cause, but excluding any article constituting stock in trade or used as a sample or sold or held for sale.

2. Moneys, stamps, coins, bullion, securities, notes, drafts, acceptances or instruments of like kind or character, resulting from any cause, except:

(i) Forgery.

(ii) Any dishonest, fraudulent or criminal act of any officer, employee, partner, director, trustee or authorized representative of the insured.

(c) Insurance by means of an all-risk policy of the type commonly known as the "Personal Property Floater" against any and all kinds of loss of or damage to, or loss of use of, any personal property other than merchandise.

The provisions of Section 2070 shall not apply to insurance written pursuant to subdivisions (b) or (c).

103. Marine insurance includes insurance against any and all kinds of loss of or damage to:

(a) Vessels, craft, aircraft, cars, automobiles and vehicles of every kind (excluding aircraft and automobiles operating under their own power or while in storage not incidental to transportation), as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, money, bullion, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property, and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same, or during any delays, storage, transshipment, or reshipment incident thereto including marine builder's risks, and all personal property floater risks.

(b) Person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance including liability for loss of or damage arising out of or in connection with the construction, repair, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds);

but except as herein specified, shall not mean insurances against loss by reason of bodily injury to the person. Inland marine insurance shall be deemed to include hull insurance on water pleasure craft not used for commercial purposes of a size and type to be determined by the commissioner.

(c) Precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise.

104. Title insurance means insuring, guaranteeing or indemnifying owners of real or personal property or the holders of liens or encumbrances thereon or others interested therein against loss or damage suffered by reason of:

(a) Liens or encumbrances on, or defects in the title to said property;

(b) Invalidity or unenforceability of any liens or encumbrances thereon; or

(c) Incorrectness of searches relating to the title to real or personal property.

105. Surety insurance includes:

(a) The guaranteeing of behavior of persons and the guaranteeing of performance of contracts (including executing or guaranteeing bonds and undertakings required or permitted in all actions or proceedings or by law allowed), other than insurance policies and other than for payments secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate.

(b) Insurance against loss resulting from the forgery or alteration of any instrument of any kind or character or of any signature thereon. Nothing in this section shall be deemed to limit any of the powers of title insurers.

(c) Any of the following insurance when included as a part of contract containing any such guarantee of behavior or performance or in a contract indemnifying any bank, banker, broker, financial or moneyed corporation or association, any state, political subdivision, public or municipal corporation, or any officer of any state, political subdivision, public or municipal corporation: Insurance indemnifying the insured named therein against loss or destruction from any cause of any evidences of debt of any kind or character, evidences of ownership of any kind or character, deeds, mortgages, warehouse receipts, bills of lading, certificates of stock, bonds,

notes, drafts, checks, instruments of similar character, stamps, documents, money, precious metals of any kind or character, refined or unrefined, and articles made therefrom, jewelry, watches, necklaces, bracelets, gems and precious and semiprecious stones, and also against loss or damage, except by fire, to the insured's premises, furnishings, fixtures, equipment, safes and vaults therein caused by burglary, robbery, holdup, theft or larceny or attempt thereat. No such insurance indemnifying against loss of any property as specified herein shall indemnify against loss of any such property occurring while in the mail or in the exclusive custody or possession of a common carrier for the purpose of transportation, except for the purpose of transportation by an armored motor vehicle.

(d) No insurance may be written as surety insurance if it falls within the definition of financial guaranty insurance as set forth in Section 12100.

106. (a) Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

(b) In statutes that become effective on or after January 1, 2002, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The term "health insurance" shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

107. Plate glass insurance includes insurance against breakage of glass.

108. Liability insurance includes:

(a) Insurance against loss resulting from liability for injury, fatal or nonfatal, suffered by any natural person, or resulting from liability for damage to property, or property interests of others but does not include worker's compensation, common carrier liability, boiler and machinery, or team and vehicle insurance.

(b) (1) With respect to operations or property covered by a policy of liability insurance as defined in subdivision (a), insurance of medical, hospital, surgical and funeral loss or expense of the insured or other persons injured, and in the case of an automobile liability policy disability benefits to the insured or other persons injured and in the event of their death, funeral and accidental death benefits to their dependents, beneficiaries or personal representatives irrespective of legal liability of the insured, when issued with or supplemental to the insurance defined in subdivision (a);

(2) When issued with or supplemental to the insurance defined in subdivision (a), disability insurance covering the insured and members of his household, or other persons who customarily operate any automobile covered by such a policy and who are named in such policy; and such disability insurance may cover against accidental injury, death or dismemberment caused by any or all hazards as defined in such coverage;

(c) Insurance covering injuries sustained by an insured resulting from a tort committed by a third party against which such third party is not himself covered by liability insurance;

(d) Insurance coverage against the legal liability of the insured, and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional services by any person who holds a certificate or license issued pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, a license issued pursuant to the Osteopathic Initiative Act, or license as a community clinic defined in subdivision (a) of Section 1203 of the Health and Safety Code, or a license as a health facility pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(e) The provisions of this code relating to disability insurance do not apply to insurance defined in this section.

108.1. Insurers admitted to transact liability insurance are also deemed to be admitted to transact workers' compensation insurance for the purpose of covering those persons defined as employees of subdivision (d) of Section 3351 of the Labor Code.

109. Workmen's compensation insurance includes insurance against loss from liability imposed by law upon employers to compensate employees and their dependents for injury sustained by the employees arising out of and in the course of the employment, irrespective of negligence or of the fault of either party.

110. Common carrier liability insurance includes insurance against loss resulting from liability of a common carrier for accident or injury, fatal or nonfatal, to any person but does not include liability or workmen's compensation insurance.

111. Boiler and machinery insurance includes insurance against loss of property and liability for damage to persons or property from explosion of, or accident to, boilers, tanks, pipes, pressure vessels, engines, wheels, electrical machinery, or apparatus connected therewith or operating thereby.

112. Burglary insurance includes:

(a) Insurance against loss by burglary or theft or both.

(b) Insurance against loss of, or destruction of, or damage to, any of the following property, resulting from any cause, when such insurance includes loss thereof by burglary or theft, or both, and excludes coverage of property while in the custody of, or possession of, or being transported by, any carrier for hire or in the mail:

Moneys, stamps, coins, bullion, securities, notes, drafts, acceptances or instruments of like kind or character, accounts, books, maps, manuscripts, indexes and other valuable papers, documents and records incidental to the business or profession or activity in which the insured is engaged.

(c) Insurance by means of an all-risk policy of the type commonly known as the "Personal Property Floater" against any and all kinds of loss of or damage to, or loss of use of, any personal property other than merchandise.

113. Credit insurance includes insurance of persons engaged in business against loss by reason of extending credit to those dealing with them, and insurance against loss from the failure of persons to meet existing or contemplated obligations to the insured. However, no insurance may be written as credit insurance if it falls within the definition of financial guaranty insurance as set forth in Section 12100.

114. Sprinkler insurance includes insurance against loss through damage by water to goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatus placed for extinguishing fires, or loss arising from the breakage or leakage of water pipes, or through accidental injury to such sprinklers, pumps, or other apparatus.

115. Team and vehicle insurance includes insurance against loss through damage or legal liability for damage, to property caused by the use of teams or vehicles other than ships, boats, or railroad rolling stock, whether by accident or collision or by explosion of engine, tank, boiler, pipe, or tire of the vehicle, and insurance against theft of the whole or part of such vehicle.

116. (a) Automobile insurance includes insurance of automobile owners, users, dealers, or others having insurable interests therein, against hazards incident to ownership, maintenance, operation, and use of automobiles, other than loss resulting from accident or physical injury, fatal or nonfatal, to, or death of, any natural

person.

(b) Automobile insurance also includes any contract of warranty, or guaranty that promises service, maintenance, parts replacement, repair, money, or any other indemnity in event of loss of or damage to a motor vehicle or any part thereof from any cause, including loss of or damage to or loss of use of the motor vehicle by reason of depreciation, deterioration, wear and tear, use, obsolescence, or breakage if made by a warrantor or guarantor who or which as such is doing an insurance business.

(c) The making of a contract covering only defects in material and workmanship, which may include towing and substitute transportation, in exchange for a separately stated charge where it is merely incidental to the business of selling or leasing automobiles, shall not be deemed insurance, provided, that the maker of the contract has an insurance policy with an admitted automobile insurer providing coverage for the making of those contracts.

The policy shall include a loss payee endorsement that provides coverage to any lending institution as its interest may appear. In addition, the contract shall conspicuously state the name and address of the licensed underwriting insurer and contain a statement that the holder shall be entitled to make a direct claim against that insurer upon the failure of the maker to pay any claim within 60 days after proof of loss has been filed with the maker. The requirements of this section shall not apply where the maker is a manufacturer, distributor, or importer of automobiles.

(d) A contract covering only defects in material and workmanship, which may include towing and substitute transportation, in exchange for a separately stated charge, where the contract is sold by an automobile dealer incidental to the automobile dealer's business of selling or leasing automobiles and the legal obligor is other than the automobile dealer shall not be deemed insurance, provided that the legal obligor of the contract complies with all of the following requirements:

(1) Maintain an insurance policy with an admitted automobile insurer providing coverage for the obligation of those contracts. The policy shall include a loss payee endorsement that provides coverage to any lending institution as its interest may appear. In addition, the contract shall conspicuously state the name and address of the licensed underwriting insurer and contain a statement that the holder shall be entitled to make a direct claim against that insurer upon the failure of the legal obligor to pay any claim within 60 days after proof of loss has been filed with the party designated in the contract.

(2) Possess a fire and casualty broker agent license.

(3) Comply with the requirements of subparagraph (A) or (B), as follows:

(A) Comply with both of the following:

(i) Maintain a funded reserve account for its obligations under its contracts issued and outstanding in this state. The reserves shall not be less than 40 percent of gross consideration received, less claims paid, on the sale of the contract for all in-force contracts. The reserve account shall be subject to examination and review by the commissioner.

(ii) Place in trust with the commissioner a financial security deposit having a value of not less than 5 percent of the gross consideration received, less claims paid, on the sale of the contract for all contracts issued and in force, but not less than twenty-five thousand dollars ($25,000) consisting of one of the following:

(I) A surety bond issued by an authorized surety.

(II) Securities of the type eligible for deposit by admitted insurers.

(III) Cash.

(IV) A letter of credit issued by a qualified financial institution.

(V) Another form of security prescribed by regulations issued by the commissioner.

(B) (i) Maintain a net worth of one hundred million dollars ($100,000,000).

(ii) An obligor that complies with this subparagraph shall, upon request, provide the commissioner with a copy of the obligor's financial statements or the obligor's parent company's financial statements. The financial statement shall be the most recent Form 10-K filed with the Securities and Exchange Commission within the last calendar year, or if the obligor does not file with the Securities and Exchange Commission, a copy of the obligor's audited financial statements, that shows a net worth of the obligor or its parent company of at least one hundred million dollars ($100,000,000). If the obligor's parent company's Form 10-K or audited financial statements are filed to meet the obligor's financial stability requirement, then the parent company shall agree to guarantee the obligations of the obligor relating to contracts of the obligor in this state.

(e) The doing or proposing to do any business in substance equivalent to the business described in this section in a manner designed to evade the provisions of this section is the doing of an insurance business.

116. (a) Automobile insurance includes insurance of automobile owners, users, dealers, or others having insurable interests therein, against hazards incident to ownership, maintenance, operation, and use of automobiles, other than loss resulting from accident or physical injury, fatal or nonfatal, to, or death of, any natural person.

(b) Automobile insurance also includes any contract of warranty, or guaranty that promises service, maintenance, parts replacement, repair, money, or any other indemnity in event of loss of or damage to a motor vehicle or a trailer, as defined by Section 630 of the Vehicle Code, or any part thereof from any cause, including loss of or damage to or loss of use of the motor vehicle or trailer by reason of depreciation, deterioration, wear and tear, use, obsolescence, or breakage if made by a warrantor or guarantor who is doing an insurance business.

(c) Automobile insurance also includes any agreement that promises repair or replacement of a motor vehicle, or part thereof, after a mechanical or electrical breakdown, at either no cost or a reduced cost for the agreement holder. However, automobile insurance does not include a vehicle service contract subject to Part 8 (commencing with Section 12800) of Division 2, or an agreement deemed not to be insurance under that part.

(d) The doing or proposing to do any business in substance equivalent to the business described in this section in a manner designed to evade the provisions of this section is the doing of an insurance business.

116.5. Notwithstanding Section 116, an agreement promising repair or replacement of a motor vehicle or part thereof subsequent to a mechanical or electrical breakdown, where the repair or replacement is at either no cost or a reduced cost for the agreement holder, shall not constitute automobile insurance if the obligor is a manufacturer of motor vehicle lubricants, treatments, fluids, or additives, provided that all of the following apply:

(a) The agreement covers only parts directly in contact with the lubricant, treatment, fluid, or additive that is manufactured by the obligor, or parts mechanically connected to those parts.

(b) No separately stated consideration is paid for the agreement by the agreement holder.

(c) The agreement is in writing and includes all of the following:

(1) A disclosure in 10-point type or larger that reads as follows:

"This agreement is a product warranty and is not insurance. It is not subject to state insurance laws but is subject to state laws concerning warranties. You must use the product as instructed in order to receive the benefit of the warranty."

(2) A disclosure of the year in which the obligor began doing business in this state.

(3) A toll-free telephone number for the agreementholder to call should there be a question or problem about the lubricant, treatment, fluids, or additives or the warranty.

116.5. An express warranty warranting a motor vehicle lubricant, treatment, fluid, or additive that covers incidental or consequential damage resulting from a failure of the lubricant, treatment, fluid, or additive, shall constitute automobile insurance, unless each of the following requirements is met:

(a) The obligor is the primary manufacturer of the product. For the purpose of this section, "manufacturer" means a person who can prove clearly and convincingly that the per unit cost of owned or leased capital goods, including the factory, plus the per unit cost of nonsubcontracted labor, exceeds twice the per unit cost of raw materials. "Manufacturer" also means a person who has formulated or produced, and continuously offered in this state for more than 10 years, a motor vehicle lubricant, treatment, fluid, or additive.

(b) The commissioner has issued a written determination that the obligor is a manufacturer as defined in subdivision (a). An obligor shall provide the commissioner with all information, documents, and affidavits reasonably necessary for this determination to be made. Approval by the commissioner shall be obtained prior to January 1, 2004, or prior to the issuance of a warranty subject to this section, whichever is later. If the commissioner determines that the obligor is not a manufacturer, the obligor may obtain a hearing in accordance with Chapter 4.5 (commencing with Section 11400) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The agreement covers only damage incurred while the product was in the vehicle.

(d) The agreement is provided automatically with the product at no extra charge.

116.6. (a) Notwithstanding Section 116, a warranty issued by the warrantor of a vehicle protection product shall constitute an express warranty, as defined in Section 1791.2 of the Civil Code, and shall

not constitute automobile insurance if the warrantor complies with all of the following requirements:

(1) The warrantor maintains an insurance policy with an admitted insurer providing coverage for 100 percent of the warrantor's obligations under the warranty. The insurance policy shall allow the warrantyholder to make a direct claim for payment from the insurer upon the failure of the warrantor to pay any covered claim within 60 days after a complete proof-of-loss has been filed with the party designated in the warranty. In addition, all of the following shall apply:

(A) The warrantor shall file with the commissioner a copy of the insurance policy. At any time, a warrantor may have on file with the commissioner only one active policy from one insurer.

(B) The insurer's liability under the policy shall not be negated by a failure of the warrantor, for any reason, to report the issuance of a warranty to the insurer or to remit moneys owed to the insurer.

(C) No policy cancellation by an insurer shall be valid unless a notice of the intent to cancel the policy is filed with the commissioner not less than 30 days prior to the effective date of the cancellation, or, in the event that the cancellation is due to fraud, material misrepresentation, or defalcation by the warrantor, not less than 10 days prior to that date.

(D) In the event an insurer cancels a policy that a warrantor has filed with the commissioner, the warrantor shall do either of the following:

(i) File a copy of a new policy with the commissioner, before the termination of the prior policy, providing no lapse in coverage following the termination of the prior policy.

(ii) Discontinue acting as a warrantor as of the termination date of the policy until a new policy becomes effective and is accepted by the commissioner.

(2) The warrantor does not use the words insurance, casualty, surety, mutual, or any other words descriptive of the casualty, insurance, or surety business or deceptively similar to the name or description of any insurance company or casualty or surety company in the vehicle protection product name or warranty or in any advertising or other materials provided to prospective purchasers.

(3) The warranty has been issued to a customer that is insured under a comprehensive vehicle insurance policy for the vehicle covered by the warranty agreement.

(4) The warranty is in writing and provides all of the following:

(A) The benefits are limited to the difference between the actual

cash value of the stolen vehicle and the vehicle's replacement cost, temporary vehicle rental expenses, reimbursement for insurance policy deductible, and registration fees and taxes on a replacement vehicle or a fixed amount for those benefits.

(B) A statement that the warrantyholder shall be entitled to make a direct claim against the insurer covering the obligations of the warranty upon the failure of the warrantor to pay any covered claim within 60 days after a complete proof-of-loss has been filed with the party designated in the warranty.

(C) A disclosure stating clearly the name, address, and telephone number of the insurer covering the obligations of the warrantor.

(D) A toll-free telephone number established and operated by the warrantor for the warrantyholder to call for questions about the warranty or the procedures to file a claim.

(E) A statement that clearly indicates the terms of the warranty, whether new or used cars are eligible for the vehicle protection product, the method for calculating the benefits paid and provided to the warrantyholder, and the procedure for filing a claim under the warranty.

(F) A disclosure in 10-point type or larger that reads as follows: "This agreement is a product warranty and is not insurance. It is not subject to state insurance laws but is subject to state law concerning warranties."

(G) A disclosure in 10-point type or larger that reads as follows: "To be eligible for this warranty, the warrantyholder must have comprehensive insurance coverage on the vehicle that is protected by the antitheft device."

(5) The benefit is payable upon the theft of the vehicle, as defined in the warranty, and subject to the satisfaction of the procedural proof of claim requirements of the warranty.

(b) For purposes of this section, the following definitions shall apply:

(1) "Warrantor" means the manufacturer or provider of a vehicle protection product who, under the terms of a vehicle protection product warranty, is the contractual obligor to the purchaser of a vehicle protection product.

(2) (A) "Vehicle protection product" means a vehicle protection device, system, or service that is installed on, or applied to, a vehicle, is designed to deter the theft of a vehicle, and includes a written warranty that provides if the product fails to deter the theft of the vehicle, that the warrantyholder shall be paid specified incidental costs by the warrantor as a result of the failure of the device, system, or service to perform pursuant to the terms of the warranty.

(B) For purposes of this section, "vehicle protection product" shall also include alarm systems, window etch products, body part marking products, steering locks, pedal and ignition locks, fuel and ignition kill switches, and electronic, radio, and satellite tracking devices.

(c) The commissioner may issue a stop order pursuant to Section 12921.8 to a warrantor who is in violation of the requirements of this section.

(d) A warrantor shall have the burden of proving that a claim filed in compliance with the terms and conditions of the warranty is not covered by the warranty. A warrantor shall have the burden of proving that a claim settlement amount fulfills the promises contained in the warranty.

(e) The requirements of this section shall not apply under either of the following conditions:

(1) The warrantor is a manufacturer of motor vehicles, as defined pursuant to Section 672 of the Vehicle Code, or a distributor of motor vehicles, as defined pursuant to Section 296 of the Vehicle Code.

(2) The warranty only provides for the repair or replacement of the vehicle protection product subsequent to a mechanical or electrical breakdown of the vehicle protection product.

(f) Nothing in this section is intended to affect any pending litigation.

117. Mortgage insurance includes the guaranteeing of the payment of the principal, interest and other sums agreed to be paid under the terms of any note or bond secured by mortgage, or other sums secured under the terms of any such mortgage, in its entirety, or of any undivided or other partial interest in any such mortgage, or in a group of such mortgages, and the guaranteeing or insuring, directly or indirectly, against loss thereon.

118. Aircraft insurance includes insurance of aircraft owners, users, dealers or others having insurable interests therein, against loss through hazards incident to ownership, maintenance, operation and use of aircraft, other than against loss resulting from accident or physical injury, fatal or nonfatal, to any natural person.

119. Mortgage guaranty insurance includes insurance against financial loss by reason of the nonpayment of principal, interest and other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate.

119.5. Insolvency insurance includes insurance against loss arising from the failure of an insolvent insurer to discharge its obligations under its insurance policies.

119.6. Legal insurance includes the assumption of a contractual obligation to reimburse the insured against all or a portion of his fees, costs, and expenses related to or arising out of services performed by or under the supervision of an attorney who is an active member of the bar of any jurisdiction or jurisdictions of the United States, in which these legal services are performed.

Legal insurance does not include any of the following:

(a) Retainer contracts made by an individual lawyer or law firm with an individual client with the fee based on an estimate of the nature and the amount of services that will be provided to that specific client, and similar contracts made with a group of clients involved in the same or closely related legal matters (such as class actions);

(b) Plans providing no benefits other than consultation and advice on matters in connection with, or a part of, referral services.

(c) Plans providing limited benefits on simple legal matters on a voluntary and informal basis, not involving a legally binding promise, in the context of an employment or educational or similar relationship; or

(d) Legal services provided by labor unions or employee associations to their members in matters relating to employment or occupation.

(e) Legal service incidental to other insurance coverages.

The foregoing is not intended as an exclusive list of legal services plans or arrangements which do not constitute legal insurance as defined by this section.

120. Miscellaneous insurance includes insurance against loss from damage done, directly or indirectly by lightning, windstorm, tornado, earthquake or insurance under an open policy indemnifying the producer of any motion picture, television, theatrical, sport, or similar production, event, or exhibition against loss by reason of the interruption, postponement, or cancellation of such production, event, or exhibition due to death, accidental injury, or sickness preventing performers, directors, or other principals from commencing or continuing their respective performance or duties; and any insurance not included in any of the foregoing classes, and which is a proper subject of insurance.

121. Except as otherwise stated, the enumeration in this chapter of the kinds of insurance in a particular class does not limit any such kind to any one of such particular classes, inasmuch as the classification of similar insurance may vary with the subject matter, risk, and connected insurances; but the fact that similar kinds of insurance occur in different classes does not extend or change the scope of any such class.

122. (a) An insurer admitted for all the classes of insurance defined in Sections 102, 107, 108, 112 and 120 is authorized, in addition to the underwriting powers granted by such classes, to include any and all insurance described in paragraph (b) in a policy which contains fire coverage written on a form complying with either Section 2070 or Section 2071 and which provides insurance covering only noncommercial risks and covering either residence properties (not more extensive than a four-family dwelling) and appurtenances, or the contents thereof other than merchandise, or both.

(b) Such insurance is any or all insurance against all risks of physical loss of, damage to, or personal liability (except workmen's compensation) for injury to person or damage to property incident to, any or all of the following:

(1) The location described and property covered by the fire insurance policy as described in subdivision (a),

(2) Personal effects,

(3) Boats not over 16 feet in length (including furnishings, equipment, outboard motors, and trailers); provided the physical loss or damage coverage does not exceed five hundred dollars ($500),

(4) Personal property intended primarily for residential or

recreational use, (excluding boats except as provided above),

(5) Farm implements or self-propelled vehicles, excluding automobiles and aircraft, and,

(6) Horses, including accouterments and vehicles or implements to be drawn thereby.

123. An insurer admitted to transact liability insurance may extend such insurance on noncommercial or farm risks to include insurance of the legal liability of the insured for damage to property caused by use of "teams" or "vehicles" as the meaning thereof is limited by Section 115.

124. "Financial guaranty insurance" means that insurance as defined by Section 12100.

INSURANCE CODE
SECTION 125-140

125. This chapter shall be known and may be cited as the California Risk Retention Act of 1991.

126. The Legislature finds and declares that the provisions of this chapter are for the purpose of providing a means for a bona fide for-profit or nonprofit association or individual business to insure against liability and those obligations imposed by statute.

127. Unless the context otherwise requires, the general provisions hereinafter set forth shall govern the application of this chapter and supersede any other provisions of law in conflict.

128. The purposes of this chapter are as follows:

(a) To regulate the formation and operation of risk retention groups and purchasing groups in this state formed pursuant to the federal Liability Risk Retention Act of 1986, to the extent permitted by that law.

(b) To promote the formation and operation of risk retention groups and purchasing groups in this state. Californians who are experiencing difficulty in obtaining liability coverage are encouraged to form and operate risk retention and purchasing groups in this state.

(c) To authorize the formation of a risk retention group for directors and officers of corporations, whether for profit or nonprofit, who are engaged in the same line of business with respect to the liability risks faced by those officers and directors within the meaning of the federal Liability Risk Retention Act of 1986.

130. The following definitions govern this chapter:

(a) "Commissioner" means the Insurance Commissioner of this state or the commissioner, director, or superintendent of insurance of any other state.

(b) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means the following:

(1) For a corporation, the state in which the purchasing group is incorporated and registered to do business pursuant to the federal Liability Risk Retention Act (15 U.S.C. Sec. 3901 and following).

(2) For an unincorporated entity, the state of its principal place of business and in which it is registered to do business under the federal Liability Risk Retention Act (15 U.S.C. 3901 and following).

(c) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group is unlikely to be able to do either of the following:

(1) Meet obligations to policyholders with respect to known claims and reasonably anticipated claims.

(2) Pay other obligations in the normal course of business.

(d) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of this state.

(e) (1) "Liability" means legal liability for damages including costs of defense, legal costs and fees, and other claims expenses because of injuries to other persons, damage to their property, or

other damage or loss to the other persons resulting from or arising out of any of the following:

(A) Any business, whether profit or nonprofit, trade, product, services, including professional services, premises, or operations.

(B) Any activity of any state or local government, or any agency or political subdivision thereof.

(2) "Liability" includes financial responsibility required by the state for any activity for which an individual is required to obtain a license or certificate to provide a service. For purposes of this subdivision, a state agency has discretion to accept or deny proof of financial responsibility.

(3) "Liability" does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. Sec. 51 et seq.).

(f) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in subdivision (f).

(g) "Plan of operation or a feasibility study" with respect to risk retention groups chartered in California includes analysis which presents the expected activities and results of a risk retention group including, at a minimum, all of the following:

(1) Information to demonstrate that its members are engaged in businesses or activities similar or related with respect to the liability to which those members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations.

(2) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.

(3) Historical and expected loss experience of the proposed members and national experience of similar exposures, to the extent that this experience is reasonably available.

(4) Pro forma financial statements and projections.

(5) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition.

(6) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements.

(h) "Public entity" includes the state, the Regents of the

University of California, a county, city, district, public authority, public agency, and any other political subdivision or public corporation in the state.

(i) "Purchasing group" means any group which does all of the following:

(1) Has as one of its purposes the purchase of liability insurance on a group basis.

(2) Purchases that insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (3).

(3) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations.

(4) Is domiciled in any state.

(j) "Risk Retention Administration Account" means an account within the Insurance Fund to be used as a depository of moneys received under this chapter or appropriated by the Legislature for the purpose of administering this chapter.

(k) "Risk retention group" means any corporation, public entity, or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands that meets all of the following criteria:

(1) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members.

(2) Which is organized for the primary purpose of conducting the activity described under paragraph (1).

(3) Which is either of the following:

(A) Chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state.

(B) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, has certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of that state, except that any group is considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as those terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the federal Liability Risk Retention Act of 1986.

(4) Does not exclude any person from membership in the group solely to provide for members of the group a competitive advantage

over that person.

(5) Has as its members only persons who comprise the membership of the risk retention group and as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by that group.

(6) Whose members are engaged in businesses or activities similar or related with respect to the liability of which those members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations.

(7) Whose activities do not include the provision of insurance other than for the following:

(A) Liability insurance for assuming and spreading all or any portion of the liability of its group members.

(B) Reinsurance with respect to the liability of any other risk retention group or any members of that other group that is engaged in businesses or activities so that the group or member meets the requirement described in paragraph (6) from membership in the risk retention group that provides that reinsurance.

(8) The name of which includes the phrase "risk retention group."

(l) "State" means any state of the United States or the District of Columbia.

131. (a) An entity seeking to be licensed in this state as a risk retention group shall be organized under the laws of this state and licensed as a liability insurance company pursuant to Article 3 (commencing with Section 699) of Chapter 1 of Part 2.

(b) An entity that has not completed its chartering and licensing as a risk retention group in its domiciliary state is subject to the requirements of Article 8 (commencing with Section 820) of Chapter 1 of Part 2.

(c) In addition to the requirements of Article 3 (commencing with Section 699) of Chapter 1 of Part 2, a risk retention group licensed in this state shall submit to the commissioner a feasibility study or plan of operations and all other documentation required by the federal Liability Risk Retention Act of 1986 (15 U. S.C. Section 3901 et seq.) to be submitted by a risk retention group to a nonchartering state.

132. Risk retention groups chartered, incorporated, or licensed in states other than this state and seeking to do business as a risk

retention group in this state shall file a notice of operation with the commissioner of its intention to do business in this state. The notice shall be filed with the commissioner within 60 days of the filing by the group of any notice filed with its chartering state of its intention to do business in this state, but in no event may a notice of intended operation be filed with the commissioner less than 60 days prior to the group commencing business in this state. In doing business in this state the risk retention group shall observe and abide by the laws of this state including the following:

(a) A risk retention group shall submit to the commissioner all of the following:

(1) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and other information, including information on its membership, as the commissioner of this state may require to verify that the risk retention group is qualified under subdivision (k) of Section 130.

(2) A copy of its plan of operations or a feasibility study and revisions of the plan or study submitted to the state in which the risk retention group is chartered and licensed. However, the provision relating to the submission of a plan of operation or a feasibility study does not apply with respect to any line or classification of liability insurance which (A) was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986, and (B) was offered before that date by any risk retention group which had been chartered and operating for not less than three years before that date.

(3) A statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(4) A registration filing fee shall accompany the statement of registration, which shall be deposited in the Risk Retention Administration Account, which is hereby created within the Insurance Fund. Notwithstanding Section 13340 of the Government Code, moneys in the account are continuously appropriated to the department for purposes of this chapter.

(b) Any risk retention group within this state shall submit to the commissioner all of the following:

(1) Upon commencement of business within this state and annually thereafter, a copy of the group's annual financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy

of Actuaries or a qualified loss reserve specialist.

(2) Upon request by the commissioner, a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination and all documentation received as part of the examination.

(3) Upon request by the commissioner, a copy of any outside audit performed with respect to the risk retention group.

(c) (1) As authorized under the federal Liability Risk Retention Act of 1986 (15 U.S.C. Sec. 3902(a)(1)(B)), each risk retention group is liable for the payment of premium taxes and taxes on premiums for business done or located within this state, and shall report to the commissioner the gross premiums written, less returned premiums, on business done within this state. The risk retention group is subject to taxation, and any applicable fines and nonconformance fees related thereto, on the same basis as a foreign admitted insurer. Nonconformance fees shall be paid to the department and deposited in the Risk Retention Administration Account within the Insurance Fund.

(2) To the extent licensed surplus line brokers are utilized pursuant to Chapter 6 (commencing with Section 1760) of Part 2, they shall report to the commissioner the premiums for direct business for risks resident or located within this state which those licensees have placed with or on behalf of, a risk retention group not chartered in this state.

(d) Any risk retention group, its agents and representatives shall comply with Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2.

(e) Any risk retention group shall comply with the laws of this state regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding that conduct, the injunction shall be obtained from a court of competent jurisdiction.

(f) Any risk retention group shall submit to an examination upon request by the commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after a request by the commissioner of this state.

(g) Every application form for insurance from a risk retention group and every policy issued by a risk retention group shall contain in 10-point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

(h) The following acts by a risk retention group are hereby prohibited:

(1) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in that group.

(2) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition.

(i) No risk retention group may offer insurance policy coverage prohibited by Section 533.5 or declared unlawful by the Supreme Court of California.

(j) The risk retention group shall make its initial registration by filing the materials specified in subdivision (a). The initial registration is valid until December 31 of the year in which it was made, as long as the risk retention group is in compliance with this chapter. To maintain the registration in force, the risk retention group shall continue in compliance with this chapter and shall file the following items with the commissioner on or before December 31 of each year:

(1) An annual reporting statement on a form prescribed by the commissioner.

(2) An annual renewal fee to be determined by the commissioner, limited to the actual cost of administering this section, not to exceed three hundred dollars ($300).

(3) Any other information required by the commissioner to determine whether the risk retention group is in compliance with the requirements of this chapter.

(k) The risk retention group shall notify the commissioner in writing of any changes in the information provided according to subdivision (a) within 30 days of the effective date of the change.

133. (a) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by that risk retention group.

(b) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

(c) When a purchasing group obtains insurance covering its members' risks from an authorized admitted insurer, only risks located in this state shall be covered by the state insurance guaranty fund.

(d) A risk retention group shall not participate in this state's joint underwriting associations, California Automobile Assigned Risk Plan, Fair Access to Insurance Requirements Plan, and market assistance plans.

134. (a) A purchasing group that intends to do business in this state shall, prior to doing business, furnish notice to the commissioner which does the following:

(1) Identify the state in which the group is domiciled.

(2) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase.

(3) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of that company.

(4) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state.

(5) Identify the principal place of business of the group.

(6) Provide other information that may be required by the commissioner to verify that the purchasing group is qualified under subdivision (i) of Section 130.

(b) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee in the amount of three hundred dollars ($300) shall be submitted to the commissioner for deposit in the Risk Retention Administration Account within the Insurance Fund, except that these requirements do not apply in the case of a purchasing group that did all of the following:

(1) Was domiciled before April 1, 1986, and is domiciled on and after October 27, 1986, in any state of the United States.

(2) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state, and since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state.

(3) Was a purchasing group under the requirements of the Product

Liability Risk Retention Act of 1981 before October 27, 1986.

(4) Does not purchase insurance that was not authorized for purposes of an exemption under that act, as in effect before October 27, 1986.

(c) Any purchasing group which was doing business in this state prior to the enactment of this chapter shall, within 30 days after January 1, 1990, furnish notice to the commissioner pursuant to subdivision (a) and furnish information that may be required pursuant to subdivisions (b) and (c).

(d) Each purchasing group which is required to give notice pursuant to subdivision (a) shall also furnish information as may be required by the commissioner to:

(1) Verify that the entity qualifies as a purchasing group.

(2) Determine where the purchasing group is located.

(3) Determine appropriate tax treatment.

(4) Verify that the purchasing group is in compliance with the requirements of this chapter.

(e) Any purchasing group that intends to do business in this state shall make its initial registration by submitting to the commissioner the materials listed in subdivision (a). The registration is valid until December 31 of the year in which it was made, as long as the purchasing group is in compliance with this chapter. To maintain the registration, the purchasing group shall continue to comply with the provisions of this chapter. Additionally, the purchasing group shall file the following documents with the commissioner on or before January 31 of each year:

(1) An annual reporting statement on a form prescribed by the commissioner.

(2) An annual renewal fee, to be determined by the commissioner, limited to the actual cost of administering this section, not to exceed two hundred dollars ($200).

(3) Any other information required by the commissioner to determine whether the purchasing group is in compliance with the requirements of this chapter or other applicable provisions of this code.

(f) The purchasing group shall notify the commissioner in writing of any changes in the information provided according to subdivision (a) within 30 days of the effective date of the change.

135. (a) No purchasing group may offer insurance policy coverage prohibited by Section 533.5 or declared invalid by the Supreme Court

of California.

(b) A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of the group which have a risk resident or located in this state all of the following:

(1) The risk is not protected by an insurance insolvency guaranty fund in this state.

(2) The risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

136. The powers authorized by this chapter shall only be exercised to the extent these powers are not preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986.

137. (a) No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state from a risk retention group unless that person, firm, association, or corporation is licensed as a fire and casualty broker-agent in accordance with Chapter 5 (commencing with Section 1621) of Part 2 and is authorized to act as an insurance broker; except salaried employees or officers of a risk retention group, provided no part of the compensation of such person is on a commission basis or otherwise based on production of business.

(b) No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless that person, firm, association, or corporation is licensed as a surplus line broker in accordance with Chapter 6 (commencing with Section 1760) of Part 2. A nonresident person may be licensed as a surplus lines broker for purposes of placing insurance on behalf of a purchasing group.

(c) Any person, firm, association, or corporation licensed pursuant to Chapter 5 (commencing with Section 1621) of Part 2, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by subdivision (g) of Section 132 in the case of a risk retention group and subdivision (b) of Section 135 in the case of a purchasing group.

138. There shall be no civil liability on the part of any agent or broker who places liability insurance coverage on behalf of any risk retention group which is incorporated and licensed in this state in the event of an insolvency by the risk retention group.

140. The commissioner may order a purchasing group or risk retention group to cease and desist from the solicitation or sale of insurance by, or the operations of, a risk retention group or purchasing group whose officers, organizers, or directors have engaged in any of the acts or omissions set forth in subdivision (a) of Section 1668.5. That order shall be made in accordance with the procedures set forth in Article 14.5 (commencing with Section 1065.1) of Chapter 1 of Part 2.

INSURANCE CODE
SECTION 150-151

150. Any person capable of making a contract may be an insurer, subject to the restrictions imposed by this code.

151. Any person except a public enemy may be insured.

INSURANCE CODE
SECTION 170-172

170. Unless the policy otherwise provides, if a mortgagor of property effects insurance in his own name providing that the loss shall be payable to the mortgagee, or assigns a policy of insurance to a mortgagee, the insurance is deemed to be upon the interest of the mortgagor and the mortgagor does not cease to be a party to the

original contract.

171. In case of such a provision or assignment, any act of the mortgagor, prior to the loss and which would otherwise avoid the insurance, will have the same effect, although the property is in the hands of the mortgagee; but any act which, under the contract of insurance, is to be performed by the mortgagor, may be performed by the mortgagee therein named, with the same effect as if it had been performed by the mortgagor.

172. If an insurer assents to the transfer of insurance from a mortgagor to a mortgagee, and, at the time of the assent, imposes further obligations on the assignee, the acts of the mortgagor cannot affect the rights of the assignee.

INSURANCE CODE
SECTION 250-253

250. Except as provided in this article, any contingent or unknown event, whether past or future, which may damnify a person having an insurable interest, or create a liability against him, may be insured against, subject to the provisions of this code.

251. A lottery or its outcome shall not be insured against.

252. A policy executed by way of gaming or wagering, is void.

253. On and after January 1, 1986, no insurer shall issue or amend contracts of insurance in this state to provide coverage for the payment of any damages awarded to a person because of Section 1029.8 of the Code of Civil Procedure.

INSURANCE CODE
SECTION 280-287

280. If the insured has no insurable interest, the contract is void.

281. Every interest in property, or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly damnify the insured, is an insurable interest.

282. An insurable interest in property may consist in:
1. An existing interest;
2. An inchoate interest founded on an existing interest; or,
3. An expectancy, coupled with an existing interest in that out of which the expectancy arises.

283. A mere contingent or expectant interest in anything, not founded on an actual right to the thing, nor upon any valid contract for it, is not insurable.

284. Except in the case of a property held by the insured as a carrier or depositary, the measure of an insurable interest in property is the extent to which the insured might be damnified by loss or injury thereof.

285. A carrier or depositary of any kind has an insurable interest in a thing held by him as such, to the extent of its value.

286. An interest in property insured must exist when the insurance takes effect, and when the loss occurs, but need not exist in the meantime; and interest in the life or health of a person insured must

exist when the insurance takes effect, but need not exist thereafter or when the loss occurs.

287. Every stipulation in a policy of insurance for the payment of loss whether the person insured has or has not any interest in the property insured, or that the policy shall be received as proof of such interest, is void.

INSURANCE CODE
SECTION 300-305

300. Except in the cases specified in the next four sections, and in the cases of life and disability insurance, a change of interest in any part of a subject insured, unaccompanied by a corresponding change of interest in the insurance, suspends the insurance to an equivalent extent until the interest in the subject and the interest in the insurance are vested in the same person.

301. A change of interest in a subject insured, after the occurrence of an injury which results in a loss, does not affect the right of the insured to indemnity for the loss.

302. A change of interest in one or more of several distinct subjects, separately insured by one policy, does not avoid the insurance as to the others.

303. A change of interest by will or succession, on the death of the insured, does not avoid insurance; and his interest in the insurance passes to the person taking his interest in the subject matter insured.

304. In the case of partners, joint owners, or owners in common, who are jointly insured, a transfer of interest by one to another thereof does not avoid insurance, even though it has been agreed that

the insurance shall cease upon an alienation of the subject insured.

305. The mere transfer of subject matter insured does not transfer the insurance, but suspends it until the same person becomes the owner of both the insurance and the subject matter insured.

INSURANCE CODE
SECTION 330-339

330. Neglect to communicate that which a party knows, and ought to communicate, is concealment.

331. Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance.

332. Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining.

333. Neither party to a contract of insurance is bound to communicate information of the matters following, except in answer to the inquiries of the other:

1. Those which the other knows.
2. Those which, in the exercise of ordinary care, the other ought to know, and of which the party has no reason to suppose him ignorant.
3. Those of which the other waives communication.
4. Those which prove or tend to prove the existence of a risk excluded by a warranty, and which are not otherwise material.

5. Those which relate to a risk excepted from insurance, and which are not otherwise material.

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

335. Each party to a contract of insurance is bound to know:

(a) All the general causes which are open to his inquiry equally with that of the other, and which may affect either the political or material perils contemplated.

(b) All the general usages of trade.

336. The right to information of material facts may be waived, either (a) by the terms of insurance or (b) by neglect to make inquiries as to such facts, where they are distinctly implied in other facts of which information is communicated.

337. Information of the nature or amount of the interest of one insured need not be communicated unless in answer to an inquiry, except as prescribed by section 381, or by the provisions of the insurance contract if such provisions are prescribed by this code as part of a standard form.

338. An intentional and fraudulent omission, on the part of one insured, to communicate information of matters proving or tending to prove the falsity of a warranty, entitles the insurer to rescind.

339. Neither party to a contract of insurance is bound to communicate, even upon inquiry, information of his own judgment upon

the matters in question.

INSURANCE CODE
SECTION 350-361

350. A representation may be oral or written.

351. A representation may be made at the time of, or before, issuance of the policy.

352. The language of a representation is to be interpreted by the same rules as contracts in general.

353. A representation as to the future is a promise, unless it is merely a statement of a belief or an expectation.

354. A representation cannot qualify an express provision in a contract of insurance; but it may qualify an implied warranty.

355. A representation may be altered or withdrawn before the insurance is effected, but not afterwards.

356. The completion of the contract of insurance is the time to which a representation must be presumed to refer.

357. When an insured has no personal knowledge of a fact, he may nevertheless repeat information which he has upon the subject, and

which he believes to be true, with the explanation that he does so on the information of others; or he may submit the information, in its whole extent, to the insurer. In neither case is he responsible for its truth, unless it proceeds from an agent of the insured, whose duty it is to give the information.

358. A representation is false when the facts fail to correspond with its assertions or stipulations.

359. If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false.

360. The materiality of a representation is determined by the same rule as the materiality of a concealment.

361. The provisions of this chapter apply as well to a modification of a contract of insurance as to its original formation.

INSURANCE CODE
SECTION 380-394

380. The written instrument, in which a contract of insurance is set forth, is the policy.

381. A policy shall specify:

(a) The parties between whom the contract is made.

(b) The property or life insured.

(c) The interest of the insured in property insured, if he is not the absolute owner thereof.

(d) The risks insured against.

(e) The period during which the insurance is to continue.

(f) Either:

(1) A statement of the premium, or

(2) If the insurance is of a character where the exact premium is only determinable upon the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid.

381.1. (a) The information described in subdivision (b) shall be provided to the policyholder at the time of application for, or issuance of, a policy of automobile insurance, as defined in Section 660, and in each renewal notice sent prior to the renewal of the policy. However, information described in paragraphs (1) and (2) of subdivision (b) may be provided to the policyholder separately upon request. The information shall not be presented as an abbreviation or code unless a key to the abbreviations or codes used is also included.

(b) For each rated driver or vehicle, as applicable, the number of incidents or other relevant data that apply to each of the following categories:

(1) Traffic convictions.

(2) At-fault accidents (property damage or bodily injury).

(3) Estimated annual mileage driven.

(4) Years of driving experience.

(5) Vehicle use (e.g., pleasure, commute, business).

(6) ZIP Code of the location where the vehicle is garaged, if different from the mailing address of the policyholder.

(7) Driver-related discounts applied.

(8) Vehicle-related discounts or surcharges applied.

(c) The disclosure of information required by this section may contain additional provisions that are not in conflict with, or derogation of, these provisions.

(d) Each insurer shall comply with this section no later than March 1, 2004.

381.2. When a policy includes coverage for loss or damage to a specific item of personal property of the insured, which item is separately listed and described and on which item a separate amount of insurance is placed, the insurer shall compute any total loss of

such item of personal property as being the amount of insurance placed on it. In the adjustment of a partial loss or damage to such item of covered property, the separately listed amount of insurance applying to the specific item shall be used as the value of the item prior to its partial loss or damage. If a different method is to be used in the computation of loss, the policy, and any application therefor, shall set forth, in type of prominent size, the actual method of such loss computation used by the insurer.

The provisions of this subdivision shall not apply to any property used for a business purpose or to any motor vehicle.

If there are two or more policies insuring the same property against the loss, the loss shall be prorated among the policies.

382. Covering notes may be issued to bind insurance temporarily pending the issuance of the policy. Within 90 days after issue of a covering note a policy shall be issued in lieu thereof, including within its terms the identical insurance bound under the covering note and premium therefor.

Covering notes may be extended or renewed beyond such 90 days with the written approval of the commissioner if the commissioner determines that such extension is not contrary to and is not for the purpose of violating any provision of this code. The commissioner may promulgate rules and regulations governing such extensions for the purpose of preventing such violations and may by such rules and regulations dispense with the requirement of written approval by him in the case of extensions in compliance with such rules and regulations.

382.5. A binder which is issued in accordance with this section shall be deemed an insurance policy for the purpose of proving that the insured has the insurance coverage specified in the binder.

(a) As used in this section, "binder" means a writing (1) which includes the name and address of the insured and any additional named insureds, mortgagees, or lienholders, a description of the property insured, if applicable, a description of the nature and amount of coverage and any special exclusions not contained in a standard policy, the identity of the insurer and the agent executing the binder, the effective date of coverage, the binder number or the policy number where applicable to a policy extension, and (2) which

temporarily obligates the insurer to provide that insurance coverage pending issuance of the insurance policy. For purposes of this section, "binder" does not include, and this section does not apply to, any writing that conditionally or unconditionally obligates an insurer to provide (1) life or disability insurance or (2) insurance in the amount of one million dollars ($1,000,000) or more.

(b) Except as superseded by the clear and express terms of the binder, a binder shall be deemed to include all of the usual terms of the policy as to which the binder was given, together with applicable endorsements as are designated in the binder.

(c) Except as otherwise provided in this subdivision, a binder shall be valid for the period specified therein not exceeding 90 days from the date of execution of the binder or, if not specified, for that period of 90 days. No binder shall remain valid on or after the date the insurance policy is issued with respect to which the binder was given. Expiration of coverage under a binder shall not be considered a cancellation or nonrenewal of a policy of insurance within the meaning of any statute limiting the right to cancel or nonrenew a policy of insurance.

(d) If any party to a contract or other agreement refuses without reasonable cause to accept a binder as proof of insurance when that proof is required by the contract or agreement, that party shall be deemed to have breached the contract and the other party thereto, shall be entitled to appropriate injunctive relief and may recover damages for the breach and reasonable attorney's fees and costs. As used in this subdivision, "reasonable cause" includes, but shall not be limited to, any of the following:

(1) Inadequate coverage or inappropriate terms of coverage with respect to the interest of the vendor, lender, lessor, or other person providing a service to the insured.

(2) Failure of the insurer to meet the financial standards "lawfully" established by the lender for all insurers for the type of loan for which the insurance is obtained.

(3) Inability of the lender to determine if the insurer is licensed as an admitted insurer by the commissioner to transact the line of insurance for which the binder is issued.

(4) Failure of the insurance agent to provide the lender with written evidence of the agent's authority to bind insurance coverage on behalf of the insurer under the binder.

(5) Failure of the binder to comply with this section.

(e) For purposes of all insurance policies providing collateral insurance coverage, binders issued in accordance with this section shall be deemed an insurance policy.

(f) The commissioner may suspend or revoke the license of any

agent issuing or purporting to issue any binder of a type for which the agent lacks authority from the insurer named in the binder.

383. It is a misdemeanor:

(a) For any insurer, or any agent of any insurer, to issue a policy in violation of the requirements of subdivision (f) of section 381.

(b) For any insurance agent or broker to assist in arranging for the insurance where the policy violates such requirements.

(c) For any insurer to violate the provisions of section 382.

383.5. "Document," as used in this section, means a policy or a certificate evidencing insurance under a master policy. The policy or certificate shall conform to Section 381 and shall segregate the premiums charged for each risk insured against. The certificate, in lieu of specifying the risks insured against, may designate them by name or by description. "Document" also includes the applicable policy form and a subsequently issued declarations page conforming to Section 381 or an endorsement.

"Owner," as used in this section, means any person who is named as an insured in the contract of insurance or document, or in a loss payable clause therein, and, whether or not he or she is named therein, the vendee, pledgor, or chattel mortgagor of a motor vehicle where insurance contracts subject to this section are procured with respect to the motor vehicle by or on behalf of either party to the purchase, pledge, or mortgage.

Every contract of insurance against hazards incident to ownership, maintenance, operation, and use of motor vehicles shall be embodied in a document.

The original or true copy of the document shall be delivered to each owner. Where it is executed by an insurer, the insurer shall deliver the original or a true copy to either of the following:

(a) The agent or broker who negotiated the insurance, for delivery to each owner of the motor vehicle.

(b) Each owner of the motor vehicle.

Any owner whose interest in the insured vehicle is for security purposes only may by written notice to the insurer waive delivery of the policy and in lieu thereof there shall be delivered to the owner a written certificate of insurance setting forth in brief form the

matters specified in Section 381.

The agent or broker receiving the original or copy shall deliver one to each owner. Where coverage subject to this section is evidenced by a document executed by an agent licensed under Chapter 5 (commencing with Section 1621) of Part 2, and not by an insurer, the agent and not the insurer is responsible for delivery of the original or a true copy to each owner.

The licenses of any agent or broker found by the commissioner after hearing to have violated this section may be suspended or revoked in accordance with the procedure provided in Article 13 (commencing with Section 1737) of Chapter 5 of Part 2, or the certificate of authority of any insurer found by the commissioner after hearing to have violated this section may be suspended or revoked in accordance with the procedure provided in Section 704.

The purpose of this section is to prevent fraud or mistake in connection with the transaction of insurance covering motor vehicles and in furtherance of that purpose the commissioner may make reasonable rules and regulations therefor. The rules and regulations shall be adopted, amended, or repealed in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

383.6. The phrase "motor vehicle" or "motor vehicles" as used in Section 383.5 includes, but is not limited to:

(a) Trailers, house trailers, mobilehomes, campers and all other wheeled vehicles or nonwheeled structures so made as to be capable of being moved as a compatible portion thereof, or trailed behind, any motor vehicle as that term is defined in the Vehicle Code, whether in immobile position or not.

(b) Motorcycles, motorbikes and motor scooters, except powered bicycles not manufactured for inclusion of a motor.

All present or future rules or regulations promulgated by the commissioner pursuant to Section 383.5 shall be applicable to motor vehicles as defined in this section.

384. (a) A certificate of insurance or verification of insurance provided as evidence of insurance in lieu of an actual copy of the insurance policy shall contain the following statements or words to the effect of:

This certificate or verification of insurance is not an insurance policy and does not amend, extend or alter the coverage afforded by

the policies listed herein. Notwithstanding any requirement, term, or condition of any contract or other document with respect to which this certificate or verification of insurance may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of the policies.

(b) This section is not applicable to a surplus line broker certificate as defined in Section 48.

386. All policies issued by incorporated insurers shall be subscribed by the president or vice president, or chairman, or chief executive officer, or, in case of the death, absence, or disability of those officers, by any two of the directors, and countersigned by the secretary of the corporation. All such policies are as binding and obligatory upon the corporation as if executed over the corporate seal.

387. When the name of the person intended to be insured is specified in a policy, it can be applied only to his own interest.

388. When an insurance contract is executed with an agent or trustee as the insured, the fact that his principal or beneficiary is the real party in interest may be indicated by describing the insured as agent or trustee, or by other general words in the policy.

389. To render an insurance effected by one partner or part-owner applicable to the interest of his copartners, or of other part-owners, it is necessary that the terms of the policy should be such as are applicable to the joint or common interest.

390. When the description of the insured in a policy is so general that it may comprehend any person or any class of persons, only he who can show that it was intended to include him can claim the

benefit of the policy.

391. A policy may be so framed that it will inure to the benefit of whomsoever, during the continuance of the risk, becomes the owner of the interest insured.

392. Any exception from the risk generally covered by a policy of insurance which insures property for the period of time when such property is under the dominion and control of a party other than the insured for the purpose of storage or for the purpose of transferring such property to another location shall be printed in at least eight-point blackface type.

393. (a) Whenever any admitted or nonadmitted insurer rejects, declines, or cancels any policy of insurance, exclusive of commercial insurance risk, and the unearned premium is tendered to an insurance broker or agent of record as the insurer's agent, such unearned premium shall be tendered by the broker or agent to the insured or the person entitled thereto within 30 days of his or her receipt of such unearned premium from the insurer except as provided in subdivision (b). Any unearned premium received by a broker or agent not tendered within the time specified above shall bear interest at the rate of 10 percent per annum from and after such 30 days, to be paid by the broker or agent.

(b) The broker or agent may, as an alternative to the provisions of subdivision (a), apply the amount of unearned premium if not previously assigned to other premiums due, if such broker or agent gives specific written notice of such application to the insured within 30 days of the broker's or agent's receipt of such unearned premiums.

394. (a) The commissioner may approve insurance policies and associated materials in languages other than English if the following conditions are met:

(1) The policyholder is given a copy of the same material in English.

(2) The English version is the official version.

(3) A policyholder document in a language other than English shall contain a disclosure statement in both that language and in English that states that the English version is the official version and the foreign language version is for informational purposes only.

(b) An insurer that knowingly misrepresents information provided in a language other than English shall be subject to Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2.

INSURANCE CODE
SECTION 410-413

410. A policy is either open or valued.

411. An open policy is one in which the value of the subject matter is not agreed upon, but is left to be ascertained in case of loss.

412. A valued policy is one which expresses on its face an agreement that the thing insured shall be valued at a specified sum.

413. A running policy is one which contemplates successive insurances, and which provides that the object of the policy may be from time to time defined, especially as to the subjects of insurance, by additional statements or indorsements.

INSURANCE CODE
SECTION 430

430. The policies issued by every insurer shall be entitled by its own name or a name approved by the commissioner under Section 881 or 882, printed on each policy in large bold type in at least as large as any other size type used in the policy or on the face page.

INSURANCE CODE
SECTION 440-449

440. A warranty is either express or implied.

441. A statement in a policy of a matter relating to the person or thing insured, or to the risk, as a fact, is an express warranty thereof.

442. A particular form of words is not necessary to create a warranty.

443. Every express warranty made at or before the execution of a policy shall be contained in the policy itself, or in another instrument signed by the insured and referred to in the policy, as making a part of it.

444. A warranty may relate to the past, the present, the future, or to any or all of these.

445. A statement in a policy, which imports that there is an intention to do or not to do a thing which materially affects the risk, is a warranty that such act or omission will take place.

446. When, before the time arrives for the performance of a warranty relating to the future, a loss insured against happens, or performance becomes unlawful at the place of the contract, or impossible, the omission to fulfill the warranty does not avoid the policy.

447. The violation of a material warranty or other material provision of a policy, on the part of either party thereto, entitles the other to rescind.

448. Unless the policy declares that a violation of specified provisions thereof shall avoid it, the breach of an immaterial provision does not avoid the policy.

449. A breach of warranty without fraud merely exonerates an insurer from the time that it occurs, or where the warranty is broken in its inception, prevents the policy from attaching to the risk.

INSURANCE CODE
SECTION 460

460. On and after January 1, 1972, every printed form of an insurance contract, including every policy, endorsement, rider, or any amendment thereof issued in this state by any insurer or issued for delivery in this state by any insurer shall state an inception hour for coverage of 12:01 a.m. of the date upon which it is to be dated. However, the contract may provide that the inception time shall not be prior to the time applied for. Unless a specific provision of this code otherwise prescribes or permits, the hour prescribed shall be standard time at the residence within this state, or the principal place of business within this state, of the insured.

This section shall not prohibit an insurer, directly or through an agent, from issuing a binder, whether it be oral or typed by insertions in blanks in a printed form, specifying an inception or termination hour other than 12:01 a.m. on the date upon which the coverage is to commence, or end, as specified in the standard form or forms issued as the normal policy. Such binder shall not be subject to Section 382 nor have the technical meaning therein ascribed to "covering notes."

This section shall not prohibit an insurer from issuing any policy

or contract on a normal printed form which contains a provision extending the period of coverage for either 12 hours preceding, or following, the effective hour otherwise required by this section.

This section shall not apply to:

(1) Life insurance as defined in Section 101 or such supplemental disability insurance as is defined in Sections 10271 and 10292.

(2) Marine insurance as defined in Section 103.

(3) Title insurance as defined in Section 104.

(4) Mortgage insurance as defined in Section 107.

(5) Mortgage guarantee insurance as defined in Section 119.

(6) Surety insurance, as defined in Section 105, or disability insurance, as defined in Section 106, unless, until, and to the extent following:

The commissioner, on or after the effective date of the amendment of this section at the 1969 Regular Session of the Legislature, from time to time, as to specific types, classes, or categories of such insurance, declares, by rules and regulations promulgated as provided by law, that this section shall apply. Such rules or regulations shall provide that no policy or other form required by law to be approved by the commissioner need be refiled for approval if the only change from a previously approved form is the inclusion or change of the inception or termination hour.

INSURANCE CODE
SECTION 480-491

480. An insurer is entitled to payment of the premium as soon as the subject matter insured is exposed to the peril insured against.

481. (a) Unless the insurance contract otherwise provides, a person insured is entitled to a return of premium if the policy is canceled, rejected, surrendered, or rescinded, as follows:

(1) To the whole premium, if the insurer has not been exposed to any risk of loss.

(2) Where the insurance is made for a definite period of time and the insured surrenders his policy, to such proportion of the premium as corresponds with the unexpired time, after deducting from the whole premium any claim for loss or damage under the policy which has previously accrued. The provisions of Section 482 apply only to the

expired time.

(b) No contract for individual motor vehicle liability or homeowners' multiple-peril insurance may contain a provision which mandates that the premium for such policy shall be fully earned upon the happening of any contingency except the expiration of the policy itself. This subdivision shall not apply to policy fees or membership fees.

(c) This section shall not apply to policies of ocean marine insurance. For purposes of this section, "ocean marine insurance" means insurance of vessels or crafts, their cargos, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance governed by the provisions of Chapter 1 (commencing with Section 1880) of Part 1 of Division 2, and as distinguished from inland marine insurance policies.

481.1. (a) In the event any conditional receipt, binder, or other evidence of temporary or implied insurance, except ocean marine insurance as defined in Section 481 and those classes of insurance as defined in Sections 101, 104, and 106, is canceled, rejected, or surrendered by the insurer, the coverage thereby extended shall terminate 10 days after written notice to the named insured is deposited, properly addressed with postage prepaid, with the United States Postal Service.

(b) Any conditional receipt, binder, or other evidence of temporary or implied insurance described in subdivision (a) shall remain in force for a period of at least 30 days from the date of its issuance unless sooner canceled, rejected, or surrendered pursuant to the provisions of subdivision (a).

481.5. (a) Whenever an insurer endorses, rejects, declines, cancels, or surrenders a policy of insurance as defined in subdivision (a) of Section 660 or Section 675, or a policy of insurance as defined in subdivision (a) of Section 660 or Section 675 is canceled pursuant to Section 673, the unearned premium shall be tendered to the insured or to the person entitled thereto or to the insurance agent of record as the insurer's agent for transmittal within 25 days after the cessation or amendment of coverage due to endorsement, cancellation, rejection, surrender, or rescission. If this unearned premium is tendered to the insurer's agent, the agent shall tender this premium to the insured or to the person entitled to

the premium within 15 days after the agent receives the premium. Any unearned premium not tendered within the time specified above shall bear interest at the rate of 10 percent per annum from and after the date on which the unearned premium is to be tendered. An agent or broker shall only be liable for the payment of interest after 15 days from the date the agent or broker has received the funds for the amount of the unearned premium from the insurer, or from the date the agent or broker has received notification from the insurer that a credit or payment for the amount of the unearned premium has been applied to an agent's or broker's account. That interest imposition shall not apply to any insurer in conservatorship or liquidation and shall constitute the sole penalty paid to the insured for a failure to refund an unearned premium. For the purposes of this section, the tender of any unearned premium to the insured shall be deemed complete upon the deposit of the unearned premium in the United States mail, prepaid, addressed to the named insured at the last known address.

(b) Whenever a policy is canceled pursuant to Section 673, other than a policy as defined in subdivision (a) of Section 660 or Section 675, the unearned premium shall be tendered to the person entitled thereto or to the insurance agent of record as the insurer's agent for transmittal within 120 days after the cessation of coverage due to cancellation. Any unearned premium not tendered within the time specified above shall bear interest at the rate of 10 percent per annum from and after that 120 days. That interest imposition shall not apply to any insurer in conservatorship or liquidation and shall constitute the sole penalty paid to the insured for a failure to refund an unearned premium.

(c) For purposes of subdivisions (a) and (b), where the unearned premium is not assigned as security to a premium finance agency pursuant to a premium finance agreement and where the amount of unearned premium is less than twenty-five dollars ($25), tender of unearned premium shall include applying the amount of unearned premium either to the renewal premium at the next renewal date or to other premiums due, provided written notice of either application is given to the insured within 30 days after the endorsement, rejection, declination, cancellation, or surrender of a policy of insurance. At the time of endorsement or surrender of a policy of insurance or, within 15 days after the mailing of the written notice required by this subdivision, the insured may request in writing that the unearned premium be tendered as provided in subdivisions (a) and (b).

Whenever the amount of unearned premium is less than five dollars ($5), tender shall be effective and the written notice required by this subdivision shall not be required provided the unearned premium

is applied either to the renewal premium at the next renewal date or to other premiums due.

482. Except as provided by section 481, or by the insurance contract, if a peril insured against has existed, and the insurer has been liable for any period, however short, the insured is not entitled to return of premiums, so far as that particular risk is concerned.

483. A person insured is entitled to a return of the premium:

(a) When the contract is voidable, on account of the fraud or misrepresentation of the insurer.

(b) When the contract is voidable on account of facts, of the existence of which the insured was ignorant without his fault.

(c) When, by any default of the insured other than actual fraud, the insurer did not incur any liability under the policy.

484. An acknowledgment in a policy of the receipt of premium is conclusive evidence of its payment, so far as to make the policy binding. Notwithstanding such acknowledgment, a policy may be canceled effective at such times as otherwise permitted by law for nonpayment of all or any portion of the premium which is actually unpaid if such cancellation right is reserved to the insurer in the policy.

485. In case of an overinsurance by several insurers, the insured is entitled to a ratable return of the premium, proportioned to the amount by which the aggregate sum insured in all the policies exceeds the insurable value of the subject at risk.

486. When an overinsurance is effected by simultaneous policies, the insurers contribute to the premium to be returned in proportion to the amount insured by their respective policies.

487. When an overinsurance is effected by successive policies, those only contribute to a return of the premium who are exonerated by prior insurance from the liability assumed by them, and in proportion as the sum for which the premium was paid exceeds the amount for which, on account of prior insurance, they could be made liable.

488. No insurer shall, in issuing or renewing a private passenger automobile insurance policy, increase the premium on that policy for the reason that the insured or applicant for insurance has been convicted for traffic violations committed while operating a motor vehicle for compensation during the hours of his employment if, with respect to a conviction, the employee or applicant has submitted to the insurer a written declaration made by the employee under penalty of perjury that the applicant or insured was, at that time, operating a motor vehicle for compensation during the hours of his or her employment. This section applies only to those individuals whose specific duties include driving their employer's motor vehicles or individuals who have authority in their name from the Public Utilities Commission to operate as a highway carrier and who are the registered owners or lease operators of the motor vehicle used in the operation as a highway carrier.

This section does not apply to any insured or applicant for insurance convicted of any of the following:

(a) Homicide or assault arising out of the operation of a motor vehicle for compensation during the hours of employment.

(b) A violation while operating a motor vehicle for compensation during the hours of employment of any of the following sections or section subdivisions of the Vehicle Code:

(1) Subdivision (a) of Section 14601.

(2) Subdivision (a) of Section 14601.1.

(3) Subdivision (a) of Section 14601.2.

(4) Section 20001 or 20002.

(5) Subdivision (a) of Section 20008.

(6) Section 23103, 23104, 23152, or 23153.

This section shall not apply to any person insured under the California assigned risk plan prescribed by Article 4 (commencing with Section 11620), Chapter 1, Part 3, Division 2 of this code.

488.5. (a) No insurer shall, in issuing or renewing a private automobile insurance policy to a peace officer, member of the California Highway Patrol, or firefighter, with respect to his or her operation of a private motor vehicle, increase the premium on that policy for the reason that the insured or applicant for insurance has been involved in an accident while operating an authorized emergency vehicle, as defined in subdivision (a) or (f) of Section 165 of the Vehicle Code or in paragraph (1) or (2) of subdivision (b) of Section 165 of the Vehicle Code, in the performance of his or her duty during the hours of his or her employment.

(b) No insurer shall, in issuing or renewing a private automobile insurance policy to a federal officer or federal customs agent, with respect to his or her operation of a private motor vehicle, increase the premium on that policy for the reason that the insured or applicant for insurance has been involved in an accident while operating an official government vehicle in the performance of his or her duty during the hours of his or her employment.

(c) As used in this section:

(1) "Peace officer" means every person defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.

(2) "Policy" shall have the same meaning as defined in subdivision (a) of Section 660.

489. (a) Upon issuance of a policy of insurance described in Section 660, the insurer or its agent shall deliver to the named insured a notice explaining the manner in which the insurer's rating plan provides for an increase in the premium based upon accidents or convictions within the meaning of Sections 13103 and 13105 of the Vehicle Code.

Every insurer or its agent, not less than 20 days prior to renewal of a policy covered by this section, shall inform the named insured of the named insured's right to be informed, upon request, of any increase in the premium, in whole or in part, charged the named insured by virtue of the involvement in any accident, or conviction within the meaning of Section 13103 and 13105 of the Vehicle Code, by the insured or any operator of the motor vehicle.

(b) Every insurer shall, after March 1, 1977, as part of the first offer required by Section 663, deliver to everyone who was a named insured under a policy of insurance described in Section 660 on March

1, 1977, a notice explaining the manner in which the insurer's rating plan provides for an increase in the premium, based upon accidents or convictions within the meaning of Sections 13103 and 13105 of the Vehicle Code. The provisions of this subdivision shall expire on March 1, 1978.

491. The rating plan of a motor vehicle liability insurer shall not provide for an increase in the premium if based upon an accident in which the insured is not at fault, in any manner, as determined by either the accident report or the insurer. In the event the insurer determines that its insured is at fault contrary to an accident report's specific finding that the insured is not at fault, the insurer shall reach its conclusion only after an investigation.

INSURANCE CODE
SECTION 500

500. Whenever any insurer has, as a regular course of conduct, sent renewal premium notices to an insured, and intends to discontinue that practice, it shall notify such insured of its intention not to send such notices.

INSURANCE CODE
SECTION 510

510. Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure containing the name, address, and toll-free telephone number of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large,

boldface type.

The disclosure shall contain, at the discretion of the insurer, either the address and telephone number of the insurer or the address and telephone number of the agent or broker of record, or both of those addresses and telephone numbers. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.

INSURANCE CODE
SECTION 515

515. Notwithstanding any other provision of law, any insurer issuing policies of automobile liability insurance or motor vehicle liability insurance shall, upon request of either the named insured or the Department of Motor Vehicles, promptly issue to that person or the department written verification as to the existence of that coverage.

INSURANCE CODE
SECTION 520

520. An agreement not to transfer the claim of the insured against the insurer after a loss has happened, is void if made before the loss except as otherwise provided in Article 2 of Chapter 1 of Part 2 of Division 2 of this code.

INSURANCE CODE
SECTION 530-533.7

530. An insurer is liable for a loss of which a peril insured against was the proximate cause, although a peril not contemplated by the contract may have been a remote cause of the loss; but he is not liable for a loss of which the peril insured against was only a remote cause.

531. An insurer is liable:

(a) Where the thing insured is rescued from a peril insured against, and which would otherwise have caused a loss, if, in the course of such rescue, the thing is exposed to a peril not insured against, and which permanently deprives the insured of its possession, in whole or in part.

(b) If a loss is caused by efforts to rescue the thing insured from a peril insured against.

532. If a peril is specially excepted in a contract of insurance and there is a loss which would not have occurred but for such peril, such loss is thereby excepted even though the immediate cause of the loss was a peril which was not excepted.

533. An insurer is not liable for a loss caused by the wilful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others.

533.5. (a) No policy of insurance shall provide, or be construed to provide, any coverage or indemnity for the payment of any fine, penalty, or restitution in any criminal action or proceeding or in any action or proceeding brought pursuant to Chapter 5 (commencing with Section 17200) of Part 2 of, or Chapter 1 (commencing with Section 17500) of Part 3 of, Division 7 of the Business and Professions Code by the Attorney General, any district attorney, any city prosecutor, or any county counsel, notwithstanding whether the exclusion or exception regarding this type of coverage or indemnity is expressly stated in the policy.

(b) No policy of insurance shall provide, or be construed to provide, any duty to defend, as defined in subdivision (c), any claim

in any criminal action or proceeding or in any action or proceeding brought pursuant to Chapter 5 (commencing with Section 17200) of Part 2 of, or Chapter 1 (commencing with Section 17500) of Part 3 of, Division 7 of the Business and Professions Code in which the recovery of a fine, penalty, or restitution is sought by the Attorney General, any district attorney, any city prosecutor, or any county counsel, notwithstanding whether the exclusion or exception regarding the duty to defend this type of claim is expressly stated in the policy.

(c) For the purpose of this section, "duty to defend" means the insurer's right or obligation to investigate, contest, defend, control the defense of, compromise, settle, negotiate the compromise or settlement of, or indemnify for the cost of any aspect of defending any claim in any criminal action or proceeding or in any action or proceeding brought pursuant to Chapter 5 (commencing with Section 17200) of Part 2 of, or Chapter 1 (commencing with Section 17500) of Part 3 of, Division 7 of the Business and Professions Code in which the insured expects or contends that (1) the insurer is liable or is potentially liable to make any payment on behalf of the insured or (2) the insurer will provide a defense for a claim even though the insurer is precluded by law from indemnifying that claim.

(d) Any provision in a policy of insurance which is in violation of subdivision (a) or (b) is contrary to public policy and void.

533.7. Notwithstanding any other law, an insurer may defend a duly licensed physician or surgeon against any cause of action involving the performance of any act for which a physician's and surgeon's certificate is required.

INSURANCE CODE
SECTION 550-557.6

550. In case of loss upon an insurance against fire, an insurer is exonerated if notice thereof is not given to him without unnecessary delay by an insured or some person entitled to the benefit of the insurance.

551. Except in the case of life, marine, or fire insurance, notice of an accident, injury, or death may be given at any time within twenty days after the event, to the insurer under a policy against loss therefrom. In such a policy, no requirement of notice within a lesser period shall be valid.

552. When preliminary proof of loss is required by a policy, the insured is not bound to give such proof as would be necessary in a court of justice; but it is sufficient for him to give the best evidence in his power at the time.

553. All defects in a notice of loss, or in preliminary proof thereof, which the insured might remedy, and which the insurer omits to specify to him, without unnecessary delay, as grounds of objection, are waived.

554. Delay in the presentation to an insurer of notice or proof of loss is waived, if caused by an act of his, or if he omits to make objection promptly and specifically upon that ground.

555. If a policy requires, by way of preliminary proof of loss, the certificate or testimony of a person other than the insured or beneficiary, there is sufficient compliance with the requirement if the insured or the beneficiary (a) uses reasonable diligence to procure the certificate or testimony, and (b) in case of refusal to give it to him, furnishes reasonable evidence to the insurer that the refusal was not induced by just grounds of disbelief in the facts necessary to be certified or testified.

557. It is a misdemeanor for any person alone or in concert to prepare or make any bid or other writing which falsely purports to be a bona fide offer to repair a damaged motor vehicle or any other damaged property, with the intent that the same be used for the purpose of fraudulently leading an automobile liability insurer to believe:

(a) That a bid of some other person represents an offer made in open competition; or

(b) That the policy provisions of such insurer governing bids for the repair of vehicles or other property insured under the policy have been complied with in good faith.

557.5. No peace officer, member of the California Highway Patrol, or firefighter shall be required to report any accident in which he or she is involved while operating an authorized emergency vehicle, as defined in subdivision (a) or (f) of Section 165 of the Vehicle Code or in paragraph (1) or (2) of subdivision (b) of Section 165 of the Vehicle Code in the performance of his or her duty during the hours of his or her employment, to any person who has issued that peace officer, member of the California Highway Patrol, or firefighter a private automobile insurance policy.

As used in this section:

(a) "Peace officer" means every person defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.

(b) "Policy" shall have the same meaning as defined in subdivision (a) of Section 660.

557.6. Any peace officer or firefighter as defined pursuant to this section who has been involved in an accident shall submit to his or her private automobile insurer within 30 days of the accident his or her written declaration under penalty of perjury stating whether or not at the time of the accident he or she was operating an authorized emergency vehicle, as defined in subdivision (a) or (f) of Section 165 of the Vehicle Code or in paragraph (1) or (2) of subdivision (b) of Section 165 of the Vehicle Code in the performance of his or her duty during the hours of his or her employment. In lieu of a written declaration, the peace officer or firefighter may submit to the private automobile insurer a copy of the incident report filed by the peace officer or firefighter with his or her employer.

As used in this section, "peace officer" means every person defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, and "firefighter" means every person defined in Section 50925 of the Government Code.

INSURANCE CODE
SECTION 560

560. Every insurer issuing an automobile collision policy, as defined in subdivision (d) of Section 660, or a policy for comprehensive coverage for a motor vehicle, as defined in Section 11580.07, shall, in the event of damage to a covered automobile by collision or otherwise and the election by the insurer to have such automobile repaired by the repairer, make payment by check or draft, payable to the repairer or to the named insured and the repairer, jointly, not later than 10 days subsequent to receipt of an itemized bill or invoice covering repairs authorized by the insurer which have been satisfactorily completed. The provisions of this section shall include all cases where the insured has received actual notice that the repairer is doing work pursuant to a contract approved by the insurance company in which case the payment shall include the name of the repairer.

INSURANCE CODE
SECTION 570-572

570. Except in the event that the insurer has previously obtained a release on a loss, each insurer which issues, amends, or renews, on or after January 1, 1975, a policy of insurance covering repair or reconstruction work on commercial, industrial, or residential real property and appurtenances thereon, shall, in the event of covered work being performed by a licensee under the Contractors License Law (Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code), make payment by check or draft directly to the contractor performing the work, and not to the owner of the property, in every case in which all of the following conditions are present and the insurer has actual knowledge thereof:

(a) The property owner of record has, in a writing signed by him and transmitted to the insurer, stated all of the following:

(1) The work completed meets with his satisfaction.

(2) The insurer, upon direct payment to the contractor, is

released from liability.

(3) The writing was not completed or signed by him until after all work was completed.

(b) The property owners of record, the named insured, and any loss payee have consented in writing to such direct payment and release from liability.

(c) The completed work has been certified by the appropriate public agency or authority as conforming to existing building, electrical, and construction codes.

(d) Each subcontractor of the contractor, and each materialman, to whom direct payment is to be made by the insurer has executed, and filed of record, releases of any and all claims, including, but not limited to, mechanic's liens, which the subcontractor and materialman might have against the property or any appurtenance thereof, the property owners of record, the named insured, and any loss payee named in the policy, for any work the subcontractor performed, or material the materialman furnished, upon the property under the contract for which such payment is being made. The property owner or the contractor, as the case may be, shall submit to the insurer proof, satisfactory to it, of such execution and filing prior to the insurer's making any direct payment provided for by this article.

571. Where the insurer has authorized the work and its liability is not in dispute, the direct payment provided for by Section 570 shall be made to the contractor performing the work not later than 30 days after the insurer has actual knowledge that the conditions of subdivisions (a) through (d) of Section 570 have been completed.

572. As used in this article, the term "loss payee" shall include, but not be limited to, any mortgagee of the insured real property.

INSURANCE CODE
SECTION 590-591

590. A double insurance exists where the same person is insured by

several insurers separately in respect to the same subject and interest.

591. In case of double insurance, the several insurers are liable to pay losses thereon as follows:

(a) In fire insurance, each insurer shall contribute ratably, without regard to the dates of the several policies.

(b) In marine insurance, the liability of the several insurers for a total loss, whether actual or constructive, where the policies are not simultaneous, is in the order of the dates of the several policies. No liability attaches to a second or other subsequent policy, except as to the excess of the loss over the amount of all previous policies on the same interest. If two or more policies bear the same date, they are deemed to be simultaneous, and each insurer on simultaneous policies shall contribute ratably. The insolvency of any of the insurers does not affect the proportionate liability of the other insurers.

All insurers on the same marine interest shall contribute ratably for a partial or average loss.

INSURANCE CODE
SECTION 620-623

620. A contract of reinsurance is one by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance.

621. A reinsurance is presumed to be a contract of indemnity against liability, and not merely against damage.

622. Where an insurer obtains reinsurance, he must communicate all the representations of the original insured, and also all the knowledge and information he possesses, whether previously or subsequently acquired, which are material to the risk.

623. The original insured has no interest in a contract of reinsurance.

INSURANCE CODE
SECTION 650-651

650. Whenever a right to rescind a contract of insurance is given to the insurer by any provision of this part such right may be exercised at any time previous to the commencement of an action on the contract. The rescission shall apply to all insureds under the contract, including additional insureds, unless the contract provides otherwise.

651. Whenever an insurer gives notice of rescission of an automobile liability policy, upon request of the driver as defined in paragraphs (1) and (2) of subdivision (b) of Section 12804 of the Vehicle Code, the insurer, within 15 days of receipt of the request, shall furnish to the insured a statement setting forth the ground or grounds upon which the notice of rescission is based. There shall be no liability on the part of, and no cause of action shall arise against, any insurer or authorized representative, or its licensed investigative sources, for any statements made by them in a written notice required to be given pursuant to this section. If the insurer fails to comply with the provisions of this section, the insured may apply to the commissioner for a certificate of the facts or information desired. Any such request shall be made in accordance with Article 3 (commencing with Section 12950) of Chapter 2 of Division 3, and the commissioner shall exercise any power conferred upon him by that article as may be necessary to ensure compliance with this section.

INSURANCE CODE
SECTION 655

655. Every insurer issuing policies of motor vehicle liability insurance within the meaning of Section 16450 of the Vehicle Code, automobile liability insurance within the meaning of Section 16054 of that code, or any other liability insurance issued for vehicles with less than four wheels that meets the requirements of Section 16056 of that code shall also, as an incident thereto, complete and file the certificate or certificates provided for under Section 16431 of that code. The proof required by this section may be provided by the filing of a single certificate.

INSURANCE CODE
SECTION 657-658

657. (a) Where any admitted insurer, licensed to issue motor vehicle liability policies as defined in Section 16450 of the Vehicle Code, or any licensed insurance agent refuses to accept an application for such a policy or refuses to issue such a policy when a written application has been made, the refusing agent or refusing insurer shall furnish to the applicant for insurance a written statement explaining the reason or reasons relied upon for such action if within 30 days of such refusal the applicant requests in writing, from the agent or insurer who has refused to accept the application or to issue the policy, such a written explanation. Such statement shall be furnished within 30 days of receipt of such request.

(b) Any insurer or agent willfully violating any provisions of this section is guilty of a misdemeanor and is punishable by a fine not exceeding one thousand dollars ($1,000) for each violation thereof.

(c) There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Insurance Commissioner or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to the reasons for such a refusal, for any statement made by any of them in any written notice of reasons for refusing to accept the application or issue the policy or in any other communication, oral or written, specifying the reasons for such action or the providing of the information pertaining thereto, or for statements made or evidence submitted in any hearings conducted in connection therewith.

658. Where any admitted insurer, licensed to issue motor vehicle liability policies as defined in Section 16450 of the Vehicle Code, refuses to accept an applicant for a good driver discount policy as defined in paragraph (1) of subdivision (b) of Section 1861.02 or refuses to issue a good driver discount policy when written application has been made, and where the applicant meets the criteria for purchase of a good driver discount policy, the refusing insurer shall furnish the applicant for insurance a written statement within 10 days of the refusal explaining the reason or reasons relied upon for denying insurance coverage.

INSURANCE CODE
SECTION 660-669.5

660. As used in this chapter:

(a) "Policy" means an automobile liability, automobile physical damage, or automobile collision policy, or any combination thereof, delivered or issued for delivery in this state, insuring a single individual or individuals residing in the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

(1) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others; or

(2) Any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less; provided, however, that this chapter shall not apply (i) to any policy issued under an automobile assigned risk plan, or (ii) to any policy insuring more than four automobiles, or (iii) to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards; or

(3) A motorcycle.

(b) "Automobile liability coverage" includes only coverage of bodily injury and property damage liability, medical payments, and uninsured motorists coverage.

(c) "Automobile physical damage coverage" includes all coverage of loss or damage to an automobile insured under the policy except loss or damage resulting from collision or upset.

(d) "Automobile collision coverage" includes all coverage of loss

or damage to an automobile insured under the policy resulting from collision or upset.

(e) "Renewal" or "to renew" means to continue coverage with either the insurer which issued the policy or an affiliated insurer, as defined in Section 1215, for an additional policy period upon expiration of the current policy period of a policy, provided that if coverage is continued with an affiliated insurer, it shall be the same or broader coverage as provided by the present insurer, and the insured shall be notified in writing at least 20 days prior to expiration of the current policy period of all of the following: (1) That the insurer has determined that it will not offer renewal of the policy with the present insurer, (2) That it is offering replacement in an affiliated insurer, and (3) That the insured may obtain in writing the reasons for the change in insurers if he or she requests in writing not later than one month following the expiration of the policy period the reason or reasons for the change in insurers. Any policy with a policy period or term of six months or less, whether or not made continuous for successive terms upon the payment of additional premiums, shall for the purpose of this chapter be considered as if written for a policy period or term of six months. Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall for the purpose of this chapter, be considered as if written for successive policy periods or terms of one year.

(f) "Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

(g) "Cancellation" means termination of coverage by an insurer (other than termination at the request of the insured) during a policy period.

(h) "Nonrenewal" means a notice by the insurer to the named insured that the insurer is unwilling to renew a policy.

(i) "Expiration" means termination of coverage by reason of the policy having reached the end of the term for which it was issued or the end of the period for which a premium has been paid.

661. (a) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(1) Nonpayment of premium.

(2) The driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the 180 days immediately preceding its effective date.

(3) Discovery of fraud by the named insured in pursuing a claim under the policy provided the insurer does not rescind the policy.

(4) Discovery of material misrepresentation of any of the following information concerning the named insured or any resident of the same household who customarily operates an automobile insured under the policy:

(A) Safety record.

(B) Annual miles driven in prior years.

(C) Number of years of driving experience.

(D) Record of prior automobile insurance claims, if any.

(E) Any other factor found by the commissioner to have a substantial relationship to the risk of loss.

Any insured who negligently misrepresents information described in this paragraph may avoid cancellation by furnishing corrected information to the insurer within 20 days after receiving notice of cancellation and agreeing to pay any difference in premium for the policy period in which the information remained undisclosed.

(5) A substantial increase in the hazard insured against.

(b) This section shall not apply to any policy or coverage that has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(c) Modification of automobile physical damage coverage by the inclusion of a deductible not exceeding one hundred dollars ($100) shall not be deemed a cancellation of the coverage or of the policy.

(d) This section shall not apply to nonrenewal.

662. No notice of cancellation of a policy to which Section 661 applies shall be effective unless mailed or delivered by the insurer to the named insured, lienholder, or additional interest at least 20 days prior to the effective date of cancellation; provided, however, that where cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason therefor shall be given. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation shall state or be

accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than 15 days prior to the effective date of cancellation, the insurer will specify the reason for such cancellation.

This section shall not apply to nonrenewal.

662.1. Proof of mailing or delivery of a notice of cancellation to a lienholder or an additional interest on a policy to which this chapter applies shall be sufficient to terminate the interest of the parties provided the notice is mailed or delivered at least the maximum number of days prior to termination of the parties' interest as required by Section 662. For purposes of this section, "delivery" includes electronic transmittal or facsimile or personal delivery. No lienholder or additional interest shall require a more restrictive form of notice.

663. (a) Before policy expiration, an insurer shall deliver to or mail to the named insured, at the address shown on the policy, one of the following:

(1) At least 20 days before expiration, a written or verbal offer of renewal of the policy, contingent upon payment of premium as stated in the offer.

(2) At least 30 days before expiration, a written notice of nonrenewal of the policy, including the statement required by Section 666.

(b) (1) An insurer that delivers a verbal offer to renew that is declined by an insured shall, at least 20 days before expiration of the policy, deliver to or mail to the named insured, at the address shown on the policy, a written confirmation of the offer and rejection.

(2) An insurer that attempts to satisfy subdivision (a) with a verbal offer to renew, but is unable to contact the named insured directly at least 20 days before policy expiration, shall, at least 20 days before policy expiration, deliver to or mail to the named insured, at the address shown on the policy, a written offer to renew the policy, contingent upon payment of premium as stated in the offer.

(c) In the event that an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 30 days from the date that

either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal. Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other replacement or succeeding automobile insurance policy procured by the insured, or his agent or broker, with respect to any automobile designated in both policies.

(d) The insurer shall not be required to notify the named insured, or any other insured, of nonrenewal of the policy if the insurer has mailed or delivered a notice of expiration or cancellation, on or prior to the 30th day preceding expiration of the policy period.

663.5. (a) No insurer shall fail to renew a policy solely on the basis of the age of the insured.

(b) On and after January 1, 2000, no insurer shall fail to renew a policy solely on the grounds that a claim is pending under the policy. This subdivision shall not be construed to limit an insurer's ability to nonrenew a policy based upon a directive from the commissioner for solvency or other financially related issues. This subdivision shall not be construed to limit an insurer's right to cancel a policy pursuant to Section 676.

664. Proof of mailing of notice of cancellation, or of intention not to renew or of reasons for cancellation, to the named insured at the address shown in the policy or to the named insured's latest known address, shall be sufficient proof of notice.

664.5. Any insurer who requires periodic physical examinations of an insured as a condition of renewal of a policy shall pay the cost of such physical examinations, except that an insurer shall not pay any cost if it elects to accept the certified written results of an insured's physical examination voluntarily conducted within 12 months preceding the policy expiration or renewal date.

665. When a policy of automobile liability insurance is canceled, other than for nonpayment of premium, or in the event of failure to renew a policy of automobile liability insurance to which Section 663 applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

666. Where the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer shall upon written request of the named insured, mailed or delivered to the insurer not less than 15 days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

667. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Insurance Commissioner or against any insurer, its authorized representative, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal, for any statement made by any of them in any written notice of cancellation or nonrenewal, or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

667.5. Unless a policy specifically provides otherwise, the cancellation of a policy, or any change in the policy, executed by an insurer, at the request of the named insured designated on the declarations page of the policy, shall be binding upon any other insured or named insured.

Notice of cancellation or an endorsement evidencing the named insured's request shall be mailed or delivered to the address stated in the policy to all individuals or to all entities designated as named insureds on the declarations page of the policy.

668. Section 663 shall not apply to policies of liability insurance issued pursuant to assigned risk plans.

668.5. No cancellation of a policy or coverage of insurance subject to this chapter but not subject to Section 661 or 662 (because it has been in effect less than 60 days) shall be effective unless a notice of cancellation subject to Sections 664 and 665, when applicable, but not to any other provision of this chapter, be mailed or delivered by the insurer to the named insured not later than the 59th day following its effective date and at least 10 days prior to the effective date of cancellation.

669. Any insurer willfully violating any provisions of Section 663 is guilty of a misdemeanor and is punishable by a fine of not exceeding one thousand dollars ($1,000) for each violation thereof.

669.5. No insurer shall fail to renew any private automobile insurance policy of a peace officer, member of the California Highway Patrol, or firefighter, with respect to his or her operation of a private motor vehicle, for the reason that the insured has been involved in an accident while operating an authorized emergency vehicle, as defined in subdivision (a) of Section 165 of the Vehicle Code or in paragraph (1) or (2) of subdivision (b) or (f) of Section 165 of the Vehicle Code, in the performance of his or her duty during the hours of his or her employment. As used in this section, "peace officer" means every person defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 and Section 830.6 of the Penal Code, and "firefighter" means every person defined in Section 50925 of the Government Code.

In the case of a volunteer firefighter, this section applies to the regular employer of the volunteer firefighter to the extent that the involvement of the volunteer firefighter in the accident shall not be cause for the employer's insurer's decision to renew the employer's insurance policy as it applies to the employee covered by this section.

INSURANCE CODE
SECTION 669.7

669.7. Notwithstanding Section 660, an insurer may deliver or issue an automobile liability, automobile physical damage, or automobile collision policy in this state insuring a single individual or individuals residing in the same household, as named insured, and under which the insured vehicle is a motor vehicle with a load capacity exceeding 1,500 pounds.

INSURANCE CODE
SECTION 670

670. (a) No admitted insurer licensed to issue motor vehicle liability policies, as defined in Section 16450 of the Vehicle Code, shall cancel, or refuse to renew, a motor vehicle liability insurance policy covering drivers hired to drive by a commercial business establishment nor execute the agreement specified in paragraph (1) of subdivision (d) of Section 11580.1 with respect to those drivers for the reason that those drivers have been convicted of violations of the Vehicle Code or the traffic laws of any subdivision of the state which were committed while operating private passenger vehicles not owned or leased by their employer.

(b) This section does not apply to any drivers convicted of any of the following:

(1) Homicide or assault arising out of the operation of a private passenger motor vehicle.

(2) A violation while operating a private passenger motor vehicle of any of the following sections or section subdivisions of the Vehicle Code:

(A) Subdivision (a) of Section 14601.

(B) Subdivision (a) of Section 14601.1.

(C) Subdivision (a) of Section 14601.2.

(D) Section 20001 or 20002.

(E) Subdivision (a) of Section 20008.

(F) Section 23104.

(G) Subdivision (c) of Section 23152.

(H) Section 23153.

(3) A violation, while operating a private passenger motor vehicle, of subdivision (a) or (b) of Section 23152 of the Vehicle Code punishable under Section 23540 or 23546 of the Vehicle Code.

INSURANCE CODE
SECTION 671

671. No insurer issuing an automobile collision policy, as defined in Section 660, or a policy for comprehensive coverage for an automobile, as defined in Section 11580.07, shall refuse to issue the policy of insurance, or the policy in combination with other coverages, when the refusal is based solely on the age of the automobile to be insured, if the market value of the automobile exceeds two thousand five hundred dollars ($2,500).

This section does not apply to any policy which includes coverage for losses resulting from wear and tear or from normal deterioration of an automobile or its component parts, nor to any policy which provides coverage for an antique or classic automobile.

INSURANCE CODE
SECTION 673

673. (a) As used in this section, "exercise the right to cancel" means the act of formally electing to use the right of the insured to cancel any insurance policy in accordance with and subject to the provisions of that policy when the right to use that right of the insured has been transferred or assigned by the insured in writing executed by, or on behalf of, the insured to a lender who has advanced to the insurer the premium for the policy. The transfer or assignment may be by power of attorney or other document. The transfer or assignment may, but need not, be accompanied by an assignment of any unearned premium due the insured on cancellation.

(b) No lender shall exercise the right to cancel a financed insurance policy because of the default of the insured under a

premium payment loan agreement except in accordance with this section.

(c) Written notice of the exercise of the right to cancel shall be mailed by the lender to the insurer and to the insured at the address shown on the premium payment loan agreement or his or her last known address, specifying a date five days or more after the date of mailing of such notice as the effective date of cancellation. Any insurer may, in writing delivered to the lender, waive, generally or specifically, the right to receive such notice or notices. A copy of such notice may be mailed to the producer of record if known to the lender, but failure to do so shall not affect any rights granted by this section. This subdivision shall not apply to an industrial loan company.

(d) An industrial loan company shall, in giving the insured 10 days' notice of its intent to cancel pursuant to Section 18608 of the Financial Code, furnish a copy of such notice to the insurance agent or insurance broker indicated on the premium finance agreement. After expiration of the 10-day period, the industrial loan company may thereafter, in the name of the insured, cancel the insurance contract or contracts by mailing to the insurer a written notice of cancellation, and the insurance contract shall be canceled as if the notice of cancellation had been submitted by the insured person, but without requiring the return of the insurance contract or contracts. The industrial loan company shall also mail a notice of cancellation, setting forth the effective date of cancellation of the finance insurance contract, to the insured at his or her last known address and to the insurance agent or insurance broker indicated on the premium finance agreement. For the purposes of this subdivision, the words "premium finance agreement" shall have the same meaning as that specified in Section 18564 of the Financial Code.

(e) A written exercise of that right containing a confirmation of the effective date of cancellation shall be mailed by the lender to the insurer within five days following that effective date of cancellation specified in the notice described in subdivision (c) unless the insured has cured any and all defaults. Cancellation shall be effective on the financed insurance policy without requiring the return of the insurance policy or insurance policies, except as provided in subdivisions (f) and (g), on the confirmation date specified in the written exercise of that right. This subdivision shall not apply to an industrial loan company.

(f) All statutory, regulatory, and contractual restrictions providing that the financed insurance policy may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under this

section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the fifth business day after the day it receives the written exercise of cancellation right containing confirmation of the cancellation date from the lender, as provided in subdivision (e), or a written notice of cancellation from an industrial loan company, pursuant to subdivision (d), and shall, for the purpose of the notice, determine the effective date of cancellation as to those persons mentioned in this subdivision only, taking into consideration the number of days' notice required to complete the cancellation.

(g) Whenever such a financed insurance policy is canceled by any party for any reason:

(1) The insurer shall, in accordance with the written agreements of which it has notice, return to the lender such unearned premiums as are due to the lender. The amount of the return premiums shall be based upon the confirmed date of cancellation specified in subdivision (e), or upon the written notice of cancellation specified in subdivision (d) in the case of an industrial loan company, lessened by the amount, if any, to compensate equitably the insurer for carrying the risk of loss as to any governmental agency, mortgagee, or other parties specified in subdivision (f) from that date to the effective date of cancellation as to those parties.

(2) When a financed insurance policy is canceled, or the insured discontinues payments to a lender, the insurer shall calculate the return premium on a pro rata basis. This paragraph shall not apply to any policy issued under an assigned risk plan or to any policy with respect to which the insurer has made a loan to the insured for the purposes of payment of premiums for the policy.

(h) The commissioner may amend the rules and regulations of any assigned risk plan, fair plan, or similar plan to provide for the equitable assignment of insurance risks among insurers now in existence or hereafter established, in such manner as may be necessary to carry out the purposes of this section.

(i) A lender which sends a written exercise of cancellation right or a written notice of cancellation to an insurer, as provided in subdivision (c), or subdivision (d) in the case of an industrial loan company, thereby represents that he or she has a valid right so to do and to receive the unearned premium. If the lender thereby accomplishes the cancellation and receives an unearned premium, such representation shall be conclusive as between the insurer and the lender. An insurer relying upon the written exercise of that right containing a confirmation of cancellation date and giving, when applicable, notice as required by subdivision (e), shall be relieved

from complying with any other duty or form of cancellation required by this code.

(j) This section shall not apply where the insurer exercises its own right to cancel the policy for nonpayment of premium, direct or indirect, or otherwise. Such a cancellation shall be subject to all applicable provisions of the policy, this code, except this section, and any rights of the lender of which the insurer has written notice.

(k) This section shall apply only to contracts entered into between an insured and a lender on or after January 1, 1974.

INSURANCE CODE
SECTION 674-674.9

674. A policy of liability insurance issued to a local public entity or state agency as a named insured shall not be canceled or renewal of such a policy declined for reasons other than nonpayment of premium unless notice is mailed to the named insured at least 45 days prior to the effective date of nonrenewal or at least 60 days prior to the effective date of cancellation. Such notice need not be sent if a renewal notice stating a premium for an additional period of coverage has been sent the named insured at least 45 days before cancellation or expiration of an existing policy and such premium has not been tendered the insurer before such cancellation or expiration. This section shall not require that notice of cancellation or nonrenewal be given an additional insured added by way of endorsement or certificate of insurance.

674.5. (a) No insurer shall cease to offer any particular class of commercial liability insurance without prior notification to the commissioner.

(b) The department shall adopt regulations implementing this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code, except that for the purposes of Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code, any regulations adopted under this section shall be deemed to be necessary for the immediate preservation of the public

peace, health and safety, or general welfare. These regulations shall remain in effect for 180 days. Unless the regulation provides for notification by some other classification or category, notification pursuant to this section shall be made for each class of insurance as defined by the Insurance Services Office.

674.6. (a) No insurer issuing policies of insurance subject to Section 674.5 or 675 shall cease to offer any particular line of coverage without prior notification to the commissioner.

(b) Except as provided in Section 674.9, an insurer shall notify the department at least 60 days prior to the date it intends to withdraw wholly or substantially from a line of (1) commercial liability insurance, (2) any insurance defined in Section 660 or 675 when coverage is provided by a separate rider or endorsement for an activity for which the insured receives compensation, a stipend, or remuneration of any kind for the activity and then only to the extent of the coverage, (3) any other insurance defined in Section 660, or (4) any insurance issued to an individual or individuals covering a risk not arising from a business or commercial activity. Upon receipt of the notice, the commissioner may request and review additional information, as deemed necessary, and investigate the market conditions to determine whether that insurance may become not readily available in the voluntary insurance market as a result of the withdrawal.

(c) For purposes of this section, "intent to substantially withdraw" means an insurer's intent to nonrenew in excess of 50 percent of its current policyholders in the line of coverage upon their next renewal.

(d) The commissioner shall adopt appropriate rules, regulations, and standards for purposes of implementing this section.

(e) Any insurer that has notified the commissioner pursuant to subdivision (b) shall (1) notify the commissioner within 10 days after the date given in the withdrawal notice if the insurer does not in fact withdraw that line of insurance from the market, or (2) notify the commissioner within 10 days after reentry if the insurer reenters that line after the withdrawal.

674.9. (a) Notwithstanding subdivision (b) of Section 674.6, an insurer issuing policies of liability insurance to long-term health care facilities, residential care facilities for the elderly, or

physicians who provide or oversee the provision of services to residents in long-term health care facilities or residential care facilities for the elderly shall notify the department at least 90 days prior to the date it intends to cease, withdraw, or substantially withdraw from offering liability policies to those facilities or physicians.

(b) Each insurer writing liability insurance for long-term health care facilities, residential care facilities for the elderly, or physicians who provide or oversee the provision of services to residents in long-term health care facilities or residential care facilities for the elderly shall, by a date to be set by the commissioner, but in any event no later than July 1 of each calendar year, report to the commissioner information specified by him or her regarding liability policies for those facilities or physicians. The information shall include, but not be limited to, the following:

(1) Whether the insurer is writing coverage for long-term health care facilities, residential care facilities for the elderly, or physicians who provide or oversee the provision of services to residents in long-term health care facilities or residential care facilities for the elderly, including new and renewal policies, and the types of policies it is writing.

(2) The number and types of long-term health care facilities or residential care facilities for the elderly and beds covered.

(3) The total amount of premiums from insureds, both written and earned, during the immediately preceding five calendar years.

(4) The total number of claims received, including the amount per claim.

(5) The number of claims incurred, together with the monetary amount reserved for loss and defense and cost containment expense for the immediately preceding accident year or report year.

(6) The number of claims closed with payment during the immediately preceding five calendar years, the total monetary amount paid for loss thereon, reported by the year the claim was incurred, and the total defense and cost containment expense paid thereon, reported by the year the claim was incurred.

(7) The monetary amount paid on claims, including the amount paid per claim, during the immediately preceding five calendar years to be reported separately by the year the claim was incurred, with defense and cost containment expense paid.

(8) The number of claims closed without payment during the immediately preceding five calendar years, reported by the year the claim was incurred, and the defense and cost containment expense paid thereon.

(9) The monetary amount reserved in the annual statement for loss

and defense cost containment expense for the immediately preceding calendar year for outstanding claims incurred but not reported to the insurer.

(10) The number and types of lawsuits filed against the insureds in the immediately preceding calendar year.

(11) Annualized information on investment income or loss, which shall be consistent with the reported information provided by insurers to the National Association of Insurance Commissioners.

(c) For the purposes of information collection conducted pursuant to this section, first priority shall be given by the department and commissioner to collecting and compiling information from insurers concerning long-term health care facilities and physicians providing services in those facilities, and, to the extent that departmental resources allow, secondary priority shall then be given to the collecting and compiling of information concerning residential care facilities for the elderly and the physicians who provide services in those facilities.

(d) Information that is collected for long-term health care facilities and the physicians for those facilities shall be collected, maintained, analyzed, and reported separately from information that is collected, maintained, analyzed, and reported concerning residential care facilities for the elderly, and the physicians for those facilities.

(e) As used in this section, "long-term health care facility" has the same meaning as that term is defined in Section 1418 of the Health and Safety Code.

(f) As used in this section, "residential care facilities for the elderly" has the same meaning as that term is defined in Section 1569.2 of the Health and Safety Code.

(g) Information collected by the department pursuant to this section shall be deemed official information and subject to the disclosure protections of Section 1040 of the Evidence Code. Nothing in this section shall require individualized information that would identify the amount paid by a specific insurer or facility to be released. However, nothing in this subdivision shall prevent the department from preparing reports and policy recommendations based on the data collected pursuant to this section.

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675. (a) Except as provided in Sections 676.8 and 679.6, this chapter shall apply to policies of insurance, other than automobile insurance and workers' compensation insurance, on risks located or resident in this state which are issued and take effect or which are renewed after the effective date of this chapter and insuring any of the following contingencies:

(1) Loss of or damage to real property which is used predominantly for residential purposes and which consists of not more than four dwelling units.

(2) Loss of or damage to personal property in which natural persons resident in specifically described real property of the kind described in paragraph (1) have an insurable interest, except personal property used in the conduct of a commercial or industrial enterprise.

(3) Legal liability of a natural person or persons for loss of, damage to, or injury to, persons or property, but not including policies primarily insuring risks arising from the conduct of a commercial or industrial enterprise.

(b) This chapter shall not be construed so as to modify or negate any of the provisions of Chapter 3 (commencing with Section 330) of Part 1 of Division 1, nor to destroy any rights or remedies therein provided.

(c) On and after January 1, 2000, an insurer may not refuse to renew a policy of insurance specified in subdivision (a) solely on the grounds that a claim is pending under the policy. This subdivision is not applicable to claims made under coverage for loss or damage caused by the peril of earthquake as provided in Chapter 8.5 (commencing with Section 10081) or Chapter 8.6 (commencing with Section 10089.5), of Part 1 of Division 2.

675.5. (a) In addition to any policy of insurance specified in Section 675, this chapter shall apply to policies of commercial insurance issued or issued for delivery in this state which are issued and take effect or are renewed on or after January 1, 1987.

(b) As used in this section, commercial insurance means commercial multiperil, commercial property, commercial liability, commercial special multiperil, commercial comprehensive multiperil, errors and omissions liability, and professional liability insurance, and any other insurance not included in subdivision (d) which covers any of the following contingencies:

(1) Loss of or damage to real property used or owned by a

commercial or industrial enterprise.

(2) Loss of or damage to personal property, except personally owned motor vehicles, used in the conduct of a commercial or industrial enterprise.

(3) Legal liability of any person for loss of, damage to, or injury to persons or property, arising from the conduct of a commercial or industrial enterprise.

(c) As used in this section, the term commercial or industrial enterprise includes a business operated for profit, a professional practice, a nonprofit organization, or a governmental entity.

(d) As used in this section, the term commercial insurance does not include any of the following:

(1) Worker's compensation insurance.

(2) Insurance provided pursuant to the California FAIR plan or the California automobile assigned risk plan.

(3) Disability insurance.

(4) Automobile insurance covered by Section 660 and property insurance covered by Section 675.

(5) Ocean marine insurance.

(6) Fidelity and surety insurance.

(7) Surplus line insurance.

(8) Reinsurance.

(9) Any insurance, other than professional liability insurance for malpractice, errors, or omissions, for which premiums are determined on a retrospective rating basis.

(10) Nuclear liability insurance.

(11) Nuclear property insurance.

676. After a policy specified in Section 675 has been in effect for 60 days, or, if the policy is a renewal, effective immediately, no notice of cancellation shall be effective unless it is based on the occurrence, after the effective date of the policy, of one or more of the following:

(a) Nonpayment of premium, including nonpayment of any additional premiums, calculated in accordance with the current rating manual of the insurer, justified by a physical change in the insured property or a change in its occupancy or use.

(b) Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against.

(c) Discovery of fraud or material misrepresentation by either of the following:

(1) The insured or his or her representative in obtaining the insurance.

(2) The named insured or his or her representative in pursuing a claim under the policy.

(d) Discovery of grossly negligent acts or omissions by the insured or his or her representative substantially increasing any of the hazards insured against.

(e) Physical changes in the insured property which result in the property becoming uninsurable.

676.1. (a) The arbitrary cancellation of a policy of homeowners' insurance solely on the basis that the policyholder has a license to operate a family day care home at the insured location shall subject the insurer to administrative sanctions authorized by this code unless, there has been a material misrepresentation of fact, the risk has changed substantially since the policy was issued, there has been a nonpayment of premium, or the insurer no longer writes homeowners policies.

(b) The arbitrary refusal to renew a policy of homeowners' insurance solely on the basis that the policyholder has a license to operate a family day care home at the insured location shall subject the insurer to administrative sanctions authorized by this code unless, there has been a material misrepresentation of fact, the risk has changed substantially since the policy was issued, there has been a nonpayment of premium, or the insurer no longer writes homeowners' policies. For purposes of this subdivision, an insured's purchase of a policy of homeowner's insurance to cover a new, primary residence from the same insurer which insured his or her previous primary residence, provided that the insurer then underwrites homeowners' insurance in the geographic area containing the new residence, shall be deemed a renewal of the policy on the previous, primary residence.

(c) It shall be against public policy for a residential property insurance policy to provide coverage for liability for losses arising out of, or in connection with, the operation of a family day care home. This coverage shall only be provided by a separate endorsement or insurance policy for which premiums have been assessed and collected.

676.2. (a) This section applies only to policies of commercial insurance which are subject to Section 675.5.

(b) After a policy has been in effect for more than 60 days, or if the policy is a renewal, effective immediately, no notice of cancellation shall be effective unless it complies with Section 677.2 and it is based on the occurrence, after the effective date of the policy, of one or more of the following:

(1) Nonpayment of premium, including payment due on a prior policy issued by the insurer and due during the current policy term covering the same risks.

(2) A judgment by a court or an administrative tribunal that the named insured has violated any law of this state or of the United States having as one of its necessary elements an act which materially increases any of the risks insured against.

(3) Discovery of fraud or material misrepresentation by either of the following:

(A) The insured or his or her representative in obtaining the insurance.

(B) The named insured or his or her representative in pursuing a claim under the policy.

(4) Discovery of willful or grossly negligent acts or omissions, or of any violations of state laws or regulations establishing safety standards, by the named insured or his or her representative, which materially increase any of the risks insured against.

(5) Failure by the named insured or his or her representative to implement reasonable loss control requirements which were agreed to by the insured as a condition of policy issuance or which were conditions precedent to the use by the insurer of a particular rate or rating plan, if the failure materially increases any of the risks insured against.

(6) A determination by the commissioner that the loss of, or changes in, an insurer's reinsurance covering all or part of the risk would threaten the financial integrity or solvency of the insurer. A certification made under penalty of perjury to the commissioner by an officer of the insurer of the loss of, or change in, reinsurance and that the loss or change will threaten the financial integrity or solvency of the insurer if the cancellation of the policy is not permitted shall constitute such a determination unless disapproved by the commissioner within 30 days of the filing. There shall be no extensions to this 30-day period.

(7) A determination by the commissioner that a continuation of the policy coverage would place the insurer in violation of the laws of this state or the state of its domicile or that the continuation of coverage would threaten the solvency of the insurer.

(8) A change by the named insured or his or her representative in the activities or property of the commercial or industrial enterprise

which results in a material added risk, a materially increased risk or a materially changed risk, unless the added, increased, or changed risk is included in the policy.

(c) After a policy has been in effect for more than 60 days, or if the policy is a renewal, effective immediately upon renewal, no increase in the rate upon which the premium is based, reduction in limits, or change in the conditions of coverage shall be effective during the policy period unless a written notice is mailed or delivered to the named insured and the producer of record at the mailing address shown on the policy, at least 30 days prior to the effective date of the increase, reduction, or change. Subdivision (a) of Section 1013 of the Code of Civil Procedure is applicable if the notice is mailed. The notice shall state the effective date of, and the reasons for, the increase, reduction, or change.

That increase, reduction, or change shall not be effective unless based upon one of the following reasons:

(1) Discovery of willful or grossly negligent acts or omissions, or of any violations of state laws or regulations establishing safety standards by the named insured which materially increase any of the risks or hazards insured against.

(2) Failure by the named insured to implement reasonable loss control requirements which were agreed to by the insured as a condition of policy issuance or which were conditions precedent to the use by the insurer of a particular rate or rating plan, if the failure materially increases any of the risks insured against.

(3) A determination by the commissioner that loss of or changes in an insurer's reinsurance covering all or part of the risk covered by the policy would threaten the financial integrity or solvency of the insurer unless the change in the terms or conditions or rate upon which the premium is based is permitted.

(4) A change by the named insured in the activities or property of the commercial or industrial enterprise which results in a materially added risk, a materially increased risk, or a materially changed risk, unless the added, increased, or changed risk is included in the policy.

(5) With respect to a change in the rate of a policy of professional liability insurance for a health care provider, the insurer's offer of renewal notifies the policyholder that the insurer has an application filed pursuant to Section 1861.05 pending with the commissioner for approval of a change in the rate upon which the premium is based, and the commissioner subsequently approves the rate change, or some different amount for the policy period. The change shall not be retroactive.

(d) The Administrative Procedure Act (Chapter 3.5 (commencing with

Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Title 2 of Division 3 of the Government Code) shall not apply to a determination pursuant to paragraph (6) or (7) of subdivision (b) or paragraph (3) of subdivision (c). The commissioner shall charge an insurer who requests a determination pursuant to paragraph (6) or (7) of subdivision (b) a fee sufficient to recover the costs of making the determination. If the commissioner does not act upon a request by a insurer to cancel or change a policy pursuant to those provisions within 30 days, the request shall be deemed to be approved.

(e) This section shall not prohibit an insurer from increasing a premium during the policy period, if the increase is calculated in accordance with the current rating manual of the insurer, and is justified by a physical change in the insured property or by a change in the activities of the commercial or industrial enterprise which materially increases any of the risks insured against.

(f) This section shall not apply to a transfer of a policy without a change in its terms or conditions or the rate upon which the premium is based between insurers which are members of the same insurance group.

676.3. Nothing in Section 676.2 shall preclude the imposition of remedial underwriting action upon coverage insuring dentists or physicians and surgeons against legal liability arising from the rendering of professional services by an insured licensed pursuant to Chapter 4 (commencing with Section 1600) or Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, respectively, if remedial underwriting action is imposed pursuant to the recommendation of an underwriting committee advising the insurer; provided that a majority of the members of that committee are licensed pursuant to the chapter of Division 2 of the Business and Professions Code that is applicable to that particular insured, and written notification of the proposed remedial underwriting action is first given to the insured, and the insured is afforded not less than 30 days to present opposition or argument to the underwriting committee as to why the remedial underwriting action should be modified or withheld, prior to any imposition thereof. Remedial underwriting action includes all actions described in subdivision (c) of Section 676.2. Remedial underwriting action imposed pursuant to this section shall not be subject to Article 7 (commencing with Section 1858) of Chapter 9 of Part 2, but nothing in this section shall deny the right of the commissioner to

investigate, pursue enforcement action, and seek other remedies as authorized by Article 1 (commencing with Section 12919) of Chapter 2 of Division 3.

It is the intent of the Legislature to encourage peer review by insurers providing coverage to persons engaged in the provision of health services and the adoption of conditions of coverage which are intended to protect the public.

676.4. Nothing in Section 676.2 shall preclude, while the policies are in force, changes in the rate upon which the premium is based or the conditions of coverage, or both, of policies insuring health care facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, if the change is imposed pursuant to the recommendation of a health care facility professional liability advisory committee advising the insurer; provided that a majority of the members of the committee are duly authorized representatives of health care facilities licensed pursuant to that Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and written notification of the change is given to all affected insureds at least 30 days prior to any such change.

676.5. (a) This section applies only to policies of commercial insurance which are subject to Section 675.5.

(b) Except as provided in subdivision (c), for purposes of this chapter only, a policy with no fixed expiration, or with a term of less than one year, shall be considered to be a policy for a term of one year, and a policy written for a term of more than one year shall be considered as if written for successive terms of one year.

(c) For purposes of this chapter, a policy shall be considered to be for a term of less than one year if the policy is issued for a specific risk which does not continue beyond the period of the policy, or if the insured requests a policy for a term of less than one year.

676.6. (a) This section applies to commercial umbrella liability insurance policies, commercial excess liability insurance policies, and commercial excess property insurance policies.

(b) As used in this section:

(1) "Umbrella liability insurance policy" means an insurance policy providing liability coverage per person or per occurrence or per claim, when written over one or more underlying liability policies or over a specified amount of self-insured retention.

(2) "Excess liability insurance policy" means an insurance policy providing liability covrage per person or per occurrence or per claim when written over one or more underlying liability policies. Excess liability policies shall include policies written over umbrella liability policies.

(3) "Excess property insurance policy" means a policy providing property coverage per occurrence or per location when written over one or more underlying property insurance policies or a specified amount of self-insured retention.

(c) After a policy defined in subdivision (b) of this section has been in effect for more than 60 days, or if the policy is a renewal, effective immediately, no notice of cancellation shall be effective unless it complies with Section 677. 2, is based on one or more of the grounds set forth in subdivision (b) of Section 676.2, or is based on one or more of the following:

(1) A material change in limits, type or scope of coverage, or exclusions in one or more of the underlying policies.

(2) Cancellation or nonrenewal of one or more of the underlying policies where such policies are not replaced without lapse.

(3) A reduction in financial rating or grade of one or more insurers, insuring one or more underlying policies based on an evaluation obtained from a recognized financial rating organization.

(d) A notice of nonrenewal shall not be required in any of the following situations:

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers which are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of

the policy period.

(6) The insurer has made a written offer to the insured, within the time period specified in subdivision (c), to renew the policy under changed terms or conditions or at a changed premium rate. As used herein, "terms or conditions" includes, but is not limited to, a reduction in limits, elimination of coverages, or an increase in deductibles.

676.7. (a) No admitted insurer, licensed to issue and issuing homeowner's or tenant's policies, as described in Section 122, shall (1) fail or refuse to accept an application for that insurance or to issue that insurance to an applicant or (2) cancel that insurance, solely on the basis that the applicant or policyholder is engaged in foster home activities in a licensed foster family home or licensed small family home, as defined in Section 1502 of the Health and Safety Code.

(b) Coverage under policies described in subdivision (a) with respect to a foster child shall be the same as that provided for a natural child. However, unless specifically provided in the policy, there shall be no coverage expressly provided in the policy for any bodily injury arising out of the operation or use of any motor vehicle, aircraft, or watercraft owned or operated by, or rented or loaned to, any foster parent.

(c) It is against public policy for a policy of homeowner's or tenant's insurance subject to this section to provide liability coverage for any of the following losses:

(1) Claims of a foster child, or a parent, guardian, or guardian ad litem thereof, of a type payable by the Foster Family Home and Small Family Home Insurance Fund established by Section 1527.1 of the Health and Safety Code, regardless of whether the claim is within the limits of coverage specified in Section 1527.4 of the Health and Safety Code.

(2) An insurer shall not be liable, under a policy of insurance subject to this section, to any governmental agency for damage arising from occurrences peculiar to the foster-care relationship and the provision of foster-care services.

(3) Alienation of affection of a foster child.

(4) Any loss arising out of licentious, immoral, or sexual behavior on the part of a foster parent intended to lead to, or culminating in, any sexual act.

(5) Any loss arising out of a dishonest, fraudulent, criminal, or intentional act.

(d) There shall be no penalty for violations of this section prior to January 1, 1987.

(e) Insurers may provide a special endorsement to a homeowners' or tenants' policy covering claims related to foster care that are not excluded by subdivision (c).

(f) Insurers may provide by a separate policy for some or all of the claims related to foster care that are excluded by subdivision (c).

676.8. (a) This section applies only to policies of workers' compensation insurance.

(b) After a policy is in effect, no notice of cancellation shall be effective unless it complies with the notice requirements of this section and is based upon the occurrence, after the effective date of the policy, of one or more of the following:

(1) The policyholder's failure to make any workers' compensation insurance premium payment when due.

(2) The policyholder's failure to report payroll, to permit the insurer to audit payroll as required by the terms of the policy or of a previous policy issued by the insurer, or to pay any additional premium as a result of a audit of payroll as required by the terms of the policy or of a previous policy.

(3) The policyholder's material failure to comply with federal or state safety orders or written recommendations of the insurer's designated loss control representative.

(4) A material change in ownership or any change in the policyholder's business or operations that materially increases the hazard for frequency or severity of loss, requires additional or different classifications for premium calculations, or contemplates an activity excluded by the insurer's reinsurance treaties.

(5) Material misrepresentation by the policyholder or its agent.

(6) Failure to cooperate with the insurer in the insurer's investigation of a claim.

(c) A policy shall not be canceled for the conditions specified in paragraph (1), (2), (5), or (6) of subdivision (b) except upon 10 days' written notice to the policyholder by the insurer. A policy shall not be canceled for the conditions specified in paragraph (3) or (4) of subdivision (b) except upon 30 days' written notice to the policyholder by the insurer, provided that no notice is required if an insured and insurer consent to the cancellation and reissuance of a policy effective upon a material change in ownership or operations of the insured. If the policyholder remedies the condition to the insurer's satisfaction within the specified time period, the policy

shall not be canceled by the insurer.

(d) Nothing in this section shall preclude, while policies are in force, changes in the premium rate required or authorized by law, regulation, or order of the commissioner, or otherwise agreed to between the policyholder and insurer.

(e) Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall be considered as if written for successive policy periods of one year.

676.9. (a) This section applies to policies covered by Sections 675 and 675.5.

(b) No insurer issuing policies subject to this section shall deny or refuse to accept an application, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate, or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be, a victim of domestic violence.

(c) Nothing in this section shall prevent an insurer subject to this section from taking any of the actions set forth in subdivision (b) on the basis of criteria not otherwise made invalid by this section or any other act, regulation, or rule of law. If discrimination by an insurer is not in violation of this section but is based on any other criteria that are allowable by law, the fact that the applicant or insured is, has been, or may be the subject of domestic violence shall be irrelevant.

(d) For purposes of this section, information that indicates that a person is, has been, or may be a victim of domestic violence is personal information within the meaning of Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2.

(e) No insurer that issues policies subject to this section, and no person employed by or under contract with an insurer that issues policies subject to this section, shall request any information the insurer or person knows or reasonably should know relates to acts of domestic violence or an applicant's or insured's status as a victim of domestic violence, or make use of this information however obtained, except for the limited purpose of complying with legal obligations, verifying a person's claim to be a subject of domestic violence, or cooperating with a victim of domestic violence in seeking protection from domestic violence or facilitating the treatment of a domestic violence-related medical condition. This subdivision does not prohibit an insurer from asking an applicant or insured about a property and casualty claim, even if the claim is

related to domestic violence, or from using information thereby obtained in evaluating and carrying out its rights and duties under the policy, to the extent otherwise permitted by this section and other applicable law.

(f) As used in this section, "domestic violence" means domestic violence as defined in Section 6211 of the Family Code.

676.10. (a) This section applies to policies covered by Section 675, 675.5, or 676.5 if the insured is a religious organization described in clause (i) of subparagraph (A) of paragraph (1) of subsection (b) of Section 170 of Title 26 of the United States Code, an educational organization described in clause (ii) of subparagraph (A) of paragraph (1) of subsection (b) of Section 170 of Title 26 of the United States Code, or other nonprofit organization described in clause (vi) of subparagraph (A) of paragraph (1) of subsection (b) of Section 170 of Title 26 of the United States Code that is organized and operated for religious, charitable, or educational purposes, or a reproductive health services facility, as defined in subdivision (h) of Section 423.1 of the Penal Code, or its administrative offices.

(b) No insurer issuing policies subject to this section shall cancel or refuse to renew the policy, nor shall any premium be excessive or unfairly discriminatory solely on the basis that one or more claims has been made against the policy during the preceding 60 months for a loss that is the result of a hate crime committed against the person or property of the insured, or an anti-reproductive-rights crime.

(c) As it relates to this section, if determined by a law enforcement agency, a "hate crime" may include any of the following:

(1) By force or threat of force, willfully injure, intimidate, interfere with, oppress, or threaten any other person in the free exercise or enjoyment of any right or privilege secured to him or her by the Constitution or laws of this state or by the Constitution or laws of the United States because of the other person's race, color, religion, ancestry, national origin, disability, gender, or sexual orientation, or because he or she perceives that the other person has one or more of those characteristics. However, the foregoing offense does not include speech alone, except upon a showing that the speech itself threatened violence against a specific person or group of persons and that the defendant had the apparent ability to carry out the threat.

(2) Knowingly deface, damage, or destroy the real or personal

property of any other person for the purpose of intimidating or interfering with the free exercise or enjoyment of any right or privilege secured to the other person by the Constitution or laws of this state or by the Constitution or laws of the United States, because of the other person's race, color, religion, ancestry, national origin, disability, gender, or sexual orientation, or because he or she perceives that the other person has one or more of those characteristics.

(d) As it relates to this section, if determined by a law enforcement agency, "anti-reproductive-rights crime" shall have the meaning set forth in subdivision (a) of Section 13776 of the Penal Code, and shall also include a violation of subdivision (e) of Section 423.2 of the Penal Code, if the crime results in a covered loss under a policy subject to this section.

(e) Upon cancellation of or refusal to renew a policy subject to this section after an insured has submitted a claim to the insurer that is the result of a hate crime committed against the person or property of the insured, or an anti-reproductive-rights crime, the insurer shall report the cancellation or nonrenewal to the commissioner.

(f) A violation of this section shall be an unfair practice subject to Article 6.5 (commencing with Section 790) of Chapter 1 of Division 2.

(g) Nothing in this section shall prevent an insurer subject to this section from taking any of the actions set forth in subdivision (b) on the basis of criteria not otherwise made invalid by this section or any other act, regulation, or law.

677. All notices of cancellation shall be in writing, mailed to the named insured at the address shown in the policy, or to his or her last known address, and shall state, with respect to policies in effect after the time limits specified in Section 676, (a) which of the grounds set forth in Section 676 is relied upon, and (b) that, upon written request of the named insured, mailed or delivered to the insurer within 15 days of the date of cancellation, the insurer shall specify the reason for the cancellation except where the reason is for nonpayment of premium and is so stated in the cancellation notice.

677.2. (a) This section applies only to policies covered by Section 675.5.

(b) A notice of cancellation shall be in writing and shall be delivered or mailed to the producer of record, provided that the producer of record is not an employee of the insurer, and to the named insured at the mailing address shown on the policy. Subdivision (a) of Section 1013 of the Code of Civil Procedure is applicable if the notice is mailed.

The notice of cancellation shall include the effective date of the cancellation and the reasons for the cancellation.

(c) The notice of cancellation shall be given at least 30 days prior to the effective date of the cancellation, except that in the case of cancellation for nonpayment of premiums or for fraud the notice shall be given no less than 10 days prior to the effective date of the cancellation. Notice of a proposed cancellation pursuant to subdivision (d) of Section 676.2 given prior to a finding of the commissioner shall satisfy the requirements of this section if it is given no less than 30 days prior to the effective date of the cancellation and if it states that cancellation will be effective only upon the approval of the commissioner.

(d) This section applies only to cancellations pursuant to Section 676.2.

677.4. A notice of cancellation with respect to a policy covered under Section 675 shall be delivered at least 20 calendar days prior to the effective date of the cancellation, except that in the case of a cancellation for nonpayment of premiums, or for fraud, the notice shall be given at least 10 calendar days prior to the effective date of the cancellation. Subdivision (a) of Section 1013 of the Code of Civil Procedure is applicable if the notice is mailed.

678. (a) At least 45 days prior to policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(1) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating any reduction of limits or elimination of coverage if any.

(2) A notice of nonrenewal of the policy. That notice shall contain or be accompanied by a statement that upon written request by the named insured, made not later than one month following the expiration of the policy period, or delivered to the insurer, the insurer will provide notice to the insured in writing, within 20 days

of his or her request, of the reason or reasons for the nonrenewal.

(b) In the event an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Any policy written for a term of less than one year shall be considered as if written for a term of one year. Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall be considered as if written for successive policy periods or terms of one year.

(d) This section applies only to policies of insurance specified in Section 675.

678. (a) At least 45 days prior to policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(1) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating each of the following:

(A) Any reduction of limits or elimination of coverage.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the renewal offer.

(2) A notice of nonrenewal of the policy. That notice shall contain each of the following:

(A) The reason or reasons for the nonrenewal.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the notice of nonrenewal.

(C) A brief statement indicating that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, he or she may have the matter reviewed by the department. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

(b) In the event an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this

section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Any policy written for a term of less than one year shall be considered as if written for a term of one year. Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall be considered as if written for successive policy periods or terms of one year.

(d) This section applies only to policies of insurance specified in Section 675.

678.1. (a) This section applies only to policies of insurance of commercial insurance that are subject to Sections 675.5 and 676.6.

(b) A notice of nonrenewal shall be in writing and shall be delivered or mailed to the producer of record and to the named insured at the mailing address shown on the policy. Subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

(c) An insurer, at least 60 days, but not more than 120 days, in advance of the end of the policy period, shall give notice of nonrenewal, and the reasons for the nonrenewal, if the insurer intends not to renew the policy, or to condition renewal upon reduction of limits, elimination of coverages, increase in deductibles, or increase of more than 25 percent in the rate upon which the premium is based.

(d) If an insurer fails to give timely notice required by subdivision (c), the policy of insurance shall be continued, with no change in its terms or conditions, for a period of 60 days after the insurer gives the notice.

(e) With respect to policies defined in subdivision (b) of Section 676.6, in addition to the bases for conditional renewal set forth in subdivision (c), an insurer may also condition renewal upon requirements relating to the underlying policy or policies. If the requirements are not satisfied as of (1) the expiration date of the policy, or (2) 30 days after mailing or delivery of such notice, whichever is later, the conditional renewal notice shall be treated as an effective notice of nonrenewal, provided the insurer has sent written confirmation to the first named insured and the producer of record that the conditions were not met and that coverage ceased at the expiration date shown in the expiring policy.

(f) A notice of nonrenewal shall not be required in any of the following situations.

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers that are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

(6) The insurer has made a written offer to the insured, within the time period specified in subdivision (c), to renew the policy under changed terms or conditions or at a changed premium rate. As used herein, "terms or conditions" includes, but is not limited to, a reduction in limits, elimination of coverages, or an increase in deductibles.

678.2. The provisions of subdivisions (c) and (e) of Section 678.1 which prohibit notice of nonrenewal earlier than 120 days in advance of the end of the policy period shall not apply to professional liability policies issued to health care providers.

678.5. No policy specified in Section 675 that is issued, amended, or renewed on or after January 1, 1990, may be canceled, and an insurer may not refuse to renew such a policy solely on the grounds of corrosive soil conditions if the policy or renewal policy contains an existing exclusion for payment of loss for that peril.

679. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer or its

authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any statement made, unless shown to have been made in bad faith with malice in fact, by any of them in (a) any written notice of cancellation or in any other oral or written communication specifying the reasons for cancellation, (b) any communication providing information pertaining to such cancellation, or (c) evidence submitted at any court proceeding or informal inquiry in which such cancellation is an issue.

679.5. Proof of mailing of a notice of cancellation and the reasons therefor or of intention not to renew to the named insured at the address shown in the policy shall be sufficient proof of the notice required by this chapter.

679.6. The commissioner may, after hearing, exempt from the provisions of this chapter insurance in respect to any risk or class of risk that is eligible under Section 1763 for placement with nonadmitted insurers by and through licensed surplus line brokers upon a finding by him that application of this chapter would diminish or tend to diminish the availability, or substantially increase the cost, of such insurance.

679.7. (a) Upon receiving a written request from an insured or the agent or broker of record where authorized by the insured, an insurer shall provide a premium and loss history report to the requesting party for the account's tenure or the three-year period ending with the inception of the current policy period, whichever is shorter, plus loss experience during the current policy period that is in force if any of the following occur:

(1) The policy is canceled or nonrenewed.

(2) The policyholder requests the information within 60 days prior to the renewal date of an existing policy.

(3) The policyholder's current insurer's rating is downrated by a nationally recognized insurance rating service to a financial rating below secure or good or to a rating that would negatively impact the ability of the policyholder to conduct its business operations.

(4) The policyholder's current insurer is conserved by the department under Section 1011, or is ordered to cease writing

business under Sections 1065.1 and 1065.2.

The premium and loss history report, and the loss experience information for the current policy period, shall be provided within 10 business days of receiving the request.

(b) This section applies only to policies of commercial insurance that are subject to Sections 675.5 and 676.6, except for professional liability insurance.

(c) This section shall not apply to a policyholder who, through automated or other means, is provided direct, ongoing access to claims information by the insurer.

(d) For purposes of this section, a loss history report includes, but is not limited to, a list of individual claims detailed by date of claim and total incurred and paid losses.

INSURANCE CODE
SECTION 679.9

679.9. If an insurer changes the annual premium under a policy specified in Section 675, it shall, within 15 business days of a request by the insured, inform the insured in writing of each of the following:

(a) The amount of the premium increase or decrease in comparison to the premium charged in the previous year.

(b) The reason or reasons for the change, including, but not limited to, the deletion of a loss-free credit, the application of a claim-related surcharge, or any other reason related to a claim or policyholder inquiry.

(c) A brief statement indicating each of the following:

(1) That the consumer may contact their agent or the insurer with any additional questions regarding the premium and providing the telephone number for the insurer's representatives who are capable of responding, and authorized to respond, to consumer inquiries and complaints.

(2) That if the insured has contacted the insurer to discuss a premium increase and the insured remains unsatisfied, he or she may contact the department with any inquiries or complaints. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

INSURANCE CODE
SECTION 679.70-679.73

679.70. This chapter shall apply to policies of insurance, other than automobile insurance and workmen's compensation insurance, on risks located or resident in this state which are issued and take effect or which are renewed after the effective date of this chapter and which insure any of the following contingencies:

(a) Loss of or damage to real property which is used predominantly for residential purposes.

(b) Loss of or damage to personal property in which natural persons resident in specifically described real property of the kind described in subdivision (a) have an insurable interest.

(c) Legal liability of a natural person or persons for loss of, damage to, or injury to, persons or property.

679.71. No admitted insurer, licensed to issue any policy of insurance covered by this chapter, shall fail or refuse to accept an application for, or to issue a policy to an applicant for, such insurance (unless such insurance is to be issued to the applicant by another insurer under the same management and control), or cancel such insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every marital status, sex, race, color, religion, national origin, or ancestry; nor shall sex, race, color, religion, national origin, or ancestry of itself constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for such insurance.

679.72. No application for insurance specified in this chapter or insurance investigation report furnished by such an insurer to its agents or employees for use in determining the insurability of the applicant shall carry any identification, or any requirement therefor, of the applicant's race, color, religion, national origin, or ancestry.

679.73. Nothing in this chapter shall prohibit use in an application for insurance specified in this chapter of a question asking for the birthplace of an applicant if such question is used only to identify the applicant and not to discriminate against the applicant.

INSURANCE CODE
SECTION 680

680. An insurer shall not transact any class of insurance which is not authorized by its charter.

INSURANCE CODE
SECTION 685-685.4

685. (a) When by or pursuant to the laws of any other state or foreign country any taxes, licenses and other fees, in the aggregate, and any fines, penalties, deposit requirements or other material obligations, prohibitions or restrictions are or would be imposed upon California insurers, or upon the agents or representatives of those insurers, that are in excess of the taxes, licenses and other fees, in the aggregate, or that are in excess of the fines, penalties, deposit requirements or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the agents or representatives of those insurers, of that other state or country under the statutes of this state, so long as the laws of the other state or country continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties, deposit requirements or other material obligations, prohibitions, or restrictions, of whatever kind, shall be imposed upon the insurers, or upon the agents or representatives of those insurers, of the other state or country doing business or seeking to do business in California. Any tax, license or other fee or other obligation imposed by any city, county, or other political

subdivision or agency of the other state or country on California insurers or their agents or representatives shall be deemed to be imposed by that state or country within the meaning of this article.

(b) On and after January 1, 1994, and before January 1, 1995, every insurer whose annual taxes exceed fifty thousand dollars ($50,000) shall make payment by electronic funds transfer. On and after January 1, 1995, every insurer whose annual taxes exceed twenty thousand dollars ($20,000) shall make payment by electronic funds transfer. The insurer shall choose one of the acceptable methods described in Section 45 for completing the electronic funds transfer.

(c) Payment is deemed complete on the date the electronic funds transfer is initiated, if settlement to the state's demand account occurs on or before the banking day following the date the transfer is initiated. If settlement to the state's demand account does not occur on or before the banking day following the date the transfer is initiated, payment is deemed to occur on the date settlement occurs.

(d) (1) Any insurer required to remit taxes by electronic funds transfer pursuant to this section who remits those taxes by means other than an appropriate electronic funds transfer, shall be assessed a penalty in an amount equal to 10 percent of the taxes due at the time of the payment.

(2) If the department finds that an insurer's failure to make payment by an appropriate electronic funds transfer in accordance with subdivision (b) is due to reasonable cause or circumstances beyond the insurer's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, that insurer shall be relieved of the penalty provided in paragraph (1).

(3) Any insurer seeking to be relieved of the penalty provided in paragraph (1) shall file with the department a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

685.1. This article shall not apply as to personal income taxes, nor as to ad valorem taxes on real or personal property nor as to special purpose obligations or assessments heretofore imposed by another state or foreign country in connection with particular kinds of insurance, other than property insurance; except that deductions, from premium taxes or other taxes otherwise payable, allowed on

account of real estate or personal property taxes paid shall be taken into consideration in determining the propriety and extent of retaliatory action under this article.

685.2. For the purposes of this article the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state in which is located its principal place of business in the United States.

In the case of an insurer formed under the laws of Canada or a province thereof, its domicile shall be deemed to be that province in which its head office is situated.

685.3. To the extent permitted by the California Constitution there is hereby imposed upon the commissioner the duty to enforce Section 685. It shall be the duty of the commissioner to initiate the enforcement and execution of Section 685 in respect to all matters which by the California Constitution or laws of this state require further or final action by other officials of this state. In respect to any matter initiated by the commissioner, it shall be the duty of the Board of Equalization and the Controller to complete the enforcement and execution of Section 685 in respect to that matter within the scope of the duties and powers of each as set forth in the California Constitution and laws of this state.

685.4. The provisions of this article shall also be applicable to reciprocals or interinsurance exchanges and fraternal benefit societies.

INSURANCE CODE
SECTION 688-688.5

688. The Legislature declares that it is desirable for the general welfare and in particular for the welfare of insurance beneficiaries, policyholders, injured claimants and others that the business of domestic insurers be continued notwithstanding the event of a

national emergency.

The specific purpose of this chapter is to facilitate the continued operation of domestic insurers in the event that a national emergency is caused by an attack on the United States or by a nuclear, atomic or other disaster which makes it impossible or impracticable for a company to conduct its business in strict accord with applicable provisions of law, its bylaws, or its charter.

688.1. The board of directors of any domestic insurer may at any time adopt emergency bylaws, subject to repeal or change by action of those having power to adopt regular bylaws for the insurer, which shall be operative during such a national emergency and which may, notwithstanding any different provisions of the regular bylaws, or of the applicable statutes, or of the insurer's charter, make any provision that may be reasonably necessary for the operation of the insurer during the period of such emergency.

688.2. In the event that the board of directors of a domestic insurer has not adopted emergency bylaws, the following provisions shall become effective upon the occurrence of such a national emergency:

(1) Three directors shall constitute a quorum for the transaction of business at all meetings of the board.

(2) Any vacancy in the board may be filled by a majority of the remaining directors, though less than a quorum, or by a sole remaining director.

(3) If there are no surviving directors, but at least three vice presidents of the company survive, the three vice presidents with the longest term of service shall be the directors and shall possess all of the powers of the previous board of directors and such powers as are granted herein or by subsequently enacted legislation. By majority vote such emergency board of directors may elect other directors. If there are not at least three surviving vice presidents, the commissioner or duly designated person exercising the powers of the commissioner shall appoint three persons as directors who shall possess all of the powers of the previous board of directors and such powers as are granted herein or by subsequently enacted legislation, and these persons by majority vote may elect other directors.

688.3. At any time the board of directors of a domestic insurer may, by resolution, provide that in the event of such a national emergency and in the event of the death or incapacity of the president, the secretary or the treasurer of the company such officers, or any of them, shall be succeeded in the office by the person named or described in a succession list adopted by the board of directors. Such list may be on the basis of named persons or position titles, shall establish the order of priority and may prescribe the conditions under which the powers of the office shall be exercised.

688.4. At any time the board of directors of a domestic insurer may, by resolution, provide that in the event of such a national emergency the home office or principal place of business of the insurer shall be at such location as is named or described in the resolution. Such resolution may provide for alternate locations and establish an order of preference.

688.5. "Insurer" as used in this article includes insurance corporations and insurer organizations of every type and reciprocal or interinsurance exchanges and the incorporated attorney in fact of a reciprocal or interinsurance exchange, which corporate attorney in fact is either organized under the laws of or has its home office and principal place of business in this State.

"Board of directors" as used in this article includes the policy-determining body of an insurer whether or not it is called by that name.

INSURANCE CODE
SECTION 690

690. If any paid in capital of an insurer is, or is to be, represented by shares of stock, such insurer shall not be organized in this State or admitted to transact any class of insurance in this State, unless all of such shares, authorized or issued, have a specified par value.

INSURANCE CODE
SECTION 699-728

699. Except as specifically permitted by this code, a certificate of authority shall not be issued to an unincorporated insurer. This section shall not be applicable to an unincorporated insurer now holding a certificate of authority to transact any class of insurance in California, nor shall it affect the right of any such unincorporated insurer to hereafter apply for or be issued a renewal certificate of authority or an amended certificate of authority to transact additional classes of insurance; provided, that any such unincorporated insurer shall continue to comply insofar as applicable with the same requirements as are now or hereafter applicable to corporate insurers; nor shall this section prohibit the issuance of a certificate of exemption to the trustees of a fund established by one employer, or by two or more employers in the same industry, or by one or more labor unions, or by one or more employers and one or more labor unions, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions.

699.1. The Public Employees' Retirement System is exempt from the provisions of this code with respect to the group life insurance program established pursuant to Article 7 (commencing with Section 21400), Chapter 9, Part 3, Title 2 of the Government Code.

699.5. (a) The ownership or financial control, in part, direct or indirect, of any domestic, foreign, or alien insurer, by any state of the United States or by a foreign government or by any political subdivision of either, or by an agency of any other state, government, or subdivision thereof, shall not, provided the insurer complies with all other requirements for issuance, renewal, or continuation of a license, restrict the commissioner from issuing, renewing, or continuing in effect the license of that insurer to transact in this state the kinds of insurance business for which that insurer is otherwise qualified under the provisions of this chapter

and under its charter unless the commissioner shall find that (1) the insurer is subject to any form of subsidy that would enable it to compete unfairly with domestic insurers, (2) the insurer is subject to governmental practices that discriminate on the basis of race, color, creed, or national origin, (3) the ownership or financial control will create the presence of any sovereign immunity in the insurer, (4) appropriate measures and controls do not exist to avoid security problems resulting from an insurer's access to confidential information and data of its insured, or (5) the ownership or financial control results in substantial or undue influence being asserted over the insurer.

(b) The failure by any applicant for a license to submit the information requested by the commissioner for the purposes of determining whether to make a finding pursuant to subdivision (a) shall be sufficient to deny the application.

(c) Nothing in the amendments to this section enacted during the 1994 portion of the 1993-94 Regular Session of the Legislature shall be interpreted to authorize the issuance of a license to an insurer wholly owned by any governmental entity described in subdivision (a).

700. (a) A person shall not transact any class of insurance business in this state without first being admitted for that class. Admission is secured by procuring a certificate of authority from the commissioner. The certificate shall not be granted until the applicant conforms to the requirements of this code and of the laws of this state prerequisite to its issue.

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

(c) After the issuance of a certificate of authority, the holder shall continue to comply with the requirements as to its business set forth in this code and in the other laws of this state, including, but not limited to, Chapter 5 (commencing with Section 1631), with regard to employees or contractors who solicit, negotiate, or effect insurance.

(d) Where a hearing is held under this section the proceedings shall be conducted in accordance with Chapter 5 (commencing with

Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

(e) The commissioner shall either issue or deny an application for a certificate of authority within 180 calendar days after the date of the application.

(f) The commissioner and his or her authorized representative shall be prohibited from seeking a waiver to extend the 180 calendar day period specified in subdivision (e), nor shall the applicant be permitted to waive that period.

700.01. In addition to any or all of the classes of insurance which it is permitted to transact by all other applicable provisions of this code, any incorporated insurer admitted or hereafter admitted for one or more of the classes of insurance stated in Section 100, except life, title, mortgage, or mortgage guaranty shall (subject to any limitations contained in its articles of incorporation or charter) be admitted after January 1, 1990, for any or all of the following classes, upon making application therefor and complying with all applicable requirements of law, if its paid-in capital is not less than two million six hundred thousand dollars ($2,600,000) or the aggregate of the amounts hereinafter set forth opposite the classes transacted by it in the United States if an alien insurer, or in any jurisdiction if other than an alien insurer, whichever is lower; provided, that the paid-in capital of incorporated insurers not transacting either fire, marine or surety insurance making application under this section shall be at least three hundred thousand dollars ($300,000) in excess of that aggregate amount. In no event shall any incorporated insurer, as a condition for its admission, be permitted to have a paid-in capital of less than one million dollars ($1,000,000) or be required to have a paid-in capital in excess of two million six hundred thousand dollars ($2,600,000) for any or all of the classes of insurance hereinafter set forth.

Number and name of class	Amount of capital
2. Fire	$350,000
3. Marine	350,000
5. Surety	350,000
6. Disability	250,000
7. Plate glass	100,000

8.	Liability)	
9.	Workers')	
	compensation)	300,000 for any
10.	Common carrier)	or all of these
	liability)	
11.	Boiler and machinery	100,000
12.	Burglary	100,000
13.	Credit	100,000
14.	Sprinkler	100,000
15.	Team and vehicle	100,000
16.	Automobile	200,000
18.	Aircraft	100,000
20.	Miscellaneous	100,000

This section shall not be applicable to life, title, mortgage, or mortgage guaranty insurance, and an insurer now or hereafter admitted to transact life, title, mortgage, or mortgage guaranty insurance shall not be admitted under the provisions of this section, but its admission is governed by other applicable provisions of this code.

Insurers admitted for one or more classes of insurance on December 31, 1989, shall be governed by the provisions of this section in effect as of December 31, 1989, until December 31, 1999. After December 31, 1999, all insurers governed by this section shall meet the capital requirements of this section as become effective January 1, 1990. Insurers admitted for one or more classes of insurance on December 31, 1989, that thereafter amend their certificate of authority to add a class or classes of insurance shall become subject to the capital requirements of this section.

700.02. No insurer shall be issued a certificate of authority other than a renewal certificate of authority for any of the classes set forth in Section 100 unless at the time of such issuance it possesses, in addition to the minimum paid-in capital required by this code a surplus of not less than 100 percent of the minimum paid-in capital required.

As used in this section, surplus means the excess of admitted assets over the sum of (1) liabilities for losses reported, expenses, taxes and all other indebtedness and reinsurance of outstanding risks as provided by law, and (2) paid-in capital, in the case of an insurer issuing or having outstanding shares of capital stock, or (3) the minimum paid-in capital required, in the case of any other insurer.

700.025. An insurer, including a reciprocal or interinsurance exchange, admitted on January 1, 1970, to transact automobile liability insurance under class 8 and automobile insurance under class 16, or which had a valid bona fide application to transact both such classes of insurance pending before the commissioner on or before August 1, 1970, shall not be affected by this section.

Any other insurer, including a reciprocal or interinsurance exchange, applying to transact either of such class of insurance in this state, shall possess, at the time of admission for either of such classes, in addition to all minimum paid-in capital required by Section 700.01 and all surplus and paid-in capital required by Sections 700.02 and 700.05, an additional surplus of two hundred thousand dollars ($200,000).

700.03. Notwithstanding the requirements of Sections 700.01 and 10511 until June 30, 1955, the minimum paid-in capital required for renewal, for the same classes of insurance, of the certificate of authority of any insurer which was in effect on July 1, 1953, shall be that required by such sections as effective on such date. After June 30, 1955, and until such time as such insurer increases its paid-in capital to the amount required by Sections 700.01 and 10511 as effective on October 1, 1953, the minimum paid-in capital required for such renewal shall continue to be that required by such sections as effective on July 1, 1953, but such insurer shall be required to maintain a surplus, as defined in Section 700.02, in an amount which, when combined with the amount of its paid-in capital, shall equal the minimum amount of paid-in capital required by Sections 700.01 and 10511 as effective on October 1, 1953.

700.04. Paid-in capital for life insurers is governed by Section 10510 of this code; for title insurers by Section 12359; for mortgage insurers by Section 12440; and for mortgage guaranty insurers by Section 12640.03.

700.05. (a) In determining the minimum amount of paid-in capital and surplus required by the applicable provisions of this code for admission of an insurer, there shall be included all of the classes

of insurance transacted by it in the United States if an alien insurer, or in any jurisdiction if other than an alien insurer; provided, that life, title, mortgage or mortgage guaranty insurance shall not be included among the classes of insurance in determining the minimum amount of paid-in capital and surplus required if the minimum paid-in capital is two million six hundred thousand dollars ($2,600,000) or more, and if the paid-in capital is less than two million six hundred thousand dollars ($2,600,000) the minimum shall be measured by adding to the amounts set forth in Section 700.01 two million two hundred fifty thousand dollars ($2,250,000) for life insurance, two hundred fifty thousand dollars ($250,000) for mortgage insurance, one million dollars ($1,000,000) for mortgage guaranty insurance and two hundred fifty thousand dollars ($250,000) for title insurance.

In applying such provisions, it shall be conclusively presumed that an insurer transacts all classes of insurance for which it is or seeks to be admitted to transact in this state.

(b) As used in this section, "insurer" includes a reciprocal or interinsurance exchange and its attorney in fact.

701. Subject to the annual fee provisions of Section 705, every certificate of authority shall be for an indefinite term and shall expire with the expiration or termination of a corporate existence of the holder thereof. Notwithstanding the provisions of this section, whenever the commissioner shall determine, after notice and hearing, that any insurer to whom such certificate has been issued is in arrears to the State, or to any county or city in the State, for fees, licenses, taxes, assessments, fines or penalties, accrued on business transacted in the State, or is otherwise in default for failure to comply with any of the laws of this State regarding the governmental control of such insurer by the State, he may order that such insurer comply with the said requirements within 30 days of such determination. If the insurer fails to comply within such period, the certificate of authority may then be revoked, unless the commissioner's order is stayed by a court of appropriate jurisdiction.

702. (a) An insurer that maintains a certificate of authority to transact insurance in this state, advertises insurance on the Internet, and transacts insurance in this state, shall identify all of the following information on the Internet, regardless of whether

the insurer maintains its Internet presence or if the presence is maintained on its behalf:

(1) Its name as it appears on its California certificate of authority, and if different, the name approved by the commissioner for doing business in this state.

(2) The state of its domicile and its principal place of business.

(3) The number on its California certificate of authority. In lieu of this number, an insurer may identify all states in which it maintains certificates of authority to transact insurance, provided that the insurer discloses its identification number as assigned by the National Association of Insurance Commissioners.

(b) An Internet presence maintained by or on behalf of an insurer not admitted to transact insurance in this state constitutes an advertisement, and the insurer shall comply with the requirements of Section 703.1 if it transacts insurance as defined in subdivision (c).

(c) A person who advertises on the Internet shall be deemed to be transacting insurance in this state if the person does any of the following:

(1) Provides an insurance premium quote specifically to a California resident.

(2) Accepts an application for coverage from a California resident.

(3) Otherwise communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

This subdivision shall not apply to any lawful placement with a nonadmitted insurer, including when a person conveys a quote, accepts an application, and conducts all communications with a California resident solely through a surplus line broker or special lines' surplus line broker pursuant to California surplus line laws.

703. Except when performed by a surplus line broker, the following acts are misdemeanors when done in this state:

(a) Acting as agent for a nonadmitted insurer in the transaction of insurance business in this state.

(b) In any manner advertising a nonadmitted insurer in this state.

(c) In any other manner aiding a nonadmitted insurer to transact insurance business in this state.

In addition to any penalty provided for commission of

misdemeanors, a person violating any provision of this section shall forfeit to this state the sum of five hundred dollars ($500), together with one hundred dollars ($100) for each month or fraction thereof during which he or she continues the violation. This section shall not apply to advertising authorized by Section 703.1, subdivision (h) of Section 1760.5, or Section 1773.

703.1. (a) Any nonadmitted insurer that is on the list of eligible surplus line insurers issued by the commissioner pursuant to subdivision (f) of Section 1765.1 may advertise in all media, provided that all of the following apply: (1) the insurer's unlicensed status in California is disclosed in type of a size no smaller than any telephone number, address, or fax number appearing in the advertisement or solicitation, (2) the advertisement does not contain any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, that is untrue, deceptive, or misleading, and that is known, or that by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading, (3) the advertisement does not contain any information about the nonadmitted insurer's premiums or rates, and (4) no specific product shall be advertised in a newspaper of general circulation, in a television or radio broadcast, or in a news magazine of general circulation.

(b) Any nonadmitted insurer that is not on the list of eligible surplus line insurers issued by the commissioner pursuant to subdivision (f) of Section 1765.1 may advertise in all media, except for media that are targeted primarily at insureds or prospective insureds residing in California, provided that all of the conditions set forth in subdivision (a) are complied with and the advertisement does not contain any information about the insurer's specific products.

(c) A group of nonadmitted insurers may advertise to the same extent as a nonadmitted insurer, subject to the same requirements set forth in subdivision (a) or (b), as applicable.

(d) An eligible nonadmitted insurer that is a member of a group of insurers may include the name of the group in advertisements that are authorized by this section.

(e) The permission to advertise granted by this section shall not be deemed to authorize an insurer to do business in this state.

703.5. Any person, including, but not limited to, persons licensed or certificated under this code or exempted from regulation under this code, who as a part of any business advertises as, or holds himself or herself out as, qualified to advise the public concerning insurance or qualified to administer workers' compensation for employers and who in connection with or as part of that business also, with or without consideration, (a) suggests or recommends to an employer, or advises an employer, that the employer purchase aggregate excess or aggregate stop-loss workers' compensation insurance, or (b) names or suggests to an employer, or advises an employer of, a nonadmitted insurer from whom aggregate excess or aggregate stop-loss workers' compensation insurance might be purchased, is guilty of a misdemeanor. This section does not apply if the employer is a self-insured public entity, including any agency, board, or commission provided for by a joint exercise of powers agreement, or those who have been issued a certificate by the Director of the Department of Industrial Relations to self-insure.

704. The commissioner may suspend the certificate of authority of an insurer for not exceeding one year whenever he finds, after proper hearing following notice, that such insurer engages in any of the following practices:

(a) Conducting its business fraudulently.

(b) Not carrying out its contracts in good faith.

(c) Habitually and as a matter of ordinary practice and custom compelling claimants under policies, or liability judgment creditors of the insured, to either accept less than the amount due under the terms of the policies or resort to litigation against such insurer to secure the payment of the amount due.

The order of suspension shall prescribe the period of such suspension.

The proceedings shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

704.5. The commissioner may decline to grant or may suspend or revoke a certificate of authority of any holder of such certificate authorized to be certificated under this code if any person or persons, directly or indirectly, or any person who as an affiliate or

part of any affiliate, directly or indirectly, owning or controlling, in the aggregate, any interest in more than 10 percent of the stock of such holder of the certificate, or its subsidiary, or any company or entity controlling such holder, or if any officer or director of such holder has been convicted on, or pleaded guilty or nolo contendere to, an indictment or information in any jurisdiction charging a felony for theft or larceny, mail fraud, or violation of any corporate securities statute or any insurance statute.

704.7. The commissioner, in any proceeding under Section 704 for any of the violations specified in that section, may, by an alternative order, permit the holder of that certificate of authority to elect in writing to pay a specified money penalty, within a specified time, in lieu of the suspension of its certificate of authority. If the holder so elects, the sum of money specified shall be paid to the commissioner for the use of the State of California. The sum specified shall not exceed fifty-five thousand dollars ($55,000). If the holder so electing fails to pay the specified sum within the specified time the commissioner shall, unless his or her order be lawfully stayed, forthwith put in effect the alternative specified in his or her order.

All moneys received by the commissioner pursuant to this section shall, when appropriated for that purpose by the Legislature, be available for expenditure by the commissioner in accordance with law in administration and enforcement of this code and other insurance laws.

The authority vested in the commissioner by this section shall be additional to and not in lieu of any other authority to enforce any penalties, fines or forfeitures, denials, suspensions, restrictions, or revocations of certificates of authority otherwise authorized by law.

705. The commissioner shall require the payment of fifty-eight dollars ($58) in lawful money of the United States, in advance as a fee for filing an application for each amendment of a certificate of authority authorizing any insurer to transact business in this state.

Notwithstanding the provisions of Section 701 each insurer possessing a certificate of authority of indefinite term pursuant to such section shall owe and pay an annual fee of one hundred seventy-seven dollars ($177) in lawful money of the United States in advance on account of such certificate until its final expiration.

Such fee shall be for annual periods commencing on July 1st of each year and ending on June 30th of each year and shall be due on each March 1st and shall be delinquent on and after each April 1st.

705.1. The commissioner shall require the payment of one thousand seven hundred seventy dollars ($1,770) in lawful money of the United States in advance as a fee for filing an application and all supporting exhibits including articles of incorporation, certificates of organization, certificates of capital and assets, certificates of deposit, financial statements, affidavits, appointments of agents for service of process, bonds, deposit schedules, appraisals, and other papers, in support of each original certificate of authority. Such fee shall be in lieu of the fees for filing or receiving such papers in support of an application for an original certificate of authority as specified in Section 940.1 and as specified in the following sections of the Insurance Code as they existed on January 1, 1963: 705, 712, 900.5, 946, 976, 1350, 1590 (but not 1599), 1601, 7034, 9034 and 11090.

706. Prior to admission each insurer shall file with the commissioner a certified copy of its last annual statement or a verified financial statement exhibiting its condition and affairs.

706.5. The commissioner, in addition to any other proper ground for denying a certificate of authority to a nonadmitted insurer, may deny such certificate whenever, in his judgment, the investments of such insurer are not so made as to make available within a reasonable time sufficient moneys to meet promptly any demand which might in the ordinary course of events be properly made against the insurer. In the case of an admitted insurer, whenever the commissioner finds such a condition to exist, he may order such insurer to cease to effect new contracts of insurance until its financial circumstances are changed sufficiently to remove such condition. The commissioner may suspend or revoke the certificate of authority of any admitted insurer which fails to comply with such order.

The commissioner shall not issue such order under this section to any solvent admitted insurer if 25 per cent or more in value of the assets thereof is in cash or invested in the securities specified by

sections 1171, 1172, 1173, 1174 and 1175, or in securities specified in sections 1191 and 1192 if such securities are listed on a securities exchange, subject to regulation, supervision, or control under a statute of the United States of America. The provisions of this section likewise apply to reciprocal or interinsurance exchanges.

706.7. As used in this section, the term "reciprocal State" means a State the laws of which prohibit an insurer domiciled therein from insuring the lives or persons of residents of, or property or operations located in, the State of California unless it then holds a valid and subsisting certificate of authority issued by the Insurance Commissioner of this State. Such prohibition may be subject to the exceptions herein set forth.

Subject to the exceptions herein set forth, a domestic insurer shall not enter into a contract of insurance upon the life or person of a resident of, or property or operations located in, a reciprocal State unless it is authorized pursuant to the laws of that State to transact such insurance therein. The commissioner shall, annually, mail notice to every domestic insurer, specifying the reciprocal States.

The exceptions to the provisions of this section are the following:

(a) Contracts entered into where the prospective insurant is personally present in the State in which the insurer is authorized to transact insurance when he signs the application.

(b) The issuance of certificates under a lawfully transacted group life or group disability policy, where the master policy was entered into in a State in which the insurer was then authorized to transact insurance.

(c) The renewal or continuance in force, with or without modification, of contracts otherwise lawful and which were not originally executed in violation of this section.

707. A domestic insurer shall, prior to admission, file with the commissioner a copy of its articles of incorporation and certificate of any increase or diminution of its capital stock, certified by the Secretary of State to be a copy of that which is filed in his office.

708. A foreign insurer shall, prior to admission, file with the commissioner the following:

(a) If organized in a jurisdiction which requires articles to be filed, a copy of its articles of incorporation, duly certified by the officer having the custody of such articles.

(b) If organized in a jurisdiction which does not require articles to be filed, a copy of the law, charter, or deed of settlement under which the insurer is organized, duly certified by the proper custodian thereof, or proved by affidavit to be a copy.

(c) A certificate under the hand and seal of the officer, if any, having supervision of insurance business in the jurisdiction of its organization, stating that the insurer is organized under the laws of such jurisdiction, and has the amount of capital stock or assets required by this code.

709. If the insurer is organized in any other State, it shall, prior to admission, file with the commissioner a certificate setting forth:

(a) The nature and character of its business.

(b) The location of its principal office.

(c) The names of the following parties:

(1) If the insurer is not incorporated, and there are more than ten owners of interests therein, the names of the ten persons who own the largest interests; if there are ten or less such owners, the names of all such owners.

(2) If the insurer is incorporated, the names of all officers and persons by whom the business is managed.

(d) The amount of actual capital to be employed therein.

The certificate must be verified by the affidavit of the chief officer, secretary, agent, or manager of the company.

709.5. (a) Any insurer that is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by designating its principal place of business at a place in this state.

The domestic insurer shall be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state.

(b) Any domestic insurer may, upon the prior approval of the

commissioner, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon the transfer shall cease to be a domestic insurer, and shall be admitted to this state if qualified as a foreign insurer. The commissioner shall approve any proposed transfer unless he or she determines that the transfer is not in the interest of the policyholders of this state. An insurer seeking to transfer its domicile shall provide the commissioner with information and documentation reasonably necessary to make this determination. The commissioner shall either approve or disapprove the transfer within 90 calendar days after the date of the request. The commissioner and his or her authorized representative shall be prohibited from seeking a waiver to extend the 90-calendar-day period, nor shall the insurer be permitted to waive that period.

(c) The certificate of authority, agent and broker appointments and licenses, rates, and other items that the commissioner allows in his or her discretion, that are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon that transfer if the insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner. Every transferring insurer shall file new policy forms with the commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the commissioner. However, every transferring insurer shall notify the commissioner of the details of the proposed transfer, and shall file promptly all resulting amendments to corporate documents filed or required to be filed with the commissioner.

(d) An insurer seeking qualification under this section shall pay to the commissioner a filing fee of four thousand two hundred fifty dollars ($4,250). Except for an insurer that is a wholly owned subsidiary of a domestic holding company, an insurer seeking qualification shall file with the Secretary of State a notice of its intent to redomesticate, and upon completion of the redomestication, shall also file a designation of an agent for service of process.

(e) Notwithstanding any other provision of the law, this section shall provide the exclusive means for an admitted insurer to change its domicile to, or transfer its domicile from, this state.

710. If there are any written articles of agreement or association, a copy thereof shall accompany such certificates.

711. An insurer organized out of the United States shall also file such certificate and articles, but the certificate need not contain the names of any officers or managers other than those resident within the United States, nor any statement of capital not employed within the United States, and the affidavit shall be made by the chief executive officer or manager in the United States.

713. A copy of the instrument or record of the action making any change in any of the documents filed with the commissioner pursuant to this article, proved by certificates of custodian of the original, or by affidavit, shall be filed with the commissioner.

714. The commissioner shall require the payment of twenty-nine dollars ($29) in lawful money of the United States, in advance, as a fee for filing papers required under Section 713, on account of change or changes made at one time.

715. The commissioner shall have no authority to issue a certificate of authority, other than a renewal certificate of authority, to any domestic insurer, whether organized and promoted directly or by means of a holding company, where the commissioner's examination shows that the expense of organization and promotion, exclusive of attorney fees, accountant fees, and actuary fees, exceeds 12 percent of the total amount actually paid on its capital stock.

716. No certificate of authority shall be granted to a foreign or alien applicant that has not actively transacted for three years the classes of insurance for which it seeks to be admitted.

This section shall not apply to any of the following:

(a) An applicant 51 percent or more of whose voting shares are owned by a reputable insurer admitted to this state for at least three years.

(b) An applicant which is the successor in interest, by merger, transformation, consolidation, purchase, or other transaction, of substantially all the insurance business and going concern value of a reputable insurer which was, and still is, the dominant factor in such transaction, and could itself have been admitted.

(c) An applicant 51 percent or more of whose voting shares are owned by a noninsurance corporation, or a corporation authorized as an insurer but not actively engaged in the insurance business, which corporation, directly or indirectly, owns 51 percent or more of the voting shares of one or more insurers all of which, except the applicant and those which are alien insurers, are reputable insurers admitted to this state for at least three years.

(d) An applicant which meets the conditions established by the commissioner for exemption from this section.

717. Before granting a certificate of authority or amended certificate of authority to any applicant, the commissioner shall consider the qualifications of said applicant in respect to the following subjects: (a) capital and surplus; (b) lawfulness and quality of investments; (c) financial stability; (d) reinsurance arrangements; (e) competency, character, and integrity of management; (f) ownership and control of issued and outstanding shares in the case of a capital stock insurer; (g) whether claims under policies are promptly and fairly adjusted and are promptly and fully paid in accordance with law and the terms of policies; (h) fairness and honesty of methods of doing business; (i) method by which said applicant was promoted if any of its promoters remain as stockholders or in management; and (j) hazard to policyholders or creditors.

Upon consideration of all relevant qualifications the commissioner shall issue a certificate of authority to such applicant, unless the commissioner shall have made a finding, or findings, that the applicant is materially deficient in respect to one or more of the items as outlined in (a) through (j), above.

717.1. Where the applicant is a wholly owned domestic subsidiary of an admitted domestic insurer the commissioner shall issue a certificate of authority to such applicant within 180 days of

application unless the commissioner shall have made a finding that the applicant is substantially deficient in respect to one or more of the items set forth in Section 717.

718. If upon due investigation the commissioner shall find that any applicant for a certificate of authority, or amended certificate of authority, will not conduct its business in conformity with all applicable provisions of the laws of this state, he shall not grant any certificate of authority, or amended certificate of authority, to such applicant.

Where the applicant is a wholly owned subsidiary of or under the management and control of an admitted insurer, or is the successor in interest by merger, consolidation, sale and purchase, or otherwise, of such an admitted insurer, and the applicant is without substantial prior operating history, the commissioner may reasonably rely on the known characteristics and reputation of the admitted insurer to the extent relevant and appropriate under the circumstances.

720. The commissioner may after notice and hearing promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient to carry out the purposes and provisions of this code governing the issuance, suspension and revocation of certificates of authority. Any such rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code.

721. As used in Sections 704.5, 716, 717 and 718, the term "applicant" includes the attorney-in-fact of a reciprocal or interinsurance exchange. Wherever reference therein is made to an officer, director, or management of the applicant, such reference is deemed to include the officers, directors, and management of the attorney-in-fact of a reciprocal or interinsurance exchange, and the members of the board of governors or other governing committee of the reciprocal itself.

725. Any person otherwise qualified may be a director of two or more insurers, but no such interlocking directorate shall be used as a means of substantially lessening competition in the business of insurance or of creating a monopoly.

Whenever the commissioner has reason to believe that there is a violation of this section, he shall serve upon the insurer or insurers and the director or directors, as the case may be, a notice pursuant to Section 38 of a hearing before the commissioner to be held not less than thirty days after the service of such notice, and requiring such insurer or insurers and such director or directors, as the case may be, to show cause why an order should not be made by the commissioner directing such insurer or insurers and such director or directors, as the case may be, to cease and desist from such violation.

If, after a hearing in accordance with the procedure provided in Section 704, the commissioner finds that there has been a violation of this section he shall issue and cause to be served upon such insurer or insurers and such director or directors, as the case may be, an order reciting the facts found by him, and setting forth the respects in which there has been a violation of this section, and directing such insurer or insurers and such director or directors, as the case may be, to cease and desist from such violation.

Any such cease and desist order of the commissioner shall be subject to judicial review. Subject to said judicial review, any person violating any such cease and desist order shall be guilty of a misdemeanor and the commissioner may, after a hearing in accordance with the procedure provided in Section 704, decline to grant or renew or may suspend or revoke a certificate of authority of any insurer or insurers violating any such cease and desist order.

726. The commissioner shall notify the Secretary of State of any refusal to issue a certificate of authority to transact insurance to an applicant therefor.

728. (a) For the purposes of this section, the following definitions are applicable:

(1) "Subject person" means any director, officer, or employee or other natural person who participates in the management, direction, or control of an insurer.

(2) "Insurer" means any domestic insurer, and any insurer which is

admitted to transact insurance in this state, provided that if a subject person of an insurer is not a resident of California, or operating out of a place of business within California, then the subject person shall be engaged in the direct management, direction, or control of the insurer in California in order to come within the provisions of this section.

(b) If, after notice and a hearing, the commissioner finds all of the following, the commissioner may issue an order removing a subject person from his or her office or employment with the insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of the insurer, except with the prior consent of the commissioner:

(1) The subject person has engaged in repeated acts of misconduct with respect to the operations of an insurer which have resulted in substantial financial loss to an insurer.

(2) The misconduct which forms the pattern is fraudulent, or consists of willful acts or omissions involving personal dishonesty in the acceptance, custody, or payment of money or property on the part of the subject person which has endangered or is likely to endanger the solvency of the insurer.

(3) The pattern of misconduct is relevant in that it demonstrates unfitness to continue as a subject person.

(c) (1) If the commissioner gives written notice pursuant to subdivision (b) to a subject person, the commissioner may immediately issue an order suspending the subject person from his or her office or employment with the insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of an insurer, except with the prior consent of the commissioner if the commissioner: (A) finds that failure to immediately issue such order threatens the financial solvency of the insurer or may otherwise cause immediate and irreparable financial injury to the insurer (B) serves that subject person and the insurer with written notice of the suspension order; and (C) finds that all of the necessary factors are present which would permit the commissioner, after notice and a hearing, to issue an order pursuant to subdivision (b) removing a subject person from his or her office or employment with the insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of an insurer.

(2) Any suspension order issued pursuant to paragraph (1) of this subdivision shall be effective until the date the commissioner dismisses the charges contained in the notice served under subdivision (b) or paragraph (1) of this subdivision, the effective date of an order issued by the commissioner pursuant to subdivision

(b), or a court issues a stay of the order pursuant to subdivision (d).

(d) Within 10 days after a subject person has been served with an order of suspension pursuant to subdivision (c), the person may apply to the superior court of the county in which the principal office of the insurer is located for a stay of the order pending completion of the proceedings pursuant to subdivision (b), and the court shall have jurisdiction to issue an order staying the suspension. Nothing in this subdivision shall be deemed to authorize the court to issue a stay order on an ex parte basis.

(e) (1) If the commissioner finds both of the following, he or she may immediately issue an order suspending a subject person from his or her office or employment with an insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of an insurer, except with the prior consent of the commissioner: (A) the subject person has been charged in an indictment issued by a grand jury, or in an information, complaint, or similar pleading issued by a United States Attorney, district attorney, or other governmental official or agency authorized to prosecute crimes, with a crime punishable by imprisonment for a term exceeding one year and which involves as one of its necessary elements a fraudulent act or an act of dishonesty in the acceptance, custody, or payment of money or property; and (B) that a failure to immediately issue the order threatens the financial solvency of the insurer, or may otherwise cause immediate and irreparable financial injury to the insurer.

In the event the criminal proceedings are terminated other than by judgment of conviction, an order issued pursuant to paragraph (1) of this subdivision shall be deemed rescinded as if it had not been issued.

(2) If the commissioner finds both of the following, he or she may immediately issue an order removing a subject person from his or her office or employment with an insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of the insurer, except with the prior consent of the commissioner: (A) the person has been convicted during the preceding five years of a crime that is punishable by imprisonment for a term exceeding one year and that has as one of its necessary elements a fraudulent act or an act of dishonesty in the accepting, custody, or payment of money or property; and (B) that a failure to immediately issue the order threatens the financial solvency of the insurer, or may otherwise cause immediate and irreparable financial injury to the insurer.

(3) The fact that any subject person charged with a crime

involving as one of its necessary elements a fraudulent act or any act of dishonesty in the acceptance, custody, or payment of money or property is not convicted of that crime shall not preclude the commissioner from issuing an order regarding the subject person pursuant to other provisions of this code.

(f) (1) Within 30 days after an order is issued pursuant to subdivision (c) or (e), the person to whom the order is issued may choose to do either of the following: (A) file with the commissioner an application for a hearing on the order. The commissioner shall, upon written request of the person, extend the 30-day period by an additional 30 days provided the request is filed with the commissioner within 30 days after the order is issued. If the commissioner fails to commence the hearing within 15 business days after the application is filed, or within a longer period of time to which the person consents, the order shall be deemed rescinded as if it had not been issued. Within 30 days after the hearing, the commissioner shall affirm, modify, or rescind the order; otherwise, the order shall be deemed rescinded as if it had not been issued, or (B) petition for judicial review of the order pursuant to Section 1085 of the Code of Civil Procedure, where the court shall exercise its independent judgment on the evidence.

(2) The right of any person to whom an order is issued pursuant to subdivision (c) or (e) to petition for judicial review of the order shall not be affected by the failure of that person to apply to the commissioner for a hearing on the order as provided by this subdivision.

(g) (1) Any person to whom an order is issued pursuant to subdivision (b), (c), or (e) may apply to the commissioner to modify or rescind the order. The commissioner shall not grant the application unless he or she finds that it is reasonable to believe that the person will, if and when he or she becomes a subject person, comply with all of the applicable provisions of this code and of any regulation or order issued thereunder.

(2) The right of any person to whom an order is issued pursuant to subdivision (b), (c), or (e) to petition for judicial review of the order shall not be affected by the failure of that person to apply to the commissioner pursuant to paragraph (1).

(h) (1) It is unlawful for any subject person or former subject person to whom an order is issued pursuant to subdivision (b), (c) or (e) to do any of the following as long as the order is effective, except with the prior consent of the commissioner: (A) to serve or act as a subject person for or in any insurer; or (B) to directly or indirectly solicit, procure, or transfer or attempt to transfer or vote any proxy, consent or authorization with respect to any shares

or other securities of any insurer having voting rights.

(2) If, after notice and a hearing, the commissioner finds that any person has violated paragraph (1) of this subdivision, the commissioner may order that person to pay to the commissioner a civil penalty in an amount the commissioner may specify; provided however, that the amount of the civil penalty shall not exceed one thousand dollars ($1,000) for each violation or, in the case of a continuing violation, one thousand dollars ($1,000) for each day for which the violation continues, which may be recovered in a civil action.

In determining the amount of civil penalty to be paid to the commissioner under this paragraph, the commissioner shall consider the financial resources and good faith of the person charged, the gravity of the violation, the history of previous violations by the person, and such other factors as in the opinion of the commissioner may be relevant.

(3) If, after notice and a hearing, the commissioner finds that any insurer has knowingly aided and abetted a subject person in a violation of paragraph (1) of this subdivision, the commissioner may order that insurer to pay to the commissioner a civil penalty in an amount the commissioner may specify; provided however, that the amount of the civil penalty shall not exceed ten thousand dollars ($10,000) for each violation, or in the case of a continuing violation, ten thousand dollars ($10,000) for each day for which the violation continues up to a maximum of one hundred thousand dollars ($100,000), which may be recovered in a civil action. Continuation of the subject person's salary or other employee benefits pending final disposition shall not be considered aiding and abetting a subject person.

In determining the amount of civil penalty to be paid to the commissioner under this paragraph, the commissioner shall consider the financial resources and good faith of the person charged, the gravity of the violation, the history of previous violations by the person, and such other factors as in the opinion of the commissioner may be relevant.

(i) Except as otherwise provided by this section any hearing required by this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, subject to the following:

(1) At the option of the subject person, all such hearings shall be a closed session and private, and the records of the hearings shall not be made public unless the hearing results in a final order adverse to the subject person.

(2) Where judicial review is sought by the subject person pursuant to Section 11523 of the Government Code, the court shall exercise

its independent judgment upon the evidence.

(3) When a subject person to whom an order has been issued pursuant to subdivision (c) or (e) applies to the commissioner for a hearing pursuant to subparagraph (A) of paragraph (1) of subdivision (f), the Office of Administrative Hearings shall schedule the hearing on a priority basis at the earliest possible time and once the hearing is commenced, it shall not be continued for more than three business days without the consent of the subject person.

(4) If the Office of Administrative Hearings cannot schedule the commencement of a hearing within 15 business days as provided by paragraph (1) of subdivision (f), and the subject person does not waive his or her right to a hearing commencing within 15 days, the hearings may be conducted by administrative law judges appointed by the commissioner. In the event the subject person chooses to accept a hearing before an administrative law judge appointed by the commissioner, the hearing shall be completed within 45 days of commencement unless additional time is requested by the subject person. If the hearing is not completed within 45 days, the order shall be deemed rescinded as if it had not been issued.

(j) Nothing in this section is intended to or shall be construed to create a private cause of action against an offending subject person or an insurer or production agency that aids and abets a subject person, based on the standards established by this section or the commissioner's findings or orders pursuant to this section.

INSURANCE CODE
SECTION 729-738

729. As used in this article, the following terms have the following meanings:

(a) "Company" means any person engaging in, or proposing or attempting to engage in, any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory, or taxing authority of the commissioner.

(b) "Examiner" means any individual or firm authorized by the commissioner to conduct an examination under this article.

(c) "Person" means any person, association, organization, business trust, partnership, limited liability company, or corporation, or any affiliate thereof.

730. (a) The commissioner, whenever he or she deems necessary or whenever he or she is requested by verified petition, signed by 25 persons interested as shareholders, policyholders, or creditors of any admitted insurer showing that the insurer is insolvent under this code, or upon information that any insurer has violated any provision of Article 7 (commencing with Section 800), shall examine the business and affairs of the insurer. The commissioner shall so examine every domestic insurer before issuing to it a certificate of authority other than a renewal.

(b) The commissioner may conduct an examination under this article of any company as often as the commissioner in his or her discretion deems appropriate but shall, at a minimum, conduct an examination of every insurer admitted in this state not less frequently than once every five years. In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners which are in effect when the commissioner exercises discretion under this section.

(c) For purposes of completing an examination of any company under this article, the commissioner may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the discretion of the commissioner, necessary or material to the examination of the company.

(d) In lieu of an examination under this article of any foreign or alien insurer admitted in this state, the commissioner may accept an examination report on the company as prepared by the insurance department of the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, these reports may only be accepted if (1) the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioner's Financial Regulation Standards and Accreditation Program, or (2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

731. Whenever any foreign insurer applies for admission the commissioner may make, or cause to be made by the insurance authority of the State where the insurer is organized, an examination of its insurance business and affairs.

732. An insurer organized or existing under the laws of any country outside of the United States shall be deemed to be organized, within the meaning of this article, in any State wherein such insurer maintains the deposits to protect policyholders as required by this code.

733. In making such examination the commissioner:

(a) Shall have free access to all the books and papers of the company.

(b) Shall thoroughly inspect and examine all its affairs.

(c) Shall ascertain its condition and ability to fulfill its obligations.

(d) Shall ascertain if it has complied with all laws applicable to its insurance transactions.

(e) May appraise or cause to be appraised by competent appraisers appointed by him or her all property in which the insurer has or claims an interest, or which is security, in any form, for the payment of any debt or obligation to the insurer. All such appraisals of real property shall be in writing.

(f) Shall, in conducting the examination, observe those guidelines and procedures set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ other guidelines or procedures which the commissioner may deem appropriate.

(g) May retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, or any of the employees of the department assigned by the commissioner to carry out the purposes of this article, the cost of which shall be borne by the company subject to examination.

734. Every company or person from whom information is sought, and

its officers, directors, employees, and agents, shall provide to the examiners appointed pursuant to this article, timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person shall assist the examiners and aid in the examination so far as it is in their power to do so. The commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. If he or she finds the books to be carelessly or improperly kept or posted, he or she shall employ sworn experts to rewrite, post, and balance the books at the insurer's expense.

734.1. (a) No later than 60 days following completion of the examination, the examiner in charge shall file with the department a verified written report of the examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice that the company has 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(b) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and shall either adopt the report as filed or with modifications or corrections, or reject the report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refiling pursuant to subdivision (a).

(c) (1) Nothing contained in this article shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state.

(2) If the commissioner terminates or suspends an examination that includes an examination of claims practices, the commissioner shall within 10 days of the termination or suspension transmit a copy of the complete examination file to the State Bureau of Audits. The State Auditor shall audit the file pursuant to Section 10527 of the Government Code to determine the propriety of the termination or suspension.

735. The hereinafter designated officer of each domestic insurer shall inform the members present at the next meeting of its governing body of the receipt from the office of the commissioner of the report of every examination of such insurer, both in the form first formally prepared by the examiners and in the form as finally settled and officially filed by the commissioner or a deputy designated by him. Such officer shall also inform such members that a copy of such report is available for inspection of any member of such governing body. There shall be entered in the minutes of each such meeting the fact that such officer did so inform the members present.

The officer above referred to, in the case of a stock or mutual insurer, shall be its secretary or comparable officer if there is no secretary. This section shall specifically apply to reciprocals and interinsurance exchanges and in that case the officer above referred to shall be the principal individual, partner or officer of its attorney-in-fact, and "governing body" shall have reference to the body exercising the subscribers' rights provided for in Section 1308.

735.5. (a) Nothing contained in this article shall be construed to limit the commissioner's authority to use and, if appropriate, to make public, any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his or her discretion, deem appropriate.

(b) Nothing contained in this code shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, or to the National Association of Insurance Commissioners, provided the recipient of the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this article, unless the prior written consent of the company to which it pertains has been obtained.

(c) All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made

pursuant to this article shall be given confidential treatment and are not subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subdivision (a) or (b).

736. All examinations shall be at the expense of the insurer, organization or person examined, except that special examinations which are in addition to regular examinations may be at the expense of the state in the discretion of the commissioner. The costs and expenses of all such examinations shall be paid from the support appropriation for the Department of Insurance current at the time of the examination but shall be charged to and collected from the insurer, organization or person examined. If any such insurer, organization, or person refuses to pay such costs and expenses promptly when due, the commissioner may refuse to issue its certificate of authority, certificate of exemption or license, as the case may be, and may revoke any existing certificate of authority, certificate of exemption or license.

736.5. The provisions of Section 736 notwithstanding, the revenue raised from the examination of insurers and other persons under this article in the 1996-97 fiscal year shall not exceed the examination fee revenue estimate for the 1996-97 Governor's Budget by more than two million dollars ($2,000,000).

737. (a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this article.

(b) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this article, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) This section shall not abrogate or modify in any way any common law or statutory privilege or immunity previously enjoyed by any person identified in subdivision (a).

(d) A person identified in subdivision (a) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities engaged in while carrying out the provisions of this article and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

738. The commissioner shall have the same powers and authority to examine the State Compensation Insurance Fund as are conferred upon him by law relative to the examination of other insurers.

INSURANCE CODE
SECTION 739-739.12

739. As used in this article, these terms shall have the following meanings:

(a) "Adjusted RBC Report" means a Risk-Based Capital (RBC) report that has been adjusted by the commissioner in accordance with subdivision (c) of Section 739.2.

(b) "Corrective Order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(c) "Domestic insurer" means any life or health insurer or property and casualty insurer organized in this state.

(d) "Foreign insurer" means any life or health insurer or property and casualty insurer that is licensed to do business in this state but is not domiciled in this state.

(e) "Life or health insurer" means any admitted insurer issuing insurance subject to Part 2 (commencing with Section 10110) of Division 2, or a licensed property and casualty insurer writing only disability insurance.

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

(g) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the RBC

Instructions defined in subdivision (i).

(h) "Property and casualty insurer" means any admitted insurer writing insurance as described in Section 102, 103, 105, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 118, 119.5, 119.6, or 120, but does not include monoline mortgage guaranty insurers, financial guaranty insurers, or title insurers.

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

(j) "RBC Level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(1) "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC.

(2) "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC.

(3) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions.

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

(k) "RBC Plan" means a comprehensive financial plan containing the elements specified in subdivision (b) of Section 739.3. If the commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "Revised RBC Plan."

(l) "RBC Report" means the report required in Section 739.2.

(m) "Total Adjusted Capital" means the sum of:

(1) An insurer's statutory capital and surplus.

(2) Other items, if any, that the RBC Instructions may provide.

739.2. (a) Every domestic insurer shall, on or prior to each March 15 (the "filing date"), prepare and submit to the commissioner 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, every domestic insurer shall file its RBC Report:

(1) With the NAIC in accordance with the RBC Instructions.

(2) 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) Fifteen days from the receipt of notice to file its RBC Report with that state.

(B) The filing date.

(b) 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:

(1) The risk with respect to the insurer's assets.

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

(3) The interest rate risk with respect to the insurer's business.

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

In each case, these shall be determined by applying the factors in the manner set forth in the RBC Instructions.

(c) 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:

(1) Asset risk.

(2) Credit risk.

(3) Underwriting risk.

(4) All other business risks and any other relevant risks as are set forth in the RBC Instructions.

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in this article and the formulas, schedules, and instructions referenced in this article is desirable in the business of insurance. Accordingly, insurers shall seek to maintain capital above the RBC levels required by this article. 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 this article.

(e) If a domestic insurer files an RBC Report that in the judgment of the commissioner is inaccurate, then the commissioner 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 referred to as an Adjusted RBC Report.

739.3. (a) "Company Action Level Event" means any of the following events:

(1) The filing of an RBC Report by an insurer that indicates either of the following:

(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.

(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.

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in subparagraph (A) or (B) of paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges an Adjusted RBC Report that indicates the event in subparagraph (A) or (B) of paragraph (1) under Section 739.7, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the commissioner a comprehensive financial plan which shall do all of the following:

(1) Identify the conditions in the insurer that contribute to the Company Action Level Event.

(2) 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.

(3) 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, or surplus, or a combination. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions.

(5) 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 in each case, if any.

(c) The RBC Plan shall be submitted as follows:

(1) Within 45 days of the Company Action Level Event.

(2) If the insurer challenges an Adjusted RBC Report pursuant to Section 739.7, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC Plan to the commissioner, the commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner 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 commissioner. Upon notification from the commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the Revised RBC Plan to the commissioner as follows:

(1) Within 45 days after the notification from the commissioner.

(2) If the insurer challenges the notification from the commissioner under Section 739.7, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under Section 739.7, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(f) Every domestic insurer that files an RBC Plan or Revised RBC Plan with the commissioner 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 do business if the following apply:

(1) That state has an RBC provision substantially similar to subdivision (a) of Section 739.8.

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer 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.

(B) The date on which the RBC Plan or Revised RBC Plan is filed under subdivision (c) of Section 739.7.

739.4. (a) "Regulatory Action Level Event" means, with respect to any insurer, any of the following events:

(1) The filing of an RBC Report by the insurer that indicates that 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.

(2) The notification by the commissioner to an insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) under Section 739.7, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure that is satisfactory to the commissioner and has cured the failure within 10 days after the filing date.

(5) The failure of the insurer to submit an RBC Plan to the commissioner within the time period set forth in subdivision (c) of Section 739.3.

(6) Notification by the commissioner to the insurer of the following:

(A) The RBC Plan or revised RBC Plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory.

(B) That notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under Section 739.7.

(7) If the insurer challenges a determination by the commissioner under paragraph (6) pursuant to Section 739.7, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected such challenge.

(8) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the Regulatory Action Level Event in accordance with its RBC Plan or Revised RBC Plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under Section 739.7.

(9) If the insurer challenges a determination by the commissioner under paragraph (8) pursuant to Section 739.7, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge, unless the failure of the insurer to adhere to its RBC Plan or Revised RBC Plan has no substantial adverse effect on the ability of the insurer to eliminate the Regulatory Action Level Event with respect to the insurer.

(b) In the event of a Regulatory Action Level Event the commissioner shall do all of the following:

(1) Require the insurer to prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan.

(2) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities, and operations of the insurer, including a review of its RBC Plan or Revised RBC Plan.

(3) Subsequent to the examination or analysis, issue a corrective order specifying such corrective actions as the commissioner shall determine are required.

(c) In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the commissioner'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 as follows:

(1) Within 45 days after the occurrence of the Regulatory Action Level Event.

(2) If the insurer challenges an Adjusted RBC Report pursuant to Section 739.7 and the challenge is not in the judgment of the commissioner frivolous, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(3) If the insurer challenges a Revised RBC Plan under Section 739.7, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities, and operations of the insurer and formulate the Corrective Order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the commissioner.

739.5. (a) "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC Report by the insurer that indicates 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.

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) under Section 739.7, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a Corrective Order, provided the insurer has not challenged the Corrective Order under Section 739.7.

(5) If the insurer has challenged a Corrective Order under Section 739.7 and the commissioner has, after a hearing, rejected the challenge or modified the Corrective Order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the Corrective Order subsequent to rejection or modification by the commissioner.

(b) In the event of an Authorized Control Level Event with respect to an insurer, the commissioner shall do the following:

(1) Take such actions as are required under Section 739.4 regarding an insurer with respect to which a Regulatory Action Level Event has occurred.

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Article 14 (commencing with Section 1010), Article 14.3 (commencing with Section 1064.1), Article 14.5 (commencing with Section 1065.1), and Article 15.5 (commencing with Section 1077). In the event the commissioner takes those actions, the Authorized Control Level Event shall be deemed sufficient grounds for the commissioner to take that action, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in those provisions. In the event the commissioner takes actions under this paragraph pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions pertaining to summary

proceedings.

739.6. (a) "Mandatory Control Level Event" means any of the following events:

(1) The filing of an RBC Report that indicates that the insurer's Total Adjusted Capital is less than its Mandatory Control Level RBC.

(2) Notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) under Section 739.7, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) (1) With respect to a life or health insurer, in the event of a Mandatory Control Level Event, the commissioner shall take actions as are necessary to cause the insurer to be placed under regulatory control under Article 14 (commencing with Section 1010), Article 14.3 (commencing with Section 1064.1), Article 14.5 (commencing with Section 1065.1), and Article 15.5 (commencing with Section 1077). In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under those acts, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth therein. In the event the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to protections as are afforded to insurers under those provisions. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the Mandatory Control Level Event if he or she finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

(2) With respect to a property and casualty insurer, the commissioner shall take those actions as are necessary to place the insurer under regulatory control, or, in the case of an insurer which 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 commissioner. In either event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Article 14 (commencing with Section 1010). If the commissioner takes actions pursuant to an Adjusted RBC Report, the

insurer shall be entitled to the protections of Article 14 (commencing with Section 1010) pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

739.7. Upon any of the events described in subdivision (a), (b), (c), or (d), the insurer shall have the right to a departmental hearing, on the record, at which the insurer may challenge any determination or action by the commissioner. The insurer shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under subdivision (a), (b), (c), or (d). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's request.

(a) Notification to an insurer by the commissioner of an Adjusted RBC Report.

(b) Notification to an insurer by the commissioner that:

(1) The insurer's RBC Plan or Revised RBC Plan is unsatisfactory.

(2) That notification constitutes a Regulatory Action Level Event with respect to the insurer.

(c) Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such 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.

(d) Notification to an insurer by the commissioner of a Corrective Order with respect to the insurer.

739.8. (a) All RBC Reports, to the extent the information within those reports is not required to be set forth in a publicly available annual statement schedule, and RBC Plans, including the results or report of any examination or analysis of an insurer performed pursuant to those plans, and any Corrective Order issued by the commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer, that are filed with the

commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this chapter or any other provision of the insurance laws of this state.

(b) It is the judgment of the Legislature that the comparison of an insurer's Total Adjusted Capital to any of its RBC Levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under this article, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's Total Adjusted Capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurers' RBC Levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(c) It is the further judgment of the Legislature that the RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans, and Revised RBC Plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers, and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding, nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write. This subdivision does not affect the validity of any action taken before its effective date.

739.9. (a) The provisions of this article 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 commissioner under such laws.

(b) The commissioner may adopt reasonable rules necessary for the implementation of this article.

(c) The commissioner may exempt from the application of this article any domestic property and casualty insurer that does all of the following:

(1) Writes direct business only in this state.

(2) Writes direct annual premiums of five million dollars ($5,000,000) or less.

(3) Assumes no reinsurance in excess of 5 percent of direct premiums written.

739.10. (a) Any foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC Report as of the end of the calendar year just ended the later of:

(1) The date an RBC Report would be required to be filed by a domestic insurer under this chapter.

(2) Fifteen days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC Plan that is filed with the insurance commissioner of any other state.

(b) In the event of a Company Action Level Event or Regulatory Action Level Event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer, or, if no RBC provision is in force in that state, under the provisions of this chapter, 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 the RBC statute, or, if no RBC provision is in force in the state, under Section 739.3, the commissioner may require the foreign insurer to file an RBC Plan with the commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the commissioner shall be grounds to order the insurer to cease and desist from

writing new insurance business in this state.

(c) In the event of a Mandatory Control Level Event with respect to any foreign insurer, if no domiciliary receiver has 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 commissioner may make application to the superior court with respect to the liquidation 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.

739.11. If any provision of this article, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this article that can be given effect without the invalid provision or application, and to that end the provisions of this article are severable.

739.12. All notices by the commissioner to an insurer that may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

INSURANCE CODE
SECTION 740-742.1

740. (a) Notwithstanding any other provision of law, and except as provided herein, any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the department unless the person or other entity shows that while providing the services it is subject to the jurisdiction of another agency of this or another state or the federal government.

(b) A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or the federal government by providing to the commissioner the appropriate certificate or license issued by the other governmental agency that permits or qualifies it to provide those services for which it is licensed or certificated.

(c) Any person or entity that is unable to show that it is subject to the jurisdiction of another agency of this or another state or the federal government, shall submit to an examination by the commissioner to determine the organization and solvency of the person or the entity, and to determine whether the person or entity is in compliance with the applicable provisions of this code, and shall be required to obtain a certificate of authority to do business in California and be required to meet all appropriate reserve, surplus, capital, and other necessary requirements imposed by this code for all insurers.

(d) Any person or entity unable to show that it is subject to the jurisdiction of another agency of this or another state or the federal government shall be subject to all appropriate provisions of this code regarding the conduct of its business.

(e) The department shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) that are not subject to the jurisdiction of another agency of this or another state or the federal government and that the department knows to be operating in this state. There shall be no liability of any kind on the part of the state, the department, and its employees for the accuracy of the list or for any comments made with respect to it.

(f) Any administrator licensed by the department who advertises or administers coverage in this state described in subdivision (a), that is provided by any person or entity described in subdivision (c), and where the coverage does not meet all pertinent requirements specified in this code and that is not provided or completely underwritten, insured or otherwise fully covered by an admitted life or disability insurer, hospital service plan or health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, and any production agency licensed by the department involved in the transaction, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of insurance or other coverage.

Any production agency obtaining knowledge of any coverage relative to the content and scope of a hospital service plan or health care service plan, as required under this subdivision, shall advise and

disclose to any purchaser, prospective purchaser, covered person or entity, the knowledge regarding the content and scope of the plan and, specifically, as to the lack of insurance by an admitted carrier or other qualified plan.

(g) A health care service plan, as defined in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall not be subject to this section.

(h) The department shall notify, in writing, the Director of the Department of Managed Health Care whenever it determines that a multiple employer trust qualifies as a health care service plan subject to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(i) Any health care service plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, or political subdivision, or a public joint labor management trust as described in subdivision (c) of Section 1349.2 of the Health and Safety Code, that is exempt pursuant to Section 1349.2 of the Health and Safety Code from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), is also exempt from this code.

742. (a) Any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric services, whether this coverage is by direct payment, reimbursement, or otherwise, and which enters into an arrangement or contract with, or underwrites, a preferred provider organization or arrangement subject to Section 10133 or 11512, is subject to the jurisdiction of the Department of Insurance.

(b) Any person or entity subject to regulation under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall not be subject to the provisions of this section.

742.1. (a) Any person or other entity or arrangement in this state that is organized for the purpose of offering or providing coverage in this state, for the benefit of employees of two or more employers, for medical, surgical, chiropractic, physical therapy, speech

pathology, audiology, professional mental health, dental, hospital, or optometric services, whether that coverage is by direct payment, reimbursement, or otherwise, is subject to the jurisdiction of the department.

(b) Any person or entity subject to regulation under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall not be subject to the provisions of this section.

INSURANCE CODE
SECTION 742.20-742.435

742.20. The Legislature finds and declares the following:

(a) An alternative to insurance programs, health care maintenance organizations, and panel provider organizations was established by Congress in 1974 through the Employee Retirement Income Security Act (ERISA). Among the various employee benefit programs established and governed by ERISA are multiple employer welfare arrangements (MEWA), which are subject as well to state regulatory and fiscal standards not inconsistent with ERISA. MEWAs permit employer members of trade associations to create trust funds for the purpose of offering and providing health care benefits to their employees. MEWAs can be created as fully insured or self-funded or partially self-funded benefit programs.

(b) The Legislature recognizes that some MEWAs provide an alternative mechanism to traditional health insurance for small employers. It is the intent of the Legislature to ensure the financial integrity of those MEWA programs that are already in existence by requiring self-funded or partially self-funded MEWAs to obtain a certificate of compliance from the Department of Insurance. In order for the Department of Insurance to grant a certificate of compliance, the MEWA must adhere to standards set forth in this act which are not inconsistent with the provisions of ERISA. Further, it is the intent of the Legislature to provide the Department of Insurance with the authority to levy monetary penalties and to revoke certificates of compliance from MEWAs that violate the provisions of this act.

(c) The Legislature has passed significant reforms in the area of small group health insurance. This article, in no manner, circumvents these reforms nor is it intended to be a precedent to do so. Therefore, the small group reform legislation applies to MEWAs

to the extent it is not inconsistent with ERISA.

(d) The provisions of this article are consistent with and authorized by ERISA, which confers upon the states limited authority to regulate MEWAs.

742.21. "Multiple employer welfare arrangement" as used in this article has the same meaning as that contained in Section 1002(40)(A) of Title 29 of the United States Code. "Employee welfare benefit plan," as used in this article, has the same meaning as that contained in Section 1002(1) of Title 29 of the United States Code. A multiple employer welfare arrangement shall comply with the criteria set forth for an employee welfare benefit plan in order to qualify to obtain a certificate of compliance.

742.215. As used in this article, "self-funded" means a multiple employer welfare arrangement that undertook at all times and for a continuous period of five years to reimburse health benefit costs incurred by covered persons pursuant to the benefits and coverages provided by their plan exclusively from plan assets. "Partially self-funded" means a multiple employer welfare arrangement that undertook at all times and for a continuous period of five years to reimburse health benefit costs incurred by covered persons pursuant to the benefits and coverages provided by their plan exclusively from plan assets, provided, however, that these benefits are reimbursable to the multiple employer welfare arrangement by stop loss insurance only to the extent that the benefits exceed fifty thousand dollars ($50,000) per claim.

742.22. It is the intent of the Legislature in enacting this article to allow a self-funded or partially self-funded multiple employer welfare arrangement to meet the requirements for a certificate of compliance to do business in California. If the self-funded or partially self-funded multiple employer welfare arrangement obtains and maintains a certificate of compliance under these sections, it shall not be considered an unauthorized insurer.

742.23. (a) After December 31, 1995, a self-funded or partially self-funded multiple employer welfare arrangement shall not provide any benefits for any resident of this state without first obtaining a certificate of compliance pursuant to this article, provided, however, that if the commissioner has not issued or denied an application for a certificate of compliance within 180 calendar days of the date of the filing of the completed application, the commissioner shall not take any action against the applicant solely on the basis that the department has not granted the certificate of compliance.

(b) The department may take regulatory action against a MEWA pursuant to all applicable provisions of this code during the period beginning on the effective date of this act and ending on the date on which the MEWA is certified under this article, at which time the provisions of this article shall apply.

742.24. To be eligible for a certificate of compliance, a self-funded or partially self-funded multiple employer welfare arrangement shall meet all of the following requirements:

(a) Be nonprofit.

(b) Be established and maintained by a trade association, industry association, professional association, or by any other business group or association of any kind that has a constitution or bylaws specifically stating its purpose, and have been organized and maintained in good faith with at least 200 paid members and operated actively for a continuous period of five years, for purposes other than that of obtaining or providing health care coverage benefits to its members. An association is a California mutual benefit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, and which uses membership dues solely for and in consideration of the membership and membership benefits.

(c) Be organized and maintained in good faith with at least 2,000 employees and 50 paid employer members and operated actively for a continuous period of five years.

(d) Have been operating in compliance with ERISA on a self-funded or partially self-funded basis for a continuous period of five years pursuant to a trust agreement by a board of trustees that shall have complete fiscal control over the multiple employer welfare

arrangement, and that shall be responsible for all operations of the multiple employer welfare arrangement. The trustees shall be selected by vote of the participating employers and shall be owners, partners, officers, directors, or employees of one or more employers participating in the multiple employer welfare arrangement. A trustee may not be an owner, officer, or employee of the insurer, administrator, or service company providing insurance or insurance-related services to the association. The trustees shall have authority to approve applications of association members for participation in the multiple employer welfare arrangement and to contract with an authorized administrator or service company to administer the day-to-day affairs of the multiple employer welfare arrangement.

(e) Benefits shall be offered only to association members.

(f) Benefits may be offered only through life agents, as defined in Section 1622, licensed in the state whose names, addresses, and telephone numbers have been filed with the commissioner as licensed life agents for the multiple employer welfare arrangement.

(g) Be operated in accordance with sound actuarial principles and conform to the requirements of Section 742.31.

(h) File an application with the department for a certificate of compliance no later than November 30, 1995.

(i) The multiple employer welfare arrangement shall at all times maintain aggregate stop loss insurance providing the arrangement with coverage with an attachment point which is not greater than 125 percent of annual expected claims. The commissioner may, by regulation, define "expected claims" for purposes of this subdivision and provide for adjustments in the amount of the percentage in specified circumstances in which the arrangement specifically provides for and maintains reserves in accordance with sound actuarial principles as provided in Section 742.31.

(j) The multiple employer welfare arrangement shall establish and maintain specific stop loss insurance providing the arrangement with coverage with an attachment point which is not greater than 5 percent of annual expected claims. The commissioner may, by regulation, define "expected claims" for purposes of this subdivision and provide for adjustments in the amount of that percentage as may be necessary to carry out the purposes of this subdivision determined by sound actuarial principles as provided in Section 742.31.

(k) The multiple employer welfare arrangement shall establish and maintain appropriate loss and loss adjustment reserves determined by sound actuarial principles as provided in Section 742.31.

(l) The association has within its own organization adequate facilities and competent personnel to serve the multiple employer

welfare arrangement, or has contracted with a licensed third-party administrator to provide those services.

(m) The association has established a procedure for handling claims for benefits in the event of the dissolution of the multiple employer welfare arrangement.

(n) On and after January 1, 2003, in addition to the requirements of this article, maintain a surplus of not less than one million dollars ($1,000,000), and that this amount be increased as follows: one million seven hundred fifty thousand dollars ($1,750,000) by January 1, 2004; two million five hundred thousand dollars ($2,500,000) by January 1, 2005; three million two hundred fifty thousand dollars ($3,250,000) by January 1, 2006; and four million dollars ($4,000,000) by January 1, 2007.

(o) Submit all proposed rate levels to the department for informational purposes no later than 45 days prior to their implementation. The proposed rates shall contain an aggregate benefit structure which has a loss ratio experience of not less than 80 percent. The loss ratio experience shall be calculated as claims paid during the contract period plus a reasonable estimate of claims liability for the contract period at the end of the current year divided by contributions paid or collected for the contract period minus unearned contributions at the end of the current year.

(p) (1) Comply with the investment requirements of Article 3 (commencing with Section 1170) of Chapter 2 of Part 2 of Division 1 and Section 1192.5, except for investments made pursuant to paragraph (2).

(2) (A) A multiple employer welfare arrangement may invest funds as provided in subparagraph (B) in an amount not to exceed 75 percent of any excess of invested assets over the sum of the following:

(i) The reserves and related actuarial items held in support of policies and contracts.

(ii) The surplus required by subdivision (n).

(B) The investments authorized by subparagraph (A) may be made only in an open-ended diversified management company, as defined in the federal Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.), that is registered with and reports to the Securities and Exchange Commission and is domiciled in the United States, and all of the assets of which are held in the United States by a bank, trust company, or other custodian chartered by the United States, or its territories or states.

(3) The commissioner may, in his or her discretion and after a hearing, require by written order the disposal of any investment made in violation of this section. The commissioner may also, after a hearing, require the disposal of any investment made pursuant to

paragraph (2) if the multiple employer welfare arrangement has failed to maintain cash or liquid assets sufficient to meet its claims and any other contractual obligations.

742.25. In determining the qualification of a multiple employer welfare arrangement, the commissioner will consider, among other things:

(a) The history of the multiple employer welfare arrangement.

(b) The competency, character, integrity, responsibility, and general fitness of the management and administration.

(c) Financial stability.

(d) Whether claims were promptly and fairly adjusted and are promptly and fully paid in accordance with the law and the terms of the plan.

(e) Fairness and honesty of methods of doing business.

(f) Hazard to covered employees or creditors.

742.26. The multiple employer welfare arrangement shall issue to each covered employee a certificate evidencing coverage and a summary plan description of benefits and coverages provided. This evidence of the benefits and coverage provided shall contain the following statement: "The benefits and coverages described herein are provided through a trust fund established and funded by the ____ Plan, sponsored by the ____ Association. The trust is a self-funded plan established under ERISA (29 U.S.C. 1001 et seq.). This is not an insurance contract and the plan and trust is not acting as, or deemed to be an insurance company."

742.27. The department shall have the authority to revoke a certificate of compliance to any self-funded or partially self-funded multiple employer welfare arrangement if the department determines any of the following:

(a) The multiple employer welfare arrangement has failed, after written request by the commissioner, to remove or discharge any officer, director, trustee, or other employee who has been convicted of any crime involving fraud, dishonesty, or moral turpitude.

(b) The multiple employer welfare arrangement has unreasonably failed or refused to furnish any report or statement or has unreasonably refused the department access to its books or records as

required by this article.

(c) The multiple employer welfare arrangement has failed for an unreasonable period to pay any judgment rendered against it by a court or other applicable regulatory agency or body.

(d) The multiple employer welfare arrangement is conducting business fraudulently or is not meeting its contractual obligations in good faith.

(e) The multiple employer welfare arrangement fails to comply with the provisions of Section 790.03.

(f) The multiple employer welfare arrangement fails to comply with Chapter 14 (commencing with Section 10700) of Part 2 of Division 2.

(g) The multiple employer welfare arrangement fails to comply with Article 3.1 (commencing with Section 1357) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(h) The multiple employer welfare arrangement fails to establish, or at all times maintain, compliance with the requirements of this article, or other laws made applicable to the multiple employer welfare arrangement by this article.

742.28. A self-funded or partially self-funded multiple employer welfare arrangement authorized by this article shall be limited to providing the following benefits:

(a) Medical, dental, optical, surgical, or other hospital care benefits.

(b) Benefits in the event of sickness, accident, or disability.

(c) Flexible benefits under Section 125 of the Internal Revenue Code. These benefits shall not include loss from liability imposed by law upon employers to compensate employees and their dependents for injury sustained by the employees arising out of and in the course of the employment, irrespective of negligence or the fault of either party.

742.29. An association seeking to establish an employee welfare benefit plan by the use of a self-funded or partially self-funded multiple employer welfare arrangement shall apply for a certificate of compliance on a form prescribed by the commissioner. The application shall be completed and submitted to the commissioner along with all of the following:

(a) Copies of all articles, bylaws, agreements, or other documents

or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the association with respect to the multiple employer welfare arrangement.

(b) Current audited financial statements of the association and the multiple employer welfare arrangement, and Internal Revenue Service Form number 5500 for the last five years.

(c) Proof of a fidelity bond in an amount equal to 10 percent of the funds handled annually by the multiple employer welfare arrangement. In no case may the amount of the bond be less than fifty thousand dollars ($50,000) nor more than five hundred thousand dollars ($500,000).

(d) A fiduciary liability policy with limits of not less than five hundred thousand dollars ($500,000).

(e) A statement showing in full detail the benefit plan upon which the association has established and maintained the multiple employer welfare arrangement.

(f) A copy of all contracts or other instruments that it makes with or issues to the association members, together with a copy of its plan description and the printed material which was used in enrolling members during 1993 and 1994.

(g) Proof of aggregate and specific stop loss insurance with an insurer licensed to do business in this state.

(h) A copy of all contracts or other instruments that were used with administrators and producers during 1993 and 1994.

(i) Biographical affidavits for the trustees, plan administrators of the multiple employer welfare arrangement, officers and directors of the association, other persons acting in a fiduciary capacity and any third-party administrators performing services on behalf of the multiple employer welfare arrangement.

742.30. The commissioner shall not issue a certificate of compliance to a self-funded or partially self-funded multiple employer welfare arrangement unless the employers participating in the multiple employer welfare arrangement are members of a bona fide trade, industrial, or professional association as described in subdivision (b) of Section 742.24.

742.31. Each self-funded or partially self-funded multiple employer welfare arrangement transacting business in the state shall file all of the following with the commissioner:

(a) No later than May 15th of each calendar year or four months and 15 days after the end of each fiscal year not on a calendar year basis, financial statements audited by a certified public accountant, and no later than March 1 of each calendar year or 60 days after the end of each fiscal year not on a calendar year basis, an actuarial opinion rendered by a qualified actuary that satisfies the requirements of Section 10489.15. The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on any additional standards that the commissioner may, by regulation, prescribe. For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in regulations of the commissioner. The qualified actuary shall be liable for damages to any person caused by his or her negligence or other tortious conduct.

(b) Within 60 days after the end of each fiscal quarter, unaudited financial statements, affirmed by an appropriate officer or agent of the multiple employer welfare arrangement.

(c) Within 60 days after the end of each fiscal quarter, a report certifying that the multiple employer welfare arrangement maintains cash or liquid assets in a claim reserve account sufficient to meet its contractual obligations and that it maintains a policy of aggregate and specific stop loss insurance.

742.32. The commissioner or any persons designated by the commissioner shall have the power to examine the affairs of any self-funded or partially self-funded multiple employer welfare arrangement and the association which established and maintains it, and for that purpose shall have access to all books, records, and documents that relate to the business of the multiple employer welfare arrangement, and may examine under oath its trustees, officers, agents, and employees in relation to the affairs, transactions, and condition of the multiple employer welfare arrangement.

742.33. Books, records, and documents pertaining to the business of the multiple employer welfare arrangement shall be maintained by the administrator for a period of five years. "Administrator," as used in this section, has the same meaning as that contained in Section 1002(16)(A) of Title 29 of the United States Code.

742.34. (a) The following notice shall be provided to employers and employees who obtain coverage from a multiple employer welfare arrangement:

NOTICE

(A) THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF A MULTIPLE EMPLOYER WELFARE ARRANGEMENT BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

(B) THE HEALTH CARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT THAT IS LICENSED BY THE STATE OF CALIFORNIA.

(C) FOR ADDITIONAL INFORMATION ABOUT THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR OR YOU MAY CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT _____.

(b) Each multiple employer welfare arrangement should include the department's current "800" consumer service telephone number in the blank provided in paragraph (C) of this notice.

742.35. The department may conduct an examination of the financial condition of a self-funded or partially self-funded multiple employer welfare arrangement, and if it determines that the multiple employer welfare arrangement's financial condition does not comply with the requirements of this article, the department may apply any remedies authorized by this code.

742.36. Subject to the annual fee provisions of Section 742.39, every certificate of compliance shall be for an indefinite term and shall expire with the expiration or termination of the existence of the holder thereof. Notwithstanding the provisions of this section, whenever the commissioner shall determine, after notice and hearing, that any person to whom the certificate has been issued is in arrears to the state or to any county or city in the state for fees,

licenses, taxes, assessments, fines, or penalties, accrued on business transacted in the state, or is otherwise in default for failure to comply with any of the laws of this state regarding the governmental control of the person by the state, the commissioner may order the certificate holder to comply with those requirements within 30 days of that determination. If the certificate of compliance holder fails to comply within that period, the certificate of compliance may then be revoked, unless the commissioner's order is stayed by a court of appropriate jurisdiction.

742.37. (a) The commissioner may suspend the certificate of compliance of a holder thereof for not exceeding one year whenever he or she finds, after proper hearing following notice, that the person engages in any of the following practices:

(1) Conducting its business fraudulently.

(2) Not carrying out its contracts in good faith.

(3) Habitually and as a matter of ordinary practice and custom compelling claimants under policies, or liability judgment creditors of the certificate of compliance holder, to either accept less than the amount due under the terms of its contracts or resort to litigation against the certificate of compliance holder to secure the payment of the amount due.

(b) The order of suspension shall prescribe the period of each suspension.

(c) Proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearings shall be conducted by administrative law judges chosen under Section 11502 or appointed by the commissioner.

742.38. The commissioner, in any proceeding under Section 742.37 for any of the violations specified in that section, may by alternative order permit the holder of that certificate of compliance to elect in writing to pay a specified money penalty, within a specified time, in lieu of the suspension of its certificate of compliance. If the holder so elects, the sum of money specified shall be paid to the commissioner for use of the state, and shall not exceed fifty-five thousand dollars ($55,000). If the holder so electing fails to pay the specified sum within the specified time,

the commissioner shall, unless his or her order is stayed, put in effect the alternatives specified in his or her order.

All money received by the commissioner pursuant to this section shall, when appropriated for that purpose by the Legislature, be available for expenditure by the commissioner in accordance with law in administration and enforcement of this code and other insurance laws.

The authority vested in the commissioner by this section shall be additional to and not in lieu of any other authority to enforce any penalties, fines or forfeitures, denials, suspensions, restrictions, or revocations of certificates of compliance unless otherwise authorized by law.

742.39. The commissioner shall require the payment of three thousand five hundred dollars ($3,500) in advance as a fee for filing an application for each certificate of compliance. Notwithstanding Section 742.36, each holder of a certificate of compliance of indefinite term shall owe and pay an annual fee of two hundred eighty-three dollars ($283) in advance on account of the certificate until final expiration. In addition, each holder of a certificate of compliance of indefinite term shall owe and pay an annual fee of two hundred eighty-one dollars ($281) for filing of financial information. These fees shall be for annual periods commencing on July 1 of each year and ending on June 30 of each year, and shall be due on each March 1 and be delinquent on and after April 1.

742.40. (a) A multiple employer welfare arrangement shall offer health care coverage benefits to any new eligible person and his or her dependents under terms and conditions no less favorable to those offered to their employers' existing employees and their dependents, if the newly eligible person had health care benefit coverage with either the same or a different multiple employer welfare arrangement within 31 days. The new coverage shall comply with existing eligibility rules of the multiple employer welfare arrangement.

(b) A multiple employer welfare arrangement shall comply with the requirements set forth in Sections 10198.7 and 10198.9.

742.405. (a) No multiple employer welfare arrangement shall refuse to enroll any person or accept any person as a subscriber or renew

any person as a subscriber after appropriate application on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring. No multiple employer welfare arrangement shall require a higher rate or charge, or offer or provide different terms, conditions, or benefits, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring than is at that time required of any other individual in an otherwise identical classification, nor shall any multiple employer welfare arrangement make or require any rebate, discrimination, or discount upon the amount to be paid or the service to be rendered under the arrangement because the person carries those traits.

(b) No multiple employer welfare arrangement shall seek information about a person's genetic characteristics for any nontherapeutic purpose.

(c) No discrimination shall be made in the fees or commissions of a solicitor or solicitor firm for an enrollment or a subscription or the renewal of an enrollment or subscription of any person on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(d) "Genetic characteristics" as used in this section shall have the same meaning as defined in Section 10123.3.

742.407. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a multiple employer welfare arrangement.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a

civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's "written authorization," as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce

compliance with Section 1374.7 of the Health and Safety Code.

742.41. All employer groups who have health care coverage benefits provided by a multiple employer welfare arrangement for their employees and their dependents, regardless of individual condition or history of that employee and their dependents, shall continue to provide coverage thereunder pursuant to the terms and conditions of their multiple employer welfare arrangement, subject to only cancellation for nonpayment of contribution, or in the event of the termination of the multiple employer welfare arrangement.

742.42. The provisions of this code governing domestic incorporated insurers, their business, and their contracts shall, so far as applicable and not inconsistent, govern multiple employer welfare arrangements subject to this article and the business and contracts of these multiple employer welfare arrangements, except that these multiple employer welfare arrangements, their business, and their contracts shall not be subject to Article 14.7 (commencing with Section 1067) of Chapter 1 of Part 2 of Division 1. There shall be a rebuttable presumption that any provision of this code is applicable to multiple employer welfare arrangements.

742.425. The provisions of this article shall not apply to multiple employer welfare arrangements as defined in Section 1144(b)(6)(D) of Title 29 of the United States Code.

742.43. The commissioner may adopt reasonable rules and regulations for the implementation and administration of this article.

742.435. The Department of Insurance, in consultation with the Department of Managed Health Care, shall conduct an evaluation of multiple employer welfare arrangements and report to the Legislature and the Governor by January 1, 2002. The evaluation shall include,

but not be limited to, the effectiveness of multiple employer welfare arrangements in providing participants with options for affordable health care coverage, and the effect of multiple employer welfare arrangements on persons or entities purchasing health care coverage who are not multiple employer welfare arrangement participants.

INSURANCE CODE
SECTION 750-754

750. (a) Except as provided in Section 750.5, any person acting individually or through his or her employees or agents, who engages in the practice of processing, presenting, or negotiating claims, including claims under policies of insurance, and who offers, delivers, receives, or accepts any rebate, refund, commission, or other consideration, whether in the form of money or otherwise, as compensation or inducement to or from any person for the referral or procurement of clients, cases, patients, or customers, is guilty of a crime.

(b) A violation of subdivision (a) is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding fifty thousand dollars ($50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of fifty thousand dollars ($50,000).

(c) Nothing in this section shall prohibit a licensed collection or lien agency from receiving a commission on the collection of delinquent debts nor prohibits the agency from paying its employees a commission for obtaining clients seeking collection on delinquent debts.

(d) Nothing in this section is intended to limit, restrict, or in any way apply to, the rebating of commissions by insurance agents or brokers, as authorized by Proposition 103, enacted by the people at the November 8, 1988, general election.

750.4. Section 750 of the Insurance Code, Sections 3215 and 3219 of the Labor Code, or Section 549 of the Penal Code shall not apply to any person, corporation, partnership, association, or firm, which both of the following:

(a) Operating on behalf of an insurer or self-insured person, company, association, or group.

(b) Operating pursuant to and within the scope of a certificate of consent issued pursuant to Section 3702.1 of the Labor Code or pursuant to and within the scope of a license issued pursuant to Article 3 (commencing with Section 14000) of Chapter 1 of Division 5.

750.5. Nothing in Section 750 of the Insurance Code, Section 549 of the Penal Code, or Section 3215 of the Labor Code shall be construed to prevent an attorney or law firm from the following:

(a) Dividing fees for legal services with a lawyer under circumstances expressly permitted by Rule 2-200 of the Rules of Professional Conduct of the State Bar.

(b) Offering or giving an incidental nonmonetary gift or gratuity to a person who has made a recommendation resulting in the employment of the attorney or law firm, provided that the gift or gratuity was not offered in consideration of any promise, agreement, or understanding that the gift or gratuity would be forthcoming or that referrals would be made or encouraged in the future.

(c) Offering or giving a bonus to an employee who has made a referral or recommendation resulting in the employment of the attorney or law firm, provided that the bonus was not offered in consideration of any promise, agreement, or understanding that the bonus would be forthcoming or that referrals or recommendations would be made or encouraged in the future.

753. (a) It is unlawful for any insurance agent or broker, or any insurance solicitor employed thereby, to receive any financial benefit from an automobile repair facility or any other form of direct or indirect consideration from any person for referring insureds to that person or that person's designee for vehicle repairs covered under the automobile comprehensive coverage, property damage coverage, or automobile collision coverage, of an insurance policy issued through the insurance agent or broker or by an insurer represented by the insurance agent.

(b) Subdivision (a) applies with respect to commercial and noncommercial policies of automobile insurance.

(c) For purposes of this section, "financial benefit" means the receiving of any commission or gratuity, discount on repair costs, free repairs, or employment by a repair facility.

754. (a) It is unlawful for any person to solicit, receive, offer, or pay any referral fee for the referral of an individual for the furnishing of services or goods for which the person knows or should have known whole or partial reimbursement is or may be made, directly or indirectly, by any insurer. As used in this section, a referral fee is a fee paid by a person furnishing goods or services to another in return for the referral of an individual to that person for the furnishing of services or goods. It includes any referral fee, kickback, bribe, or rebate, whether made directly or indirectly, overtly or covertly, or in cash or in kind. This subdivision does not apply to any of the following:

(1) Discounts or similar reductions in prices.

(2) Referral fees between attorneys if legal services are provided pursuant to a contingency fee arrangement if any referral fee is consistent with the Rules of Professional Conduct of the State Bar of California.

(b) This section applies to all forms of insurance covering a motor vehicle, including commercial and personal lines, and comprehensive coverage, property damage coverage, collision coverage, and liability coverage.

(c) A violation of this section is a misdemeanor punishable by a fine not to exceed one thousand dollars ($1,000) for each violation. Proceedings to enforce this section may be brought by any district attorney or other prosecuting attorney.

INSURANCE CODE
SECTION 755-758.5

755. If at the time of the solicitation and issuance of a policy of life or disability insurance, or of a surety bond which by its terms continues until canceled, a person may lawfully receive commissions on it, that person, or in the event of that person's death, his or her estate or heirs may continue to receive commissions on it during the continuance in force or renewal of the policy or bond without being licensed under the provisions of Chapter 5 (commencing with Section 1621) of Part 2 if all of the following requirements are met:

(a) The recipient does not transact insurance in connection with

the policy or bond while not so licensed.

(b) The payment is made pursuant to a contract entered into, before that solicitation and issuance, between the insurer paying or allowing the commission and that person.

756. When the premium on a policy insuring an employer is based upon the amount or segregation of the employer's payroll, and the employer, personally or knowingly through his or her employee, procures a lower premium by willfully misrepresenting the amount or segregation, that misrepresentation is an unlawful act as to the employer.

In addition to any penalty provided by law, the employer in that case is liable to the state in an amount 10 times the difference between the lower premium paid and the premium properly payable. The commissioner shall collect the amount so payable and may bring a civil action in his or her name as commissioner to enforce collection unless the misrepresentation is made to, and the lower premium procured from the State Compensation Insurance Fund. In the latter case the liability to the state under this section shall be enforced in a civil action in the name of the State Compensation Insurance Fund and any amount so collected shall become a part of that fund.

757. When a statement of the amount or segregation of a payroll is materially false, and an insurer, through a person employed by it in a managerial capacity, accepts the statement as the basis for the premium on a policy, the acceptance is an unlawful act if the accepting employee knows of the falsity.

758. (a) It is unlawful for an insurer to require an auto body repair shop registered pursuant to Sections 9884 and 9889.52 of the Business and Professions Code, as a condition of participation in the insurer's direct repair program, to pay for the cost of an insured's rental vehicle that is replacing an insured vehicle damaged in an accident, or to pay for the towing charges of the insured with respect to that accident. However, the insurer and the auto body repair shop may agree in writing to terms and conditions under which the rental vehicle charges become the responsibility of the auto body repair shop when the shop fails to complete work within the

agreed-upon time for repair of the damaged vehicle.

(b) A registered auto body repair shop that is denied participation in an insurer's direct repair program may report a denial to the department, which shall maintain a record of all those denials for the purposes of gathering market conduct information. An insurer, upon the request of the department, shall disclose the fact that a denial was made.

(c) Any insurer that conducts an auto body repair labor rate survey to determine and set a specified prevailing auto body rate in a specific geographic area shall report the results of that survey to the department, which shall make the information available upon request. The survey information shall include the names and addresses of the auto body repair shops and the total number of shops surveyed.

758.5. (a) No insurer shall require that an automobile be repaired at a specific automotive repair dealer, as defined in Section 9880.1 of the Business and Professions Code.

(b) (1) No insurer shall suggest or recommend that an automobile be repaired at a specific automotive repair dealer unless either of the following applies:

(A) A referral is expressly requested by the claimant.

(B) The claimant has been informed in writing of the right to select the automotive repair dealer.

(2) If the recommendation is accepted by the claimant, the insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as is otherwise allowed by law. If the recommendation of an automotive repair dealer is done orally, and if the oral recommendation is accepted by the claimant, the insurer shall provide the information contained in this paragraph, as noted in the statement below, to the claimant at the time the recommendation is made. The insurer shall send the written notice required by this paragraph within five calendar days from the oral recommendation. The written notice required by this paragraph shall include the following statement plainly printed in no less than 10-point type:

"WE ARE PROHIBITED BY LAW FROM REQUIRING THAT REPAIRS BE DONE AT A SPECIFIC AUTOMOTIVE REPAIR DEALER. YOU ARE ENTITLED TO SELECT THE AUTO BODY REPAIR SHOP TO REPAIR DAMAGE COVERED BY US. WE HAVE RECOMMENDED AN AUTOMOTIVE REPAIR DEALER THAT WILL REPAIR YOUR DAMAGED VEHICLE. IF YOU AGREE TO USE OUR RECOMMENDED AUTOMOTIVE REPAIR DEALER, WE WILL CAUSE THE DAMAGED VEHICLE TO BE RESTORED TO ITS

CONDITION PRIOR TO THE LOSS AT NO ADDITIONAL COST TO YOU OTHER THAN AS STATED IN THE INSURANCE POLICY OR AS OTHERWISE ALLOWED BY LAW. IF YOU EXPERIENCE A PROBLEM WITH THE REPAIR OF YOUR VEHICLE, PLEASE CONTACT US IMMEDIATELY FOR ASSISTANCE."

(c) Except as provided in subparagraph (A) of paragraph (1) of subdivision (b), after the claimant has chosen an automotive repair dealer, the insurer shall not suggest or recommend that the claimant select a different automotive repair dealer.

(d) Any insurer that, by the insurance contract, suggests or recommends that an automobile be repaired at a particular automotive repair dealer shall also do both of the following:

(1) Prominently disclose the contractual provision in writing to the insured at the time the insurance is applied for and at the time the claim is acknowledged by the insurer.

(2) If the claimant elects to have the vehicle repaired at the shop of his or her choice, the insurer shall not limit or discount the reasonable repair costs based on charges that would have been incurred had the vehicle been repaired by the insurer's chosen shop.

(e) For purposes of this section, "claimant" means a first-party claimant or insured, or a third-party claimant who asserts a right of recovery for automotive repairs under an insurance policy.

(f) The powers of the commissioner to enforce this section shall include those granted in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1.

INSURANCE CODE
SECTION 759-765

759. This article establishes consumer protections in connection with retail sales practices, solicitations, advertising, or offers of any insurance product or annuity to a consumer by either of the following:

(a) Any depository institution, as defined in subdivision (b) of Section 760.

(b) Any person who is engaged in those activities at an office of a depository institution or on behalf of a depository institution.

760. As used in this article, the following terms have the following meanings:

(a) "Affiliate" has the same meaning as defined in Section 1215.

(b) "Depository institution" means any of the following:

(1) National banks, operating subsidiaries of a national bank, and federal branches or agencies of a foreign bank, as defined in Section 1 of the International Banking Act of 1978 (12 U.S.C. Sec. 3101 et seq.), in the case of institutions supervised by the Office of the Comptroller of the Currency.

(2) State member banks in the case of the Board of Governors of the Federal Reserve System.

(3) State nonmember banks in the case of the Federal Deposit Insurance Corporation (FDIC).

(4) Savings associations and operating subsidiaries of savings associations, in the case of the Office of Thrift Supervision.

(c) "Company" means any corporation, partnership, business trust, association, or similar organization, or any other trust, other than a trust that by its terms must terminate within 25 years or not later than 21 years and 10 months after the death of individuals living on the effective date of the trust. "Company" does not include any corporation the majority of the shares of which are owned by the United States or by any state, or a qualified family partnership, as defined in paragraph (10) of subsection (o) of Section 2 of the federal Bank Holding Company Act of 1956, as amended (12 U.S.C. Sec. 1841(o)(10)).

(d) "Consumer" means an individual who purchases, applies to purchase, or is solicited to purchase from a covered person insurance products or annuities primarily for personal, family, or household purposes.

(e) "Control" has the same meaning as defined in Section 1215.

(f) (1) "Covered person" means either of the following:

(A) A depository institution.

(B) Another person only when the person sells, solicits, advertises, or offers an insurance product or annuity to a consumer at an office of a depository institution, or on behalf of a depository institution.

(2) For purposes of this definition, activities on behalf of a depository institution include activities pursuant to which a person, whether at an office of the depository institution or at another location, sells, solicits, advertises, or offers an insurance product or annuity and where at least one of the following applies:

(A) The person represents to a consumer that the sale, solicitation, advertisement, or offer of any insurance product or

annuity is by or on behalf of the depository institution.

(B) The depository institution refers a consumer to a seller of insurance products or annuities and the institution has a contractual arrangement to receive commissions or fees derived from a sale of an insurance product or annuity resulting from that referral.

(C) Documents evidencing the sale, solicitation, advertising, or offer of an insurance product or annuity identify or refer to the depository institution.

(g) "Electronic media" includes any means for transmitting messages electronically between a covered person and a consumer in a format that allows visual text to be displayed on equipment such as a personal computer monitor.

(h) "Office" means the premises of a depository institution where retail deposits are accepted from the public.

(i) "Subsidiary" has the same meaning as defined in Section 1215.

761. (a) A covered person shall not engage in any practice that would lead a consumer to believe that an extension of credit, in violation of subsection (b) of Section 106 of the federal Bank Holding Company Act Amendments of 1970 (12 U.S.C. Sec. 1972), is conditional upon either of the following:

(1) The purchase of an insurance product or annuity from the depository institution or any of its affiliates.

(2) An agreement by the consumer not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an affiliated entity.

(b) A covered person shall not engage in any practice or use any advertisement at any office of, or on behalf of, the depository institution or a subsidiary of the depository institution that could mislead any person or otherwise cause a reasonable person to reach an erroneous belief with respect to any of the following:

(1) The fact that any insurance product or annuity sold or offered for sale by a covered person or any subsidiary of the depository institution is not backed by the federal government or the depository institution, or the fact that the insurance product or annuity is not insured by the Federal Deposit Insurance Corporation.

(2) In the case of an insurance product or annuity that involves investment risk, the fact that there is an investment risk, including the potential that principal may be lost and that the product may decline in value.

(3) In the case of a depository institution or subsidiary of the depository institution at which insurance products or annuities are

sold or offered for sale, the fact that:

(A) The approval of an extension of credit to the consumer by the depository institution or subsidiary may not be conditioned on the purchase of an insurance product or annuity by the consumer from the depository institution or a subsidiary of the depository institution.

(B) The consumer is free to purchase the insurance product or annuity from another source.

762. (a) In connection with the initial purchase of an insurance product or annuity by a consumer from a covered person, a covered person shall disclose to the consumer, except to the extent the disclosure would not be accurate, all of the following:

(1) That the insurance product or annuity is not a deposit or other obligation of, or guaranteed by, the depository institution or an affiliate of the depository institution.

(2) That the insurance product or annuity is not insured by the Federal Deposit Insurance Corporation or any other agency of the United States, the depository institution, or, if applicable, an affiliate of the depository institution.

(3) In the case of an insurance product or annuity that involves an investment risk, that there is investment risk associated with the product, including the possible loss of value.

(b) In the case of an application for credit in connection with which an insurance product or annuity is solicited, offered, or sold, a covered person shall disclose that the depository institution may not condition an extension of credit on either of the following:

(1) The consumer's purchase of an insurance product or annuity from the depository institution or any of its affiliates.

(2) The consumer's agreement not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity.

(c) (1) The disclosures required by subdivision (a) shall be provided orally and in writing during any solicitation of an insurance product or annuity to a consumer. The disclosures required by subdivision (b) shall also be made orally and in writing at the time the consumer applies for an extension of credit in connection with which an insurance product or annuity will be solicited, offered, or sold.

(2) If a sale of an insurance product or annuity is conducted by mail, a covered person is not required to make the oral disclosures required by subdivision (a). If a covered person takes an

application for credit by mail, the covered person is not required to make the oral disclosures required by subdivision (b).

(3) If the sale of an insurance product or annuity is conducted by telephone, a covered person shall provide the written disclosure required by subdivision (a) by mail within three business days, beginning on the first business day after the sale, but excluding Sundays and the legal public holidays specified in subsection (a) of Section 6103 of Title 5 of the United States Code.

(4) Subject to the requirements of subsection (c) of Section 101 of the federal Electronic Signatures in Global and National Commerce Act (15 U.S.C. Sec. 7001(c)), a covered person may provide the written disclosures required by subdivisions (a) and (b) through electronic media instead of paper, if the consumer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the consumer may retain or obtain later, for example, through printing or storing electronically by downloading. Any disclosures required by subdivision (a) or (b) that are provided by electronic media are not required to be provided orally.

(5) The disclosures provided shall be conspicuous, simple, direct, readily understandable, and designed to call attention to the nature and significance of the information provided. For example, a covered person may use the following disclosures in visual media, including television, broadcasting, ATM screens, billboards, signs, posters, and written advertisements and promotional materials, as appropriate and consistent with subdivisions (a) and (b):

(A) "NOT A DEPOSIT."

(B) "NOT FDIC-INSURED."

(C) "NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY."

(D) "NOT GUARANTEED BY THE BANK (OR SAVINGS ASSOCIATION)."

(E) "MAY GO DOWN IN VALUE."

(6) (A) A covered person shall provide the disclosures required by subdivisions (a) and (b) in a meaningful form. Examples of the types of methods that could call attention to the nature and significance of the information provided include all of the following:

(i) A plain language heading to call attention to the disclosure.

(ii) A typeface and type size that are easy to read.

(iii) Wide margins and ample line spacing.

(iv) Boldface or italics for key words.

(v) Distinctive type style, and graphic devices, such as shading or sidebars, when the disclosures are combined with other information.

The disclosures required by subdivisions (a) and (b) shall be in the same language as principally used in any oral solicitation leading to the execution of the purchase by the consumer of the insurance product or annuity.

(B) A covered person has not provided the disclosures in a meaningful form if the covered person merely states to the consumer that the required disclosures are available in printed material, but does not provide the printed material when required and does not orally disclose the information to the consumer when required.

(C) With respect to disclosures made through electronic media for which paper or oral disclosures are not required, the disclosures are not meaningfully provided if the consumer may bypass the visual text of the disclosures before purchasing an insurance product or annuity.

(7) A covered person shall obtain from the consumer, at the time the consumer receives the disclosures required by subdivisions (a) and (b), or at the time of initial purchase by the consumer of the insurance product or annuity, a written acknowledgment by the consumer that the consumer received the disclosures. A covered person may permit a consumer to acknowledge receipt of the disclosures electronically or in paper form. If the disclosures required under subdivisions (a) and (b) are provided in connection with a transaction that is conducted by telephone, a covered person shall do the following:

(A) Obtain an oral acknowledgment of receipt of the disclosures and maintain sufficient documentation to show that the acknowledgment was given.

(B) Make reasonable efforts to obtain a written acknowledgment from the consumer.

(d) The disclosures described in subdivision (a) are required in advertisements and promotional material for insurance products or annuities unless the advertisements or promotional material are of a general nature describing or listing the services or products offered by the depository institution.

763. (a) A depository institution shall, to the extent practicable, keep the area where the depository institution conducts transactions involving insurance products or annuities physically segregated from areas where retail deposits are routinely accepted from the general public, identify the areas where insurance products or annuity sales activities occur, and clearly delineate and distinguish, with appropriate signage, those areas from the areas where the depository

institution's retail deposit-taking activities occur.

(b) Any person who accepts deposits from the public in an area where those transactions are routinely conducted in the depository institution may refer a customer who seeks to purchase an insurance product or an annuity to a qualified person who sells that product only if the person making the referral receives no more than a one-time nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction.

764. A depository institution may not permit any person to sell or offer for sale any insurance product or annuity in any part of its office or on its behalf, unless the person is at all times appropriately qualified and licensed as required by this code with regard to the specific products being sold or recommended.

765. The commissioner may adopt reasonable regulations necessary to administer this article.

INSURANCE CODE
SECTION 769-769.55

769. (a) After a written agency or written brokerage contract, where the broker-agent represents the insurer, has been in effect for at least one year, it shall not be terminated or amended by an insurer, except by mutual agreement, unless 120 days' advance written notice has been given by the insurer to the broker-agent.

(b) The advance notice required by this section does not apply if the broker-agent has done any of the following:

(1) Exceeded his or her binding authority under the agency or brokerage contract.

(2) Violated the written underwriting rules or regulations of the insurer, a copy of which has been provided to the broker-agent, which misleads the insurer concerning the nature or extent of a risk.

(3) Failed to comply with the fiduciary requirements set forth in Section 1733, 1734, 1734.5, or 1735.

(4) Failed, either within 10 days after written notice upon failure to remit funds within the time limits set forth in the agency or brokerage contract or within 30 days after written demand if the agency or brokerage contract does not set forth time limits, to remit funds due and owing to the insurer.

(5) Had his or her license suspended or revoked by the commissioner.

(6) Engaged in fraudulent acts affecting his or her relationship with the insurer or its insureds.

(7) Transferred ownership, control, or servicing of policies written with the insurer to another insurer, or to an entity directly or indirectly owned or controlled by an insurer or to an entity directly or indirectly owning or controlling an insurer.

(c) When a broker-agent's contract is terminated as provided by this section, the rights, duties, and obligations set forth in the terminated contract of the broker-agent having property rights in renewals shall continue solely with respect to policies then in force or renewed as provided by this section until those policies are canceled in accordance with law, placed by the broker-agent with another insurer, or have expired. The broker-agent's authority during the period following notice of termination of his or her contract shall be governed by the written contract between the broker-agent and the insurer, except that, after the receipt of the notice of termination, the broker-agent shall not bind new risks on behalf of the insurer, renew policies except as permitted by this section, or otherwise increase the obligation of the insurer, without the express approval of the insurer or in accordance with the terms of an existing policy.

(d) If a terminated broker-agent is unable, after making a good faith effort, to place existing policies with another insurer, the insurer then insuring the risk shall, at the broker-agent's request, renew any insurance contract written by the broker-agent for the insurer for one policy term or a period of one year, whichever is shorter. Where the insurer is prohibited by subdivision (c) of Section 1861.03 from nonrenewing the risk, the insurer shall continue to compensate the broker-agent for servicing the policies written by the insurer prior to termination of the broker-agent relationship until the insurer can cancel or nonrenew the policyholder pursuant to statute or the broker-agent moves the policyholder to another insurer but, in no event, shall the insurer's obligation to compensate the broker-agent exceed three years after termination of the broker-agent's contract, unless otherwise provided by terms of the contract. The renewal shall be at the insurer's premium rates in effect on the date of renewal and at prevailing commission rates for

that class or line of business in effect on the date of renewal for broker-agents whose contracts are not terminated. An insurer shall not be precluded from paying a commission to a terminated broker-agent pursuant to this section at a level the insurer is paying at the time it provides notice to the broker-agent that it is terminating the contract or as set forth in the written agreement, providing that there has not been any unilateral change in the commission paid by the insurer within 180 days of the notice of the broker-agent's termination. An insurer shall be allowed to subtract from the three-year time period provided to a broker-agent upon termination, the time period that elapsed during which the broker-agent is involved in a rehabilitation program with an insurer.

(e) (1) Notwithstanding any other provision of this section, no insurer shall be required to renew any policy of insurance or compensate a terminated broker-agent pursuant to the provisions of this section if any of the following apply:

(A) The broker-agent is no longer the broker-agent of record with respect to the policy, or the broker-agent has transferred ownership, control, or servicing of policies written with the insurer to another insurer or an entity owned or controlled, directly or indirectly, by another insurer or to an entity owning or controlling, directly or indirectly, another insurer.

(B) The broker-agent has died or has become unable to conduct his or her business affairs.

(C) The broker-agent has failed, either within 10 days after written demand upon failure to remit funds within the time limits set forth in the agency or brokerage contract or within 30 days after written demand if the agency or brokerage contract does not set forth time limits, to remit funds due and owing to the insurer.

(D) The broker-agent has failed to follow the written instructions of the insurer, a copy of which has been provided to the broker-agent, generally applicable to the renewal of policies.

(E) The commissioner has determined that the renewal of the policy would threaten the solvency of the insurer.

(F) The insurer suffers the withdrawal of reinsurance covering all or part of the risk and this withdrawal of reinsurance is likely to threaten, in the opinion of the commissioner, the financial integrity or solvency of the insurer.

(G) The insurer has withdrawn from the State of California in accordance with Sections 1070 to 1076, inclusive.

(2) Nothing in this subdivision shall be construed to authorize the nonrenewal of a good driver discount policy as defined and issued pursuant to the provisions of Sections 1861.02, 1861.025, and

1861.03.

(f) This section shall not apply to a life insurer, an agent of a life insurer, a disability insurer, a nonprofit hospital service plan, an agent of a disability insurer or nonprofit hospital service plan, an agent who is the employee of an insurer, or to an agent who, by contractual agreement either represents only one insurer or group of affiliated insurers or who is required by contract to submit risks to a specified insurer or group of affiliated insurers prior to submitting them to other insurers.

(g) This section does not apply to any management contract of a managing general agent as defined in Section 1735, but it shall continue to apply to any agency or brokerage contract of a managing general agent or any portion of a management contract authorizing a managing general agent to act in his or her capacity as an insurance agent as defined in Section 1621, or an insurance broker as defined in Section 1623.

(h) (1) For purposes of this section, a "rehabilitation program" shall include, but not be limited to, all of the following:

(A) Written communication to the broker-agent outlining the fact that the broker-agent is on rehabilitation status.

(B) Identification by the company of problem areas.

(C) Mutual agreement on performance objectives and specific dates for accomplishment.

(D) Length of rehabilitation plan to be negotiated, but not less than six months.

(2) For purposes of subdivision (d), a good faith effort is satisfied by a terminated broker-agent who markets his or her book of business to other insurers that underwrite the same or similar lines of insurance, consistent with the interests of the policyholders. An insurer who terminates a broker-agent shall be entitled to be informed of the marketing activity and to obtain copies of any correspondence reflecting these efforts. However, nothing in this section shall be interpreted to allow the insurer to require the terminated broker-agent to obtain written rejections of an agency appointment from other insurers, or written rejections from individual policyholders.

(i) An insurer that takes action, other than terminating the written agency or brokerage contract, solely for the purpose of avoiding the provisions of subdivision (a) shall be required to extend existing policies pursuant to the applicable provision of subdivision (d) if both of the following apply:

(1) The action is designed to impact only a specific agency or agencies and the business produced by them.

(2) The action results in the cancellation or nonrenewal of

substantially all of the agency's or agencies' business.

(j) This section shall apply to written agency contracts becoming effective on or after January 1, 1987. The amendments to this section by the act adding this sentence also apply to any written agency contract amended after January 1, 1988.

(k) The amendments to this section made by the act adding this subdivision shall apply to any written brokerage contract becoming effective, or amended, on or after January 1, 1996.

769.2. (a) In determining the amount of an insurer's rollback obligation pursuant to Section 1861.01 or any regulations promulgated to implement this section, each insurer shall be given full credit for all premium taxes, commissions, and brokerage expenses that the insurer actually paid during the rollback period. No insurer shall be required or permitted to seek, directly or indirectly, reimbursement from the state of any premium taxes paid on premiums earned during the rollback period or reimbursement from any employee or third-party contractor of an insurer of any compensation paid to them for services rendered during the rollback period.

(b) The provisions of this section and the findings and declarations in support thereof take effect immediately upon enactment and apply to any order, settlement agreement, consent decree, or any other resolution of an insurer's rollback obligation pursuant to Section 1861.01 that occurs after the effective date of this section.

(c) Nothing in this section shall be deemed in any regulatory or judicial proceeding or for any other purpose to constitute legislative intent to endorse or approve any regulations on the issue of Proposition 103 rollback refunds.

769.55. Notwithstanding any other provision of this code, for the purposes of Chapter 6 (commencing with Section 520) through Chapter 11 (commencing with Section 675), inclusive of Part 1 of Division 1, the obligation of an insurer to furnish any notice to its insured required by law may be carried out by an insurer's general agent, provided, however, that an insurer's delegation of a notice obligation to a general agent shall not limit or negate the insurer's responsibility or liability if the general agent fails to provide the required notice.

As used in this section, "general agent" means a licensed fire and

casualty broker-agent who, pursuant to a written contract with an admitted insurer manages the transaction of one or more classes of insurance written by the insurer and has the power to (1) appoint, supervise, and terminate local agents, (2) accept or decline risks, and (3) collect premium moneys from producing broker-agents.

Nothing in this section shall provide an exemption from Article 5.4 (commencing with Section 769.80) to any fire and casualty broker-agent who is otherwise subject to that article.

INSURANCE CODE
SECTION 769.80-769.87

769.80. This act shall be known and may be cited as the Managing General Agents Act.

769.81. As used in this article:

(a) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries, the Casualty Actuarial Society, or the Society of Actuaries, and is qualified to sign a statement of actuarial opinion on loss reserves.

(b) "Insurer" means any person, firm, association, or corporation duly licensed as an insurer and operating under a certificate of authority in this state.

(c) "Managing General Agent" (MGA) means any person, firm, association, partnership, or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and acts as an agent for that insurer whether known as an MGA, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than 5 percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following: (1) adjusts or pays claims in excess of an amount determined by the commissioner, or (2) negotiates reinsurance on behalf of the insurer.

Notwithstanding the above, the following persons shall not be considered as MGAs for the purposes of this act:

(1) An employee of the insurer.

(2) A United States manager of the United States branch of an alien insurer.

(3) An underwriting manager which, pursuant to contract, manages the insurance operations of the insurer, is under common control with the insurer, subject to the holding company regulatory act, and whose compensation is not based on the volume of premiums written.

(4) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

(d) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

769.82. (a) No producer shall act in the capacity of an MGA with respect to risks located in this state for an insurer which holds a certificate of authority unless that producer is licensed as a fire and casualty broker-agent or as a life agent in this state.

(b) No producer shall act in the capacity of an MGA representing an insurer domiciled in this state with respect to risks located outside this state unless that producer is licensed as a fire and casualty broker-agent or as a life agent in this state.

(c) The commissioner may require a fidelity bond in an amount acceptable to him or her for the protection of the insurer.

(d) The commissioner may require the MGA to maintain an errors and omissions policy. If a policy is not generally available at a reasonable cost, the commissioner may, by rule, suspend the requirement of this subdivision until that coverage becomes generally available at a reasonable cost.

769.83. No producer acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

(a) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(b) The MGA shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(c) All funds collected for the account of an insurer shall be held by the MGA in a fiduciary capacity in a bank or savings association the deposits of which are insured by the Bank Insurance Fund or the Savings Association Insurance Fund of the Federal Deposit Insurance Corporation. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The requirements of this subdivision shall be in addition to the requirements of Sections 1734 and 1735.

(d) Separate records of business written by the MGA shall be maintained. The insurer shall have access to and the right to copy all accounts and records related to its business in a form usable by the insurer and the commissioner shall have access to all books, bank accounts, and records of the MGA in a form usable to the commissioner. Those records shall be retained by the MGA, and shall be the joint property of the insurer and MGA.

(e) The contract may not be assigned in whole or part by the MGA.

(f) Appropriate underwriting guidelines including:

(1) The maximum annual premium volume.

(2) The basis of the rates to be charged.

(3) The types of risks which may be written.

(4) Maximum limits of liability.

(5) Applicable exclusions.

(6) Territorial limitations.

(7) Policy cancellation provisions.

(8) The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance, except as limited by any other provision of this code.

(g) If the contract permits the MGA to settle claims on behalf of the insurer:

(1) All claims shall be reported to the insurer in a timely manner.

(2) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim is subject to any of the following:

(A) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less.

(B) Involves a coverage dispute.

(C) May exceed the MGA's claims settlement authority.

(D) Is open for more than six months.

(E) Is closed by payment of an amount set by the commissioner or an amount set by the insurer, whichever is less.

(3) All claim files shall be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate; the MGA shall have reasonable access to and the right to copy the files on a timely basis.

(4) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(h) Where electronic claims files are in existence, the contract shall address the timely transmission of the data.

(i) If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to Section 769.84.

(j) The MGA shall not do any of the following:

(1) Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules. This paragraph shall not operate to prohibit transactions which are subject to Chapter 6.5 (commencing with Section 1781.1) of Part 2 of Division 1, if the MGA has complied with all of the requirements of that chapter.

(2) Commit the insurer to participate in insurance or reinsurance syndicates.

(3) Appoint any agent without assuring that the agent is lawfully licensed to transact the type of insurance for which he or she is appointed.

(4) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed 1 percent of the insurer's policyholder's

surplus as of December 31 of the last completed calendar year.

(5) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer.

(6) Permit any agent appointed pursuant to paragraph (3) to serve on the insurer's board of directors.

(7) Jointly employ an individual who is employed with the insurer.

(8) Appoint a sub-MGA.

769.84. (a) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each MGA with which it has done business.

(b) If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

(c) The insurer shall periodically (at least semiannually) conduct an onsite review of the underwriting and claims processing operations of the MGA.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

(e) Within 30 days of entering into or termination of a contract with an MGA, the insurer shall provide written notification of such appointment or termination to the commissioner. Notices of appointment of an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(f) An insurer shall review its books and records each quarter to determine if any producer has become, by operation of Section 769.81, an MGA as defined in that section. If the insurer determines that a producer has become an MGA pursuant to the above, the insurer shall promptly notify the producer and the commissioner of that determination and the insurer and the producer shall fully comply with this article within 30 days.

(g) An insurer shall not appoint to its board of directors an officer, director, employee, any agent appointed pursuant to

paragraph (3) of subdivision (j) of Section 769.83, or controlling shareholder of its MGAs. This subdivision shall not apply to relationships governed by Article 4.7 (commencing with Section 1215) of Chapter 2 of Part 2 of Division 1.

769.85. The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined as if it were the insurer.

769.86. (a) If the commissioner finds after hearing that any person has violated any provision of this article he or she may order any of the following:

(1) For each separate violation, a penalty in an amount not to exceed twenty-five thousand dollars ($25,000).

(2) Revocation or suspension of the producer's license.

(b) Hearings held pursuant to subdivision (a) shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearings shall be conducted by administrative law judges chosen under Section 11502 or appointed by the commissioner.

(c) The decision, determination, or order of the commissioner pursuant to subdivision (a) shall be subject to judicial review.

(d) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in this code, nor limit any other authority required or authorized by this code to be exercised by the commissioner.

(e) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

769.87. The commissioner may adopt reasonable rules and regulations for the implementation and administration of this article.

INSURANCE CODE
SECTION 770-776

770. No person engaged in the business of financing the purchase of

real or personal property or of lending money on the security of real or personal property and no trustee, director, officer, agent or other employee, or affiliate of, any such person shall require, as a condition precedent to financing the purchase of such property or to loaning money upon the security thereof, or as a condition prerequisite for the renewal or extension of any such loan or for the performance of any other act in connection therewith, that the person for whom such purchase is to be financed or to whom the money is to be loaned or for whom such extension, renewal or other act is to be granted or performed negotiate any insurance or renewal thereof covering such property through a particular insurance agent or broker.

770.1. No person making a loan of money on the security of real property shall use or make available to any person information contained in a policy of fire or casualty insurance for the purpose of soliciting either type of insurance coverage if the borrower has filed with the lender a statement signed by the borrower that the policy information shall not be so used or made available. The statement may be included by the borrower in his or her letter of authorization designating an insurance agent or broker to the lender.

The statement or letter of authorization shall be effective until superseded or revoked by the borrower. This section shall not apply to any person authorized or licensed to make loans pursuant to Division 7 (commencing with Section 18000), Division 9 (commencing with Section 22000), Division 10 (commencing with Section 24000), or Division 11 (commencing with Section 26000) of the Financial Code.

770.3. No state department or agency shall negotiate any life or disability insurance or require the placing of that insurance through particular agents, brokers, or companies, except to the extent that the state has a direct financial interest in the subject of the insurance. The state has no financial interest in an annuity purchased for an employee where the premium therefor is paid from a deduction from or reduction in the employee's salary, and any annuity paid for through a deduction or reduction shall not be deemed to have been provided by the state for its employees for purposes of this section, and the state shall not negotiate or require the placing of the annuity through particular agents, brokers, or companies. Nothing herein contained shall affect the program of life

and disability insurance in connection with veterans' farm and home purchases through the Department of Veterans Affairs except that the total life insurance benefit under that program shall in no event exceed one hundred twenty percent (120%) of the unpaid contract balance. Except in those cases where the premium for an annuity is paid entirely from a deduction from or reduction in an employee's salary, nothing contained herein shall affect life or disability insurance programs which may be provided by the state for its employees.

Notwithstanding anything in this section to the contrary, in any case in which a tax-sheltered annuity under an annuity plan which meets the requirements of Section 403(b) of the Internal Revenue Code of 1954 is to be placed or purchased for an employee, the employee shall have the right to designate the licensed agent, broker, or company through whom the employee's employer shall arrange for the placement or purchase of the tax-sheltered annuity. In any case in which the employee has designated an agent, broker, or company, the employer shall comply with that designation, except in the case of designations subject to the provisions of Sections 1153 and 12420.2 of the Government Code.

As used in this section, "state department or agency" shall include, but not be limited to, school districts and the University of California.

This section shall apply to all local governmental agencies, as well as state departments and agencies.

771. Sections 770 and 770.1 shall not prevent:

(a) The exercise by any person engaged in such business of his right to approve or disapprove, for reasonable cause, as determined by appropriate regulatory authority, of the insurer selected to underwrite the insurance, nor of his right to furnish such insurance or to renew any insurance required by the contract of sale or trust deed or other loan agreement if the borrower or purchaser shall have failed to furnish the insurance or renewal thereof within such reasonable time or form as may be specified in the sale or loan agreement. The lender shall not refuse to accept insurance provided by an acceptable insurer on the ground that such insurance provides more coverage than is required in the sale or loan agreement, unless the additional coverage consists of automobile, life or disability insurance.

The Commissioner of Financial Institutions and the Commissioner of Corporations, in conjunction with the Insurance Commissioner, shall

issue appropriate regulations defining "reasonable cause."

(b) Any lender from recommending to any borrower or prospective borrower the placing of insurance with a specified insurer or through a specified insurance agent or broker as long as such recommendation, with respect to a sale of real property or a loan upon the security of real property, clearly sets forth both the name and the mailing address of the recommended insurer or insurance agent or broker and does not violate the provisions of Section 770 or of any other section of this code. On and after July 1, 1972, such recommendation clearly setting forth the name and the mailing address of the recommended insurer or insurance agent or broker, shall be in writing.

(c) The free choice of insurance agent or broker by any borrower or purchaser at any time, and he or she may revoke any designation of insurance agent or broker at any time irrespective of the provisions of any loan or purchase agreement or trust deed.

(d) The exercise of any person engaged in such business of his right to furnish such insurance or to renew such insurance, and to charge the account of the borrower or purchaser with the costs thereof, if the borrower or purchaser fails to deliver to the lender such insurance at least 30 days prior to the expiration of the policy. If an insurance policy renewing or replacing, at expiration time, the policy then in force is received by the lender less than 15 days prior to the expiration of the policy held by the lender, or if an insurance policy procured by the borrower or purchaser is subsequently substituted for that then in force, the lender may impose a reasonable service charge as determined by the Insurance Commissioner for the transaction, the payment of which charge by the agent or broker is not a violation of any other provision of this code. No service charges shall be imposed for normal insurance changes made during the term of the policy.

(e) The commissioner is authorized to adopt a uniform statewide schedule of permissive maximum charges for the substitution of policies authorized in subdivision (d).

771.01. No person making a loan of money on the security of residential real property shall reject or refuse to accept a policy of fire and casualty insurance underwritten by an insurer chosen by the borrower for any reason that the lender would not impose on an insurer chosen by the lender when the borrower requests the lender to obtain the insurance. This section applies to a lender's rejection or refusal to accept a policy of fire and casualty insurance due to,

but not limited to, terms of coverage, conditions of payment, or financial rating of the insurer.

771.02. When a lender or purchaser of a mortgage on real property has required and obtained a copy of the insurance policy covering that real property, it shall be responsible for providing a copy of that insurance policy or other evidence of insurance acceptable to the purchaser to a subsequent purchaser of the mortgage, servicing agent, or insurance tracking service with whom the lender or purchaser of the mortgage subsequently contracts. A copy of the policy or other evidence of insurance shall be provided so that the subsequent purchaser, servicing agent, or insurance tracking service may verify that the borrower has obtained or is maintaining insurance required by the mortgage. This section does not abrogate the responsibility of an insurer, agent, or broker to provide annually, if requested, a copy of the insurance policy directly to the lender or purchaser of the mortgage named as an additional loss payee or lienholder at an address provided by the lender or purchaser of the mortgage.

771.1. Nothing in this article shall prevent any person licensed pursuant to Part 1 (commencing with Section 10000) of Division 4 of the Business and Professions Code from recommending, soliciting, negotiating or effecting home protection contracts issued by a company qualified under Part 7 (commencing with Section 12740) of Division 2, in connection with his or her licensed function authorized by Sections 10131 or 10131.6 of the Business and Professions Code, notwithstanding that such person is not a fire and casualty licensee as defined in Section 1625.

772. In any trial, hearing or proceeding to determine a violation of this article a written statement signed by the person for whom any purchase is financed, to whom any money is loaned or for whom any extension, renewal or other act in connection with a loan is to be granted or performed, declaring that such person voluntarily chooses the insurance agent or broker through whom the insurance or its renewal was transacted, and that the choice of such insurance agent, or broker was not made a condition precedent to such purchase, loan,

extension, renewal or other act shall be prima facie evidence that no violation of Section 770 has occurred, if the borrower or purchaser in his own handwriting shall have written the name of his chosen insurance agent or broker into an authorization of such insurance agent or broker.

773. The commissioner may suspend or revoke any license held by any person who violates Section 770, pursuant to Article 13 of Chapter 5 of this part.

774. The commissioner, after hearing upon notice, may issue a cease and desist order to any person if he finds that such person has, in more than one transaction, violated Section 770. The violation of such a cease and desist order is a misdemeanor.

775. The commissioner may investigate any person, whether licensed or not, for the purpose of determining if there has been any violation of this article, however, if such investigation be upon a complaint, the complainant must be a party to the contract of sale, trust deed, or loan agreement and must make such complaint within three months of the execution or any modification thereof.

776. No person who sells real property shall require, as a condition precedent to the sale of such real property, that the person buying the real property negotiate any insurance or renewal thereof covering such property through a particular insurance agent, insurance broker, or insurance solicitor.

INSURANCE CODE
SECTION 777.1-777.3

777.1. No insurer shall participate in any plan to offer or effect any kind or kinds of insurance or annuities in this state as an inducement to the purchase or rental by the public of any property,

real or personal or mixed, or services, without any separate charge to the insured for such insurance, nor shall any agent, broker, or solicitor arrange the sale of any such insurance. The provisions of this article shall not be applicable to insurance written in connection with subscriptions to newspapers of general circulation; nor shall it apply to insurance issued to credit unions or to members of credit unions in connection with the purchase of shares in such a credit union; nor shall it apply to insurance offered as a guarantee of the performance of goods, which insurance is designed to protect the purchasers or users of such goods; nor shall it be applicable to any title insurance or life or disability insurance written in connection with an indebtedness, the purpose of which insurance is to pay the balance of the indebtedness in the event of the death or disability of the person insured; nor shall it be applicable to any of the provisions of Part 5 (commencing at Section 12140), Division 2 of this code; nor shall it be applicable to insurance provided incidentally to the sale of services if the cost of the insurance to the seller of the services does not exceed the sum of one dollar ($1) per annum for each purchaser of those services.

777.2. If any insurer, agent, broker or solicitor wilfully violates the provisions of this article, the Insurance Commissioner may suspend or revoke his certificate or license or other authority to do business or engage in his occupation for a period not exceeding one year. The proceedings shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

777.3. As used in this article "insurer" includes any person or organization to which Article 4 (commencing with Section 730), Chapter 1, Part 2, Division 1 is applicable.

INSURANCE CODE
SECTION 778-778.4

778. As used in this article, "premium financing" means engaging in

the business of advancing money, directly or indirectly, to an insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement, wherein the insured has assigned the unearned premiums, accrued dividends, or loss payments as security for such advancement in payment of premiums on insurance contracts only, and does not include the financing of insurance contract premiums purchased in connection with the financing of goods and services.

778.1. As used in this article, "premium finance agreement" means a loan contract, note, agreement, or obligation by which an insured agrees to pay to a lender in installments the principal amount advanced by the lender to an insurer or producer in payment of premium on an insurance contract or contracts, plus charges, with the assignment, as security therefor, of the unearned premiums, accrued dividends, or loss payments.

778.2. (a) Any person engaged in business as an insurance agent or broker and who participates in the arrangement of a premium financing agreement shall, if he accepts compensation for arranging, directing, or performing services in connection with the premium financing agreement, disclose to the insured, in a manner and form established by the commissioner, the amount of compensation he is to receive from the premium financer and maintain for three years and make available to the commissioner a list of accounts in connection with which he has accepted compensation for premium financing services showing the amount of such compensation with respect to each premium financing agreement and with respect to each financing schedule used by the agent or broker. The requirements of this subdivision shall not apply with respect to interest paid to the broker or agent by the premium financer based upon delay in payment of the premium due the insurer as permitted under subdivision (a) or (b) of Section 18628 of the Financial Code.

(b) The commissoner shall hold a hearing and adopt by regulation a standard procedure and form for making the disclosure to the insured required by subdivision (a).

778.3. The amount of the periodic finance charges, if any, imposed for the premium financing purchased and the annual percentage rate

associated with those charges shall be disclosed in the policy itself, or if arranged pursuant to a separate premium financing agreement in the premium financing agreement itself, and in the premium finance billings. If the finance charge is a fixed fee, regardless of the amount of the loan or the balance due, the disclosure is not required to include the annual percentage rate associated with those charges. This section shall not apply to any insurance policy or premium finance billing if the same information is otherwise disclosed to the insured as required by any other provision of state or federal law.

778.4. (a) Every fire and casualty broker-agent shall, prior to arranging premium financing for any new or renewal policy of insurance specified in Section 660, do all of the following:

(1) Provide the applicant or prospective insured with any information that is required by the federal Truth in Lending Act (15 U.S.C. Sec. 1601 et seq.).

(2) Obtain the signature of the applicant or prospective insured on the following disclosure, which shall be in 10-point bold face type on a separate form or sheet of paper:

Some insurance companies and the California Automobile Assigned Risk Plan (CAARP) provide the opportunity to make payments on insurance premiums. Your agent or broker is required to disclose these options, if any are available for the insurance you are purchasing. If you choose to enter into a contract that provides for premium financing, your agent is required by law to make certain disclosures concerning interest, fees, or other charges. If your insurance has been financed by any person or business other than your insurance company, and your insurance is canceled for any reason, your loan may be subject to continued interest charges, or other charges that may result from delays by your insurance company in repaying the premium finance company. You should understand all of the charges associated with your financing plan. If you are uncertain about how the financing plan works, you should ask your insurance agent or broker.

(b) Every fire and casualty agent-broker shall comply with the requirements of the Consumer Contract Awareness Act of 1990 (Title 1.86 (commencing with Section 1799.200) of Part 4 of Division 3 of the Civil Code) to the extent that its provisions are applicable to any transaction subject to this section.

(c) If a transaction subject to subdivision (a) is conducted over the telephone, the fire and casualty broker-agent shall be deemed to

have complied with the requirements of subdivision (a) if, within 72 hours after transacting the contract or agreement, the disclosure form and other information required by subdivision (a) is mailed to the applicant or insured at the address provided by the applicant or insured. Proof of mailing shall be established by the method described in Section 38.

INSURANCE CODE
SECTION 779.1-779.36

779.1. The purpose of this article is to promote the public welfare by regulating credit life insurance and credit disability insurance. Nothing in this article is intended to prohibit or discourage reasonable competition.

779.2. All life insurance and all disability insurance sold in connection with loans or other credit transactions shall be subject to the provisions of this article, except (a) such insurance sold in connection with a loan or other credit transaction of more than 10 years duration, and (b) such insurance where its issuance is an isolated transaction on the part of the insurer not related to an agreement or a plan or regular course of conduct for insuring debtors of the creditor. Nothing in this article shall be construed to relieve any person from compliance with any other applicable law of this state, including, but not limited to, Article 6.5 (commencing with Section 790), nor shall anything in this article be construed so as to alter, amend, or otherwise affect existing case law.

For the purpose of this article:

(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction, exclusive of any such insurance procured at no expense to the debtor. Insurance shall be deemed procured at no expense to the debtor unless the cost of the credit transaction to the debtor varies depending on whether or not the insurance is procured.

(2) "Credit disability insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy, exclusive of any insurance procured at no expense to the

debtor. Insurance shall be deemed to have been procured at no expense to the debtor unless the cost of the credit transaction to the debtor varies depending on whether or not the insurance is procured.

(3) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them.

(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

779.3. Credit life insurance and credit disability insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the term plan;

(b) Individual policies of disability insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(d) Group policies of disability insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

779.4. (a) The amount of credit life insurance and credit disability insurance shall not exceed, but, except as provided in subdivision (b), may be less than, the following:

(1) Credit Life Insurance. The initial amount of credit life insurance shall at no time exceed the unpaid amount financed plus earned interest. Where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the greater of the scheduled or the actual unpaid amount financed plus earned interest. In the case of revolving loan or revolving charge accounts the insurance shall not at any time exceed the unpaid

amount financed plus earned interest.

Notwithstanding the provisions of the above paragraph, the amount of insurance on agricultural or horticultural loan commitments may be equal to the amount of the loan commitment.

(2) Credit Disability Insurance. The total amount of periodic indemnity payable by credit disability insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness, and the amount of each periodic indemnity shall not exceed the original indebtedness divided by the number of periodic installments.

(b) The amount of credit life and credit disability insurance may be less than the amounts specified in subdivision (a) except as provided by subdivision (a) of Section 18291, subdivision (e) of Section 22458.1, or subdivision (e) of Section 24458.1 of the Financial Code, or by any other provision of law specifically prohibiting credit life or credit disability insurance in some lesser amount.

779.5. The term of any credit life insurance or credit disability insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor or the date the debtor applies for such insurance, whichever is later, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to 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 cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in Section 779.14.

779.6. Notwithstanding the provisions of Section 10203.5, all

credit life insurance and credit disability insurance subject to this article shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

Each individual policy or group certificate of credit life insurance or of credit disability insurance or any combination thereof shall, in addition to other requirements of law, set forth the name and home office address of the insurer, the identity by name or otherwise of the person or persons insured the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit disability insurance, a description of the coverage including the amount and term thereof, and any exceptions, limitations or restrictions, and shall state that the benefits shall be paid to the creditor holding the indebtedness to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate. Said individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the insurance commences except as hereinafter provided.

Notwithstanding the provisions of the above paragraph, a certificate issued under a group policy in cases where the debtor obligates himself to pay the insurance premium or payment periodically with the debt payments on the decreasing amount of the insurance or where the indebtedness is a revolving loan or revolving charge account the rate of insurance premium or payment per unit of coverage may be set forth in lieu of "the premium or amount of payment, if any, by the debtor".

779.7. If a creditor requires a debtor to make any payment for credit life insurance or credit disability insurance, and an individual policy or group certificate of insurance is not delivered to the debtor at the time the insurance commences, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor separately for credit life insurance and credit disability insurance, the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time such indebtedness is incurred, or at the time the debtor applies for such insurance, whichever is later. The copy of the application

for, or notice of proposed insurance shall refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which (1) the indebtedness is incurred, (2) the application for such insurance is received by the insurer, or (3) the insurer determines the evidence of insurability, if required, to be satisfactory, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. Said application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective either as of the date the indebtedness is incurred or the date of application for such insurance, whichever is applicable; provided that where evidence of insurability is required and such evidence is furnished more than thirty (30) days after either the date when the debtor becomes obligated to the creditor or the date the debtor applies for such insurance, which ever is applicable, the term of the insurance shall commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. A debtor shall not be deemed to be required to make any payment for credit life insurance or credit disability insurance unless the cost of the credit transaction to the debtor varies depending upon whether or not such insurance is procured.

779.8. All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner.

779.9. The commissioner shall within 30 days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are

contrary to any provision of the Insurance Code or of any rule or regulation promulgated thereunder.

779.10. The provisions of Sections 10290 and 10291 relating to the filing, approval and disapproval of disability policy forms shall be applicable to forms, whether of life or disability insurance, required by this article to be filed with or approved by the commissioner.

779.11. The provisions of subdivisions (d) and (e) of Section 10291.5 shall be applicable to the withdrawal of the approval of forms, whether of life or disability insurance, required by this article to be filed with or approved by the commissioner.

779.12. Any order or final determination of the commissioner under the provisions of Sections 779.8 to 779.11, both inclusive, shall be subject to judicial review.

779.12a. If a group policy of credit life insurance or credit disability insurance (1) has been delivered in this State before September 18, 1959, or (2) has been or is delivered in another state before or after such date, the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this State as specified in Sections 779.6 and 779.7 of this article, and such forms shall be approved by the commissioner if, (a) they conform with the requirements specified in said Sections 779.6 and 779.7; (b) they are accompanied by a certification in a form satisfactory to the commissioner that the substance of such forms are in substantial conformity with the master policy; and (c) the schedules of premium rates applicable to the insurance evidenced by any such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the commissioner; provided, however, the premium rate in effect on existing group policies may be continued until the first policy anniversary date following October 1, 1963.

779.13. Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit disability insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the commissioner.

779.14. (a) Each individual policy, group certificate, or notice of proposed insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid promptly to the person entitled thereto or credited to the next payment or payments due on the indebtedness. However, the commissioner shall prescribe a minimum refund and no refund that would be less than that minimum need be made. The formula to be used in computing that refund shall be filed with and approved by the commissioner.

(b) An individual policy or group certificate of credit life insurance or of credit disability insurance or a combination thereof, or a notice of proposed insurance, shall allow an insured to rescind the insurance within 30 days of receipt of the policy or certificate or notice of proposed insurance issued pursuant to Section 779.7 and to receive a full refund, or credit if financed, of any premium that has been paid. The right to rescind shall be disclosed on the face of the individual policy, group certificate, or notice of proposed insurance in at least 14-point type and shall include the disclosure of the department's toll-free telephone number and other disclosures set forth in Section 510.

(c) No statement, disclosure, or notice made in accordance with Section 779.14 or 779.35 shall be construed to cause the policy forms, certificates of insurance, or notices of proposed insurance, by themselves, to be considered as nonstandard forms as described in Article 6.9 (commencing with Section 2249) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations.

(d) This section applies to all policies issued or delivered in this state on or after January 1, 1999. All policies subject to this section that are in effect on January 1, 1999, shall be construed to be in compliance with this section, and any provision in any policy which is in conflict with this section shall be of no force or effect.

779.15. If a creditor requires a debtor to make any payment for credit life insurance or credit disability insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the next payments due on the account.

779.16. The amount charged to a debtor for any credit life or credit disability insurance shall not exceed the premium rates filed with the commissioner for the coverage provided or the premiums charged by the insurer, as computed at the time the charge to the debtor is determined, whichever is less.

779.17. Nothing in this act shall be construed to authorize any charge now prohibited under any statute or rule governing credit transactions, irrespective of whether the same is contained in this code or made pursuant thereto.

779.18. All policies of credit life insurance and credit disability insurance shall be delivered or issued for delivery in this State only by an admitted insurer, and shall be issued only through holders of certificates, licenses or authorizations issued by the commissioner. This article is hereby specifically made applicable to reciprocal or interinsurance exchanges and fraternal benefit societies.

779.19. All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

779.20. When credit life insurance or credit disability insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this State. This section shall not prevent the creditor from exercising his right to approve or disapprove of the insurer furnishing the credit insurance.

779.21. The commissioner may adopt, pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, reasonable rules and regulations necessary to carry out this article.

779.22. The commissioner, in his discretion, may revoke or suspend the license or certificate of authority of any person guilty of a violation of any provisions of this article or any rules and regulations adopted pursuant thereto. In addition to any other penalty provided by law, any person who violates an order of the commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of California a sum not to exceed two hundred fifty dollars ($250) which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed one thousand dollars ($1,000).

779.23. Whenever the commissioner finds that there has been a violation by an insurer of this article or any rules or regulations issued pursuant thereto, he shall proceed as provided in Section 701.

Whenever the commissioner finds that there has been such a violation by any licensee other than an insurer, he shall proceed as provided in Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code.

779.24. Any party affected by an order of the commissioner shall be entitled to judicial review in accordance with the provisions of Section 12940.

779.25. If any provision of this article, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the article, and the application of such provision to any person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

779.26. Credit life insurance and credit disability insurance within the scope of this article, where the form of policy including the premium rates pertaining thereto have been filed with the commissioner and not disapproved by him or the premiums charged have been in accordance with those provided by any law of this state or regulation of the commissioner promulgated thereunder, are not subject to the provisions of Section 10214 or Section 10270.65 of the Insurance Code.

779.27. In accordance with this article and the regulations adopted pursuant to Section 779.21, the commissioner shall, after notice and public hearing, promulgate regulations setting forth standard forms of credit life and disability insurance policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders. The use of such forms shall be mandatory, except that commissioner may approve the use of nonstandard forms which are in accord with this article and the regulations adopted pursuant to Section 779.21.

779.28. For purposes of establishing the fact of disability in credit disability insurance, chiropractors' certifications of disability when made within the scope of their license shall be accepted by insurers as equally valid as physicians and surgeons' certifications of disability when made within the scope of their license.

779.30. (a) An individual policy or group certificate may exclude from credit disability insurance coverage only those preexisting illnesses, diseases, or physical conditions for which the debtor actually received medical advice, consultation, or treatment both within six months before and six months after the effective date of the debtor's coverage and which result in disability commencing within two years of the effective date. This provision shall not preclude the exclusion of other preexisting diseases or physical conditions by name or specific description.

(b) An individual policy or group certificate may exclude from credit life insurance coverage only those preexisting illnesses, diseases, or physical conditions for which the debtor actually received medical advice, consultation, or treatment both within six months before and six months after the effective date of the debtor's coverage and that result in death within six months after the effective date.

(c) Preexisting condition provisions on revolving accounts for credit disability insurance shall be subject to the limitations of subdivision (a), and for credit life insurance shall be subject to the limitations of subdivision (b).

(d) In the case of revolving accounts, any preexisting condition provision may be applied separately to each charge or advance, in which case the time periods in the applicable subdivision shall be measured from the date of each separate charge or advance.

If any preexisting condition provision is applied to a subsequent charge or advance on a revolving account the consumer shall be given the following notice at least annually:

"NOTICE: THIS INSURANCE MAY NOT COVER AN ADVANCE OR CHARGE UNDER YOUR CREDIT LINE IF YOUR DISABILITY OR DEATH RESULTS FROM A CONDITION FOR WHICH YOU HAVE SEEN A DOCTOR OR CHIROPRACTOR IN THE SIX MONTHS BEFORE THE ADVANCE OR CHARGE."

(e) The notice required by subdivision (d) may be printed on a periodic billing statement or given separately.

(f) Subdivision (d) does not apply to a credit card as defined in

Section 1747.02 of the Civil Code.

779.31. The debtor shall have the right to terminate credit life insurance or credit disability insurance at any time for any reason upon notice to the creditor. A refund shall be paid or credited as provided in Section 779.14 or by the regulation of the commissioner. If the premium refund is paid to the creditor, the creditor shall credit the debtor's account with the refund and any interest or finance charge adjustment as provided in the credit agreement.

779.32. (a) The term "compensation," for the purpose of this article means any valuable consideration including, but not limited to, all paid or credited commissions, contingent commissions, service fees, fees, consulting fees paid or credited within or outside this state in relation to business produced or to be produced or written or to be written in this state, electronic data process equipment or services, supplies (other than forms approved by the commissioner and the usual claims and reporting forms and envelopes for transmitting the claims and brochures, rate books, and rate charts), rental equipment of any type, advertising, telephone provided by an insurer, its agent, or any related person without charge of actual charge or at a charge less than the usual cost, profit sharing plans, experience rating refunds, experience rating credits, dividends, expense allowances, stock plans or bonuses, and any other form of credit, including moneys assumed, or expenditures in any form whatsoever, direct or indirect, paid by or on behalf of the insurer, or by any subsidiary or parent, or subsidiary of the parent of the insurer, or by any other person to or on behalf of any group policyholder, agent, general agent, or disability broker or withheld by any group policyholder, agent, general agent, or disability broker.

(b) The maximum amount of total compensation, as defined in subdivision (a), payable by any insurer shall not exceed 35 percent of the prima facie credit life insurance rates and 30 percent of the prima facie disability insurance rates. Of the maximum total compensation allowable, the creditor shall be limited to a compensation rate of 27.5 percent of the prima facie credit life insurance rates and 23.75 percent of the prima facie credit disability insurance rates. The general agent's maximum total compensation allowable shall be limited to 7.5 percent of the prima

facie credit life insurance rates and 6.25 percent of the prima facie credit disability insurance rates. A creditor may not receive both the creditor's and the general agent's compensation on its own produced insurance. A general agent may also receive additional primary compensation deducted from the maximum primary compensation allowable to the creditor.

If the commissioner has reason to believe that compensation is in fact or is contracted to be in excess of the maximum amount specified in this section, the commissioner may conduct a hearing or investigation, including the right to examine any contracts relating to the direct or indirect payment of compensation, to determine whether the insurer, general agent, or any other person is paying or whether an agent, general agent, or broker is receiving any form of compensation in excess of the applicable maximum amount of compensation specified in this section.

(c) On and after January 1, 1988, no contract of credit life or credit disability insurance shall be issued in this state unless, if applicable, the maker first ascertains, using reasonable diligence, that any nonadmitted reinsurer possesses capital and surplus of at least one million dollars ($1,000,000).

(d) Nothing in this article shall be construed to authorize the payment of any form of compensation to any creditor or to any person otherwise prohibited from receiving that form of compensation. Nor shall this article be construed to authorize the payment of experience rating refunds prior to the anniversary date of the policy. Those refunds shall be computed annually based on premiums earned to that anniversary date.

779.33. The use of compensating balances or special deposit accounts in connection, either directly or indirectly, with a credit life insurance program or a credit disability insurance program of a credit institution, whether on a group or an individual basis, is prohibited.

Compensating balances or special deposit accounts include, but not to the exclusion of other types of balances and accounts, the following:

(1) The deposit of premiums to the account of the insurer in the financial institution for which the insurer provides the credit insurance program, when the account is either noninterest bearing or at a rate of interest less than usual or is controlled by the institution.

(2) Remitting premiums to the insurer after the expiration of the grace period on a regular basis so that the arrearage period is

constant.

(3) The retention of premiums by an agent or broker to whom the financial institution remits premiums for a period of time which is not reasonably related to the time normally expected to be needed for the agent or broker to remit the premium to the insurer, if that delay is a continuing feature of the premium paying process.

(4) Any other practice which unduly delays receipt of premiums by the insurer on a regular basis, or which is followed by an insurer when the practice involves use of the financial resources of the insurer for the benefit of the credit institution.

The foregoing criteria apply regardless of whether premiums are due the insurer on the single premium in advance system or on the monthly outstanding balance system. Nothing herein shall prevent the insurer from making deposits in a financial institution which are not related to a credit insurance program if it is in fact not related to whether the insurer is the insurer which insures the credit insurance program.

779.36. (a) The commissioner shall adopt regulations that become effective no later than January 1, 2001, specifying prima facie rates based upon presumptive loss ratios, with rates which would be expected to result in a target loss ratio of 60 percent, or any other loss ratio as may be dictated after applying the factors contained in this subdivision, for each class of credit disability, credit unemployment, credit property, and credit life insurance. The prima facie rates shall be based upon loss experience filed with the commissioner, aggregated by class.

If any rate established under the commissioner's ratemaking authority produces actual loss ratios that are lower than the presumptive loss ratio, prospective rates may be adjusted, but no retroactive refunds shall be required. In order to provide insurers an opportunity to earn a fair and reasonable rate of return, the commissioner in the ratemaking process shall consider the following factors: acquisition costs, including commissions and other forms of compensation, expenses, profits, loss ratios, reserves, and other reasonable actuarial considerations.

(b) The commissioner shall provide for rate deviations. Upward and downward deviations shall be considered by the commissioner upon initiation by the department, or at the insurer's request at the time of review of annual experience reports filed by insurers, or as provided by regulations pursuant to Section 779.21. Requested deviation rates shall be deemed approved if not disapproved within

120 days after submission to the department for approval. Creditor and agent compensation shall be based upon the prima facie rate, and shall not be affected by a deviated rate pursuant to this subdivision. This subdivision does not prohibit an insurer from paying compensation that is less than the prima facie rate.

(c) The commissioner shall adopt regulations that become effective no later than January 1, 2001, specifying prima facie rates based upon presumptive loss ratios, with rates which would be expected to result in a target loss ratio of 60 percent, or any other loss ratio as may be dictated after applying the factors contained in this subdivision, for each class of joint life insurance, joint disability insurance, joint credit unemployment insurance, and joint credit property insurance. Those rates shall be expressed as a multiple of the prima facie rate for each class of insurance subject to subdivision (a), and shall be based upon loss experience filed with the commissioner, aggregated by class.

If any rate established under the commissioner's ratemaking authority produces actual loss ratios that are lower than the presumptive loss ratio, prospective rates may be adjusted, but no retroactive refunds shall be required. In order to provide insurers an opportunity to earn a fair and reasonable rate of return, the commissioner in the ratemaking process shall consider the following factors: acquisition costs, including commissions and other forms of compensation, expenses, profits, loss ratios, reserves, and other reasonable actuarial considerations.

(d) Loss ratios shall consist of the ratio of incurred losses to earned premiums in a specified reporting period.

(e) The commissioner shall, on an annual basis, make actual annual loss ratios under subdivisions (a) and (c) available to the public.

INSURANCE CODE
SECTION 780-784

780. An insurer or officer or agent thereof, or an insurance broker or solicitor shall not cause or permit to be issued, circulated or used, any misrepresentation of the following:

(a) The terms of a policy issued by the insurer or sought to be negotiated by the person making or permitting the misrepresentation.

(b) The benefits or privileges promised thereunder.

(c) The future dividends, payable thereunder.

781. A person shall not make any misrepresentation (a) to any other person for the purpose of inducing, or tending to induce, such other person either to take out a policy of insurance, or to refuse to accept a policy issued upon an application therefor and instead take out any policy in another insurer, or

(b) To a policyholder in any insurer for the purpose of inducing or tending to induce him to lapse, forfeit or surrender his insurance therein.

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

782. Any person violating the provisions of Sections 780 or 781 is guilty of a misdemeanor and punishable by a fine not exceeding one thousand five hundred dollars ($1,500) or by imprisonment not exceeding six months.

783. Whenever any insurance agent, broker, or solicitor knowingly violates any provisions of Sections 780 or 781, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part, may suspend the license of any such person for not exceeding three years.

783.5. If an insurer knowingly violates any provision of Sections 780 or 781, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 704, may suspend the insurer's certificate of authority to do the class of insurance in respect to which the violation occurred.

784. Any person may be compelled to testify and produce books and

writings at the trial or hearing of any person charged with violating any provision of sections 780 or 781 even though such testimony or evidence may incriminate him. A person shall not be prosecuted for any act concerning which he is compelled so to testify or produce evidence, except for perjury committed in so testifying.

INSURANCE CODE
SECTION 785-789.10

785. (a) All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

(b) Conduct of an insurer, broker, or agent, or other person engaged in the transaction of insurance, during the offer and sale of a policy or certificate previous to the purchase is relevant to any action alleging a breach of the duty of good faith and fair dealing.

(c) Except where explicitly provided to the contrary, this article shall not apply to any of the following:

(1) Medicare supplement insurance as defined in subdivision (l) of Section 10192.4.

(2) Long-term care insurance as defined in Section 10231.2.

(3) Disability coverage provided through the insured's employer or former employer.

(4) Disability insurance policies or certificates principally designed to provide coverage for accidents or expenses incurred while traveling if the premium for the policy or certificate is ten dollars ($10) or less.

(5) Blanket disability insurance as defined in Section 10270.3.

(6) Credit disability insurance as defined in Section 779.2.

(7) Accidental death insurance.

(8) Until January 1, 2002, disability policies or certificates that are sold through direct response methods of delivery.

(9) Disability income insurance as defined in subdivision (i) of Section 799.01.

(d) Provided that the requirements of Section 10296 are met, this article shall not apply to transportation ticket policies and baggage insurance policy types allowable for sale by travel agents pursuant

to Section 1753.

786. All disability insurance and life insurance policies and certificates offered for sale to individuals age 65 or older in California shall provide an examination period of 30 days after the receipt of the policy or certificate for purposes of review of the contract, at which time the applicant may return the contract. The return shall void the policy or certificate from the beginning, and the parties shall be in the same position as if no contract had been issued. All premiums paid and any policy or membership fee shall be fully refunded to the applicant by the insurer or entity in a timely manner.

(a) For the purposes of this section a timely manner shall be no later than 30 days after the insurer or entity issuing the policy or certificate receives the returned policy or certificate.

(b) If the insurer or entity issuing the policy or certificate fails to refund all of the premiums paid, in a timely manner, then the applicant shall receive interest on the paid premium at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the insurer or entity received the returned policy or certificate.

(c) Each policy or certificate shall have a notice prominently printed in no less than 10-point uppercase type, on the cover page of the policy or certificate and the outline of coverage, stating that the applicant has the right to return the policy or certificate within 30 days after its receipt via regular mail, and to have the full premium refunded.

(d) In the event of any conflict between this section and Section 10127.10 with respect to life insurance, the provisions of Section 10127.10 shall prevail.

786.5. (a) All brokers, agents, or other entities offering a contract of disability insurance to persons 65 years of age or older in this state shall provide the prospective insured with a full and accurate written comparison with existing health coverage, and shall explain the relationship of the proposed coverage to any existing health benefits provided by Medicare, Medi-Cal, or any other health benefits available to the applicant. The written comparison shall be maintained in accordance with Section 10508.5. Disability insurers marketing through direct response to persons 65 years of age or older shall include in the application form questions to ascertain whether the prospective insured is currently 65 years of age or older, and

whether the prospective insured is covered by Medi-Cal or a Medicare supplement policy. These direct response insurers shall provide the required comparison as early in the transaction as possible, but not later than the delivery of the insurance contract.

(b) The commissioner may prescribe a standard comparison form and an informational brochure that shall be distributed to every prospective insured at the time insurance is offered for sale by an agent, broker, or other producer. In the case of a transportation ticket policy, the informational brochures shall be delivered to the prospective insured not later than delivery of the insurance contract. Disability insurers marketing through direct response to persons 65 years of age or older shall provide the informational brochure as early in the transaction as possible, but not later than the delivery of the insurance contract.

(c) The amendments to this section made by Assembly Bill 1178 of the 2001-02 Regular Session shall become operative January 1, 2002.

787. Any advertisement or other device designed to produce leads based on a response from a potential insured which is directed towards persons age 65 or older shall prominently disclose that an agent may contact the applicant if that is the fact. In addition, an agent who makes contact with a person as a result of acquiring that person's name from a lead generating device shall disclose that fact in the initial contact with the person.

(a) No insurer, agent, broker, solicitor, or other person or other entity shall solicit persons age 65 and older in this state for the purchase of disability insurance, life insurance, or annuities through the use of a true or fictitious name which is deceptive or misleading with regard to the status, character, or proprietary or representative capacity of the entity or person, or to the true purpose of the advertisement.

(b) For the purposes of this section, an advertisement includes envelopes, stationery, business cards, or other materials designed to describe and encourage the purchase of a policy or certificate of disability insurance, life insurance, or an annuity.

(c) Advertisements shall not employ words, letters, initials, symbols, or other devices which are so similar to those used by governmental agencies, a nonprofit or charitable institution, senior organization, or other insurer that they could have the capacity or tendency to mislead the public. Examples of misleading materials, include, but are not limited to, those which imply any of the

following:

(1) The advertised coverages are somehow provided by or are endorsed by any governmental agencies, nonprofit or charitable institution or senior organizations.

(2) The advertiser is the same as, is connected with, or is endorsed by governmental agencies, nonprofit or charitable institutions or senior organizations.

(d) No advertisement may use the name of a state or political subdivision thereof in a policy name or description.

(e) No advertisement may use any name, service mark, slogan, symbol, or any device in any manner that implies that the insurer, or the policy or certificate advertised, or that any agency who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

(f) No advertisement may imply that the reader may lose a right, or privilege, or benefits under federal, state, or local law if he or she fails to respond to the advertisement.

(g) An insurer, agent, broker, or other entity may not use an address so as to mislead or deceive as to the true identity, location, or licensing status of the insurer, agent, broker, or other entity.

(h) No insurer may use, in the trade name of its insurance policy or certificate, any terminology or words so similar to the name of a governmental agency or governmental program as to have the capacity or the tendency to confuse, deceive, or mislead a prospective purchaser.

(i) All advertisements used by agents, producers, brokers, solicitors, or other persons for a policy of an insurer shall have written approval of the insurer before they may be used.

(j) No insurer, agent, broker, or other entity may solicit a particular class by use of advertisements which state or imply that the occupational or other status as members of the class entitles them to reduced rates on a group or other basis when, in fact, the policy or certificate being advertised is sold on an individual basis at regular rates.

(k) In addition to any other prohibition on untrue, deceptive, or misleading advertisements, no advertisement for an event where insurance products will be offered for sale may use the terms "seminar," "class," "informational meeting," or substantially equivalent terms to characterize the purpose of the public gathering or event unless it adds the words "and insurance sales presentation" immediately following those terms in the same type size and font as those terms.

788. An insurer, agent, broker, or other person engaged in the transaction of insurance shall not knowingly recommend for sale, or sell, disability insurance providing health benefits directly to a Medi-Cal beneficiary who is age 65 or older. For disability insurance providing health benefits sold to a person age 65 or older, the application or other supplemental record signed by the applicant shall contain a question designed to determine if the applicant is receiving Medi-Cal benefits.

788.5. No insurer, broker, agent, or other person shall cause an insured aged 65 years or older to replace a disability insurance policy or certificate unnecessarily.

(a) No insurer, broker, agent, or other entity within the jurisdiction of the department shall promote or cause overloading of disability coverage to persons aged 65 years or older. For purposes of this section, "overloading" means possession by an insured of functionally identical coverages that overlap or duplicate benefits to the extent that a reasonable person would not consider their ownership to be cost-effective.

(b) It shall be presumed that the sale of disability insurance that is the subject of this article, sold to a person aged 65 years or older, is overloading, as defined in subdivision (a), if the insured is already covered by Medicare Parts A and B as well as one Medicare supplement policy, certificate, or contract and coverage for excess charges under Part B.

(c) The application for disability insurance for a person age 65 years or older shall contain a question or questions designed to elicit information regarding all other existing health and disability coverage in force by type and company.

788.7. No insurer, broker, agent, or other person shall knowingly recommend for purchase or sell disability insurance to a person age 65 or older which results in the insured having coverage, for medical benefits, for more than 100 percent of actual medical expenses.

789. (a) The commissioner shall have the administrative authority to assess penalties against insurers, brokers, agents, and other entities engaged in the transaction of insurance or any other person or entity for violations of this article.

(b) Upon a showing of a violation of this article in any civil action, a court may also assess the penalties prescribed in this chapter.

(c) Whenever the commissioner has reasonable cause to believe or determines after a public hearing that any insurer, agent, broker, or other person or entity engaged in the transaction of insurance, has violated this article the commissioner shall make and serve upon the insurer, broker, agent, or other person or entity a notice of hearing. The notice shall state the commissioner's intent to assess the administrative penalties, the time and place of the hearing, and the conduct, condition or ground upon which the commissioner is holding the hearing, and assessing the penalties. The hearing shall occur within 30 days after the notice is served. Within 30 days after the hearing the commissioner shall issue an order specifying the amount of the penalties to be paid. The penalties resulting from the hearing shall be paid to the Insurance Fund.

(d) The powers vested in the commissioner by this section shall be in addition to any and all powers and remedies vested in the commissioner by law.

(e) Actions for injunctive relief, penalties specified in Section 789.3, damages, restitution, and all other remedies in law, may be brought in superior court by the Attorney General, district attorney, or city attorney on behalf of the people of California. The court shall award reasonable attorney's fees and court costs to the prevailing plaintiff who establishes a violation of this article.

789.3. (a) Any broker, agent, or other person or other entity engaged in the transactions of insurance, other than an insurer, who violates this article is liable for an administrative penalty of no less than one thousand dollars ($1,000) for the first violation.

(b) Any broker, agent, other person, or other entity engaged in the business of insurance, other than an insurer, who engages in practices prohibited by this article a second or subsequent time or who commits a knowing violation of this article, is liable for an administrative penalty of no less than five thousand dollars ($5,000) and no more than fifty thousand dollars ($50,000) for each violation.

(c) If the commissioner brings an action against a licensee

pursuant to subdivision (a) or (b) and determines that the licensee may reasonably be expected to cause significant harm to seniors, the commissioner may suspend his or her license pending the outcome of the hearing described in subdivision (c) of Section 789.

(d) Any insurer who violates this article is liable for an administrative penalty of ten thousand dollars ($10,000) for the first violation.

(e) Any insurer who violates this article with a frequency as to indicate a general business practice or commits a knowing violation of this article, is liable for an administrative penalty of no less than thirty thousand dollars ($30,000) and no more than three hundred thousand dollars ($300,000) for each violation.

(f) The commissioner may require rescission of any contract found to have been marketed, offered, or issued in violation of this article.

789.5. If any provision of this article or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the article which can be given effect, without the invalid provision or application, and to this end the provisions of the article are severable.

789.6. (a) Insurance policies or certificates of disability insurance sold to persons age 65 or older shall return to policyholders or certificate holders benefits that have a minimum loss ratio of 60 percent for individual policies and 75 percent for group policies. The loss ratio shall be on the basis of incurred claims experience and earned premiums.

(b) The commissioner shall require every entity providing insurance policies or certificates of disability insurance sold to persons age 65 or older in this state to maintain detailed experience data for policies and certificates subject to this section and require them to make an annual filing with the commissioner disclosing the loss ratio for each policy form or certificate subject to this section. The annual filing shall, at a minimum, include rates, rating schedules, and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration. That information shall demonstrate that each policy form or certificate is in compliance with the applicable loss ratio

standards.

(c) The commissioner shall assure that reserves are reasonable and based on sound actuarial principles with respect to the aggregate dollar amount of reserves for claims that are incurred but not yet paid, and for claims that are incurred but not yet reported.

(d) Policy forms or certificates shall be deemed to comply with the purposes of this section if the expected losses in relation to premiums over the entire period for which the policy form or certificate is rated comply with the requirements of this section and either of the following applies:

(1) For policies or certificates that have been in force for three years or more, for the most recent year the ratio of incurred losses to earned premiums is greater than or equal to the minimum loss ratios established by this section.

(2) For policies or certificates that have been in force for three years or less, the expected third year loss ratio can be demonstrated to be greater than or equal to the minimum loss ratio.

(e) If the annual filing or other information received by the commissioner indicates that the actual loss ratio for a policy or certificate is less than the minimum loss ratio established by this section, the commissioner shall require that the insurer or entity providing the insurance file and implement a corrective plan. This plan shall include the utilization of premium reductions, dividends, benefit increases, or any combination of these or other methods so that the minimum loss ratio can be reasonably expected to be achieved. Any corrective plan shall be reviewed and approved by the commissioner prior to implementation.

(f) If, in the opinion of the commissioner, a policy's or certificate's failure to meet the minimum loss ratio requirements is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the commissioner may exempt the policy or certificate from the need for a corrective plan for that year. Any exemption shall be in writing and shall specify the reasons for the granting of the exemption.

(g) If the insurer or other entity providing disability insurance to persons 65 years of age or older in this state fails to file and implement a corrective plan in a timely manner, the commissioner shall withdraw approval of the policy or certificate according to the procedures set forth in Section 10293. This remedy is in addition to any remedy available in that section or under other laws of this state. Any report, plan, exemption, or other document prepared pursuant to this section shall be accessible to the public as a public record.

(h) The commissioner may adopt regulations to implement or

administer this article.

789.7. (a) Sales of disability insurance regulated by this article, as well as Medicare supplement insurance and long-term care insurance sold to persons aged 65 years or older, shall be registered by the insurer with the commissioner. The commissioner shall provide facilities for the computerized recordkeeping of all registered policies and certificates. The commissioner shall adopt regulations to implement and administer registration pursuant to this section. Regulations shall include, but need not be limited to, a system for assessing insurers in accordance with each insurer's market share in order to finance the cost of registration, an appropriate method and schedule for the filing of data with the commissioner, the content and format required for each filing in accordance with subdivision (d), appropriate sanctions for failure to comply with this section or with regulations promulgated under this section, and criteria for releasing the registered information to parties outside the department.

(b) Access to the registered information, including the identity of policyholders, shall be strictly limited to the department, with the exception that the Attorney General, a district attorney, or city attorney may be granted access upon request for the purpose of investigating or prosecuting suspected unlawful practices or for purposes of this article. The commissioner may, at his or her discretion, allow access to the registered information to the Health Insurance Counseling and Advocacy Program in the Department of Aging.

(c) Access to registered information in a purely statistical format, which neither identifies nor enables identification of a particular policyholder, may be released at the discretion of the commissioner to any party who demonstrates that the information will be used only for other than commercial purposes.

(d) The content of the filing shall contain no more than the following information:

(1) Policyholder's Medicare identification number or social security number. The policyholder's name shall be specifically excluded from the filing.

(2) A description of the policy as being Medicare supplemental insurance; long-term care insurance; or disability insurance.

(3) Date of sale.

(4) Date of lapse.

(5) Whether the policy is in force as of the date of the filing.

(6) The policy form number, if applicable.

(7) The name of any insurer, broker, agent, or other person engaged in the transaction of insurance who was responsible for the sale of the policy.

789.8. (a) "Elder" for purposes of this section means any person residing in this state who is 65 years of age or older.

(b) If a life agent offers to sell to an elder any life insurance or annuity product, the life agent shall advise an elder or elder's agent in writing that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation, and that the elder or elder's agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold. This section does not apply to a credit life insurance product as defined in Section 779.2.

(c) A life agent who offers for sale or sells a financial product to an elder on the basis of the product's treatment under the Medi-Cal program may not negligently misrepresent the treatment of any asset under the statutes and rules and regulations of the Medi-Cal program, as it pertains to the determination of the elder's eligibility for any program of public assistance.

(d) A life agent who offers for sale or sells any financial product on the basis of its treatment under the Medi-Cal program shall provide, in writing, the following disclosure to the elder or the elder's agent:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than (insert amount of individual's resource allowance) in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly

income a personal allowance of (insert amount of personal needs allowance) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of community countable assets).

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or (insert amount of the minimum monthly maintenance needs allowance), whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than (insert amount of community spouse resource allowance plus individual's resource allowance) in countable resources. The order also may allow the at-home spouse to retain more than (insert amount of the monthly maintenance needs allowance) in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

ONE PRINCIPAL RESIDENCE: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL PROPERTY USED IN A BUSINESS OR TRADE: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.

ONE MOTOR VEHICLE.

IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.

THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I have read the above notice and have received a copy. Dated: _____ Signature: _____"

The statement required in this subdivision shall be printed in at least 12-point type, shall be clearly separate from any other document or writing, and shall be signed by the prospective purchaser and that person's spouse, and legal representative, if any.

(e) The State Department of Health Services shall update this form to ensure consistency with state and federal law and make the disclosure available to agents and brokers through its Internet Web site.

(f) Nothing in this section allows or is intended to allow the unlawful practice of law.

(g) Subdivisions (b) and (d) shall become operative on July 1, 2001.

789.9. (a) In addition to any other reasons that a sale of an individual annuity to a senior may violate any provision of law, an annuity shall not be sold to a senior in any of the following circumstances:

(1) The senior's purpose in purchasing the annuity is to affect Medi-Cal eligibility and either of the following is true:

(A) The purchaser's assets are equal to or less than the community spouse resource allowance established annually by the State Department of Health Services pursuant to the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(B) The senior would otherwise qualify for Medi-Cal.

(2) The senior's purpose in purchasing the annuity is to affect Medi-Cal eligibility and, after the purchase of the annuity, the senior or the senior's spouse would not qualify for Medi-Cal.

(b) In the event that a fixed annuity specified in subdivision (a) is issued to a senior, the issuer shall rescind the contract and refund to the purchaser all premiums, fees, any interest earned under the terms of the contract, and costs paid for the annuity. This remedy shall be in addition to any other remedy that may be available.

789.10. (a) This section applies to the sale, offering for sale, or generation of leads for the sale of life insurance, including annuities, to senior insureds or prospective insureds by any person.

(b) Any person who meets with a senior in the senior's home is required to deliver a notice in writing to the senior no less than 24 hours prior to that individual's initial meeting in the senior's home. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice shall be delivered to the senior prior to the meeting. The notice shall be in substantially the following form, with the appropriate information inserted, in 14-point type:

"(1) During this visit or a followup visit, you will be given a sales presentation on the following (indicate all that apply):

( ) Life insurance, including annuities

( ) Other insurance products (specify): _____.

(2) You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

(3) You have the right to end the meeting at any time.

(4) You have the right to contact the Department of Insurance for information, or to file a complaint. (The notice shall include the consumer assistance telephone numbers at the department)

(5) The following individuals will be coming to your home: (list all attendees, and insurance license information, if applicable)"

(c) Upon contacting the senior in the senior's home, the person shall, before making any statement other than a greeting, or asking the senior any other questions, state that the purpose of the contact is to talk about insurance, or to gather information for a followup visit to sell insurance, if that is the case, and state all of the following information:

(1) The name and titles of all persons arriving at the senior's home.

(2) The name of the insurer represented by the person, if known.

(d) Each person attending a meeting with a senior shall provide the senior with a business card or other written identification stating the person's name, business address, telephone number, and any insurance license number.

(e) The persons attending a meeting with a senior shall end all discussions and leave the home of the senior immediately after being asked to leave by the senior.

(f) A person may not solicit a sale or order for the sale of an annuity or life insurance policy at the residence of a senior, in person or by telephone, by using any plan, scheme, or ruse that misrepresents the true status or mission of the contact.

INSURANCE CODE
SECTION 790-790.15

790. The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, Seventy-ninth Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

790.01. This article applies to reciprocal and interinsurance exchanges, Lloyds insurers, fraternal benefit societies, fraternal fire insurers, grants and annuities societies, insurers holding certificates of exemptions, motor clubs, nonprofit hospital associations, life agents, broker-agents, surplus line brokers and special lines surplus line brokers as well as all other persons

engaged in the business of insurance.

790.02. No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to this article to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

790.03. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his or her insurance.

(b) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

(c) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) Filing with any supervisory or other public official, or

making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

(f) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if those differentials are substantially supported by valid pertinent data segregated by sex, including, but not necessarily limited to, mortality data segregated by sex.

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. "Compliance date" as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing

mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.5 and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), as amended, and (2) tax sheltered annuities for employees of public schools or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds,

when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

790.031. The requirements of subdivision (b) of Section 790.034, and Sections 2071.1 and 10082.3 shall apply only to policies of residential property insurance as defined in Section 10087, policies and endorsements containing those coverages prescribed in Chapter 8.5 (commencing with Section 10081) of Part 1 of Division 2, policies issued by the California Earthquake Authority pursuant to Chapter 8.6 (commencing with Section 10089.5) of Part 1 of Division 2, policies and endorsements that insure against property damage and are issued to common interest developments or to associations managing common interest developments, as those terms are defined in Section 1351 of the Civil Code, and to policies issued pursuant to Section 120 that insure against property damage to residential units or contents thereof owned by one or more persons located in this state.

790.034. (a) Regulations adopted by the commissioner pursuant to this article that relate to the settlement of claims shall take into consideration settlement practices by classes of insurers.

(b) (1) Upon receiving notice of a claim, every insurer shall immediately, but no more than 15 calendar days after receipt of the claim, provide the insured with a legible reproduction of Section 790.03 of the Insurance Code, in at least 12-point type and a written notice containing the following:

"In addition to Section 790.03 of the Insurance Code provided here, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet site, www.insurance.ca.gov. You may also obtain a copy of these regulations free of charge from this insurer."

(2) Every insurer shall provide, whether requested orally or in writing by an insured, a copy of the Fair Claims Settlement Practices Regulations as set forth in Sections 2695.5, 2695.7, 2695.8, and 2695.9 of subchapter 7.5 of Chapter 5 of Title 10 of the California Code of Regulations, unless the regulations are inapplicable to that class of insurer. These regulations shall be provided to the insured within 15 calendar days of request.

(3) The provisions of this subdivision shall apply to all insurers except for those that are licensed pursuant to Chapter 1 (commencing

with Section 12340) of Part 6 of Division 2, with respect to policies and endorsements described in Section 790.031.

790.035. (a) Any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in Section 790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section.

(b) The penalty imposed by this section shall be imposed by and determined by the commissioner as provided by Section 790.05. The penalty imposed by this section is appealable by means of any remedy provided by Section 12940 or by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

790.036. (a) It is an unfair and deceptive act or practice in the business of insurance for an insurer to advertise insurance that it will not sell.

(b) Nothing in this section shall be construed to prohibit any insurer from advertising insurance products for which it is licensed to sell in this state where the product is not available for sale so long as the unavailability is disclosed in the advertisement.

(c) A violation of this section is subject to the sanctions provided for by this article.

(d) An intentional violation of this section is a misdemeanor punishable by a fine not exceeding ten thousand dollars ($10,000).

(e) This section does not apply to any insurer that refuses to sell a policy of insurance on the basis of its underwriting guidelines.

(f) This section does not apply to advertisements by an insurer where the advertisements are broadcast and originate from outside this state. As used in this subdivision, "broadcast" includes electronic media, television, and radio. As used in this subdivision, "originate from outside this state" includes cable transmittal of programs broadcast by stations located outside

California.

790.04. The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in the State in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 790.03 or determined pursuant to this article to be an unfair method of competition or an unfair or deceptive practice in the business of insurance. Such investigation may be conducted pursuant to Article 2 (commencing at Section 11180) of Chapter 2, Part 1, Division 3, Title 2 of the Government Code.

790.05. Whenever the commissioner shall have reason to believe that a person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 790.03, and that a proceeding by the commissioner in respect thereto would be to the interest of the public, he or she shall issue and serve upon that person an order to show cause containing a statement of the charges in that respect, a statement of that person's potential liability under Section 790.035, and a notice of a hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that person to, pay the penalty imposed by Section 790.035, and to cease and desist those methods, acts, or practices or any of them.

If the charges or any of them are found to be justified the commissioner shall issue and cause to be served upon that person an order requiring that person to pay the penalty imposed by Section 790.035 and to cease and desist from engaging in those methods, acts, or practices found to be unfair or deceptive.

The hearing shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing at Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act.

The person shall be entitled to have the proceedings and the order reviewed by means of any remedy provided by Section 12940 of this code or by the Administrative Procedure Act.

790.06. (a) Whenever the commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of the business that is not defined in Section 790.03, and that the method is unfair or that the act or practice is unfair or deceptive and that a proceeding by him or her in respect thereto would be in the interest of the public, he or she may issue and serve upon that person an order to show cause containing a statement of the methods, acts or practices alleged to be unfair or deceptive and a notice of hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the alleged methods, acts or practices or any of them should be declared to be unfair or deceptive within the meaning of this article. The order shall specify the reason why the method of competition is alleged to be unfair or the act or practice is alleged to be unfair or deceptive.

The hearings provided by this section shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act. If the alleged methods, acts, or practices or any of them are found to be unfair or deceptive within the meaning of this article the commissioner shall issue and service upon that person his or her written report so declaring.

(b) If the report charges a violation of this article and if the method of competition, act or practice has not been discontinued, the commissioner may, through the Attorney General of this state, at any time after 30 days after the service of the report cause a petition to be filed in the superior court of this state within the county wherein the person resides or has his or her principal place of business, to enjoin and restrain the person from engaging in the method, act or practice. The court shall have jurisdiction of the

proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue any writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(c) A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings shall be filed with the petition. If either party shall apply to the court for leave to adduce additional evidence and shall show, to the satisfaction of the court, that the additional evidence is material and there were reasonable grounds for the failure to adduce the evidence in the proceeding before the commissioner, the court may order the additional evidence to be taken before the commissioner and to be adduced upon the hearing in the manner and upon the terms and conditions as to the court may seem proper. The commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence so taken, and shall file modified or new findings with the return of the additional evidence.

(d) If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair or deceptive, that the proceeding by the commissioner with respect thereto is to the interest of the public and that the findings of the commissioner are supported by the weight of the evidence, it shall issue its order enjoining and restraining the continuance of the method of competition, act or practice.

790.07. Whenever the commissioner shall have reason to believe that any person has violated a cease and desist order issued pursuant to Section 790.05 or a court order issued pursuant to Section 790.06, after the order has become final, and while the order is still in effect, the commissioner may, after a hearing at which it is determined that the violation was committed, order that person to forfeit and pay to the State of California a sum not to exceed five thousand dollars ($5,000) plus any penalty due under Section 790.05, which may be recovered in a civil action, except that, if the violation is found to be willful, the amount of the penalty may be a sum not to exceed fifty-five thousand dollars ($55,000) plus the penalty due under Section 790.05.

For the purposes of this section, the failure to pay any penalty imposed pursuant to Section 790.035 which has become final shall constitute a violation of the cease and desist order.

For any subsequent violation of the cease and desist order or of the court order or the order to pay the penalty, while the order is

still in effect, the commissioner may, after hearing, suspend or revoke the license or certificate of that person for a period not exceeding one year; provided, however, no proceeding shall be based upon the subsequent violation unless the same was committed or continued after the date on which the order imposing the penalty pursuant to the preceding paragraph became final.

The hearings provided by this section shall be conducted in accordance with the Administrative Procedure Act, except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act.

The person shall be entitled to have the proceedings and the order of the commissioner therein reviewed by means of any remedy provided by Section 12940 or by the Administrative Procedure Act.

790.08. The powers vested in the commissioner in this article shall be additional to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

790.09. No order to cease and desist issued under this article directed to any person or subsequent administrative or judicial proceeding to enforce the same shall in any way relieve or absolve such person from any administrative action against the license or certificate of such person, civil liability or criminal penalty under the laws of this State arising out of the methods, acts or practices found unfair or deceptive.

790.10. The commissioner shall, from time to time as conditions warrant, after notice and public hearing, promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article.

790.15. (a) If an insurer or any affiliate of an insurer has failed to pay any valid claim from Holocaust survivors, the certificate of authority of the insurer shall be suspended until the insurer, or its affiliates, pays the claim or claims.

(b) As used in this section:

(1) "Holocaust survivor" means any person who is the beneficiary of an insurance policy, if the insurance policy insured a person's life, property, or other interest, and the insured person was killed, died, was displaced, or was otherwise a victim of persecution of Jewish and other peoples preceding and during World War II by Germany, its allies, or sympathizers.

(2) "Beneficiary" means any person or entity entitled to recover under any policy of insurance, including any named beneficiary, any heir of a named beneficiary, and any other person entitled to recover under the policy.

(3) "Claim" means any claim submitted by a Holocaust survivor or other beneficiary arising under an insurance policy for any loss or damage caused by or arising because of discriminatory practices or persecution by the Nazi-controlled German government or its allies, or by insurers that refused to pay claims because of a claim that policies of insurance or records were missing or confiscated because of actions by the Nazi-controlled German government or its agents or allies. Claim also includes any claim by Holocaust survivors or beneficiaries to collect proceeds from dowry or education policies or from annuities.

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

(5) "Control" includes the terms "controlling," "controlled by," and "under common control with," and 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 other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, more than 10 percent of the voting securities of any other person.

(c) An action to suspend a certificate of authority under this section shall be conducted in accordance with the Administrative

Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), except that (1) if the Office of Administrative Hearings is unable to assign an administrative law judge to preside over a hearing that commences within 30 days of the filing of an accusation or order initiating an action under this section, the administrative law judge may be appointed by the commissioner; and (2) if the commissioner determines that it is necessary to protect the interests of Holocaust survivors, he or she may issue an order of suspension pursuant to this section prior to holding a hearing.

(d) If the commissioner issues an order pursuant to paragraph (2) of subdivision (c), he or she shall immediately issue and serve upon the insurer a statement of reasons for the immediate action, as well as a copy of the accusation or order containing the allegations that support the order. Any order issued pursuant to this subdivision shall include a notice stating the time and place of a hearing on the order, which shall not be less than 20, nor more than 30 days after the order is served.

(e) When considering an action to suspend a certificate of authority under this section, the commissioner shall include consideration of whether the insurer has participated in good faith in an international commission on Holocaust survivor insurance claims, and whether the commission is making meaningful and expeditious progress toward paying claims to survivors and righting the historic wrong done to Holocaust victims.

INSURANCE CODE
SECTION 791-791.27

791. The purpose of this article is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance

transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

791.01. (a) The obligations imposed by this article shall apply to those insurance institutions, agents or insurance-support organizations which, on or after October 1, 1981:

(1) In the case of life or disability insurance:

(A) Collect, receive or maintain information in connection with insurance transactions which pertains to natural persons who are residents of this state, or

(B) Engage in insurance transactions with applicants, individuals or policyholders who are residents of this state.

(2) In the case of property or casualty insurance:

(A) Collect, receive or maintain information in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state, or

(B) Engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state.

(b) The rights granted by this article shall extend to:

(1) In the case of life or disability insurance, the following persons who are residents of this state:

(A) Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions.

(B) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions.

(2) In the case of property or casualty insurance, the following persons:

(A) Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state, and

(B) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state.

(c) For purposes of this section, a person shall be considered a resident of this state if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this state.

(d) This article shall not apply to any person or entity engaged

in the business of title insurance as defined in Section 12340.3.

(e) This article shall not apply to a person or entity engaged in the business of a home protection company, as defined in Section 12740, which does not obtain or maintain personal information, as defined in this article, of its policyholders and applicants.

(f) Insurance institutions, agents, insurance support organizations or any insurance transaction subject to this article shall be exempt from Part 2.6 (commencing with Section 56) of Division 1 of, and Sections 1785.20 and 1786.40 of, the Civil Code.

791.02. As used in this act:

(a) (1) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an agent to apply for insurance coverage with a specific insurance institution that the agent represents and that is requested by an applicant.

(D) In the case of a property or casualty insurance coverage:

(i) Placement by an insurance institution or agent of a risk with a residual market mechanism, with an unauthorized insurer, or with an insurance institution that provides insurance to other than preferred or standard risks, if in fact the placement is at other than a preferred or standard rate. An adverse underwriting decision, in case of placement with an insurance institution that provides insurance to other than preferred or standard risks, shall not include placement if the applicant or insured did not specify or apply for placement as a preferred or standard risk or placement with a particular company insuring preferred or standard risks, or

(ii) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished.

(E) In the case of a life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

(2) Notwithstanding paragraph (1), any of the following actions shall not be considered adverse underwriting decisions but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(A) The termination of an individual policy form on a class or

statewide basis.

(B) A declination of insurance coverage solely because coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(b) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(c) "Agent" means any person licensed pursuant to Chapter 5 (commencing with Section 1621), Chapter 5A (commencing with Section 1759), Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), or Chapter 8 (commencing with Section 1831).

(d) "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

(e) "Consumer report" means any written, oral, or other communication of information bearing on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with an insurance transaction.

(f) "Consumer reporting agency" means any person who:

(1) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee.

(2) Obtains information primarily from sources other than insurance institutions.

(3) Furnishes consumer reports to other persons.

(g) "Control," including the terms "controlled by" or "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 other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(h) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

(i) "Individual" means any natural person who is any of the following:

(1) In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder.

(2) In the case of life or disability insurance, is a past, present, or proposed principal insured or certificate holder.

(3) Is a past, present, or proposed policyowner.

(4) Is a past or present applicant.

(5) Is a past or present claimant.

(6) Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this act.

(j) "Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution, or insurance-support organization, other than any of the following:

(1) An agent.

(2) The individual who is the subject of the information.

(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

(k) "Insurance institution" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, or other person engaged in the business of insurance. "Insurance institution" shall not include agents, insurance-support organizations, or health care service plans regulated pursuant to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(l) "Insurance-support organization" means:

(1) Any person who regularly engages, in whole or in part, in the business of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including either of the following:

(A) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction.

(B) The collection of personal information from insurance institutions, agents, or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(2) Notwithstanding paragraph (1), the following persons shall not be considered "insurance-support organizations": agents, governmental institutions, insurance institutions, medical care institutions, medical professionals, and peer review committees.

(m) "Insurance transaction" means any transaction involving insurance primarily for personal, family, or household needs rather than business or professional needs that entails either of the following:

(1) The determination of an individual's eligibility for an

insurance coverage, benefit, or payment.

(2) The servicing of an insurance application, policy, contract, or certificate.

(n) "Investigative consumer report" means a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning those items of information.

(o) "Medical care institution" means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to, hospitals, skilled nursing facilities, home health agencies, medical clinics, rehabilitation agencies, and public health agencies.

(p) "Medical professional" means any person licensed or certified to provide health care services to natural persons, including but not limited to, a physician, dentist, nurse, optometrist, physical or occupational therapist, psychiatric social worker, clinical dietitian, clinical psychologist, chiropractor, pharmacist, or speech therapist.

(q) "Medical record information" means personal information that is both of the following:

(1) Relates to an individual's physical or mental condition, medical history or medical treatment.

(2) Is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(r) "Person" means any natural person, corporation, association, partnership, limited liability company, or other legal entity.

(s) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and "medical record information" but does not include "privileged information."

(t) "Policyholder" means any person who is any of the following:

(1) In the case of individual property or casualty insurance, is a present named insured.

(2) In the case of individual life or disability insurance, is a present policyowner.

(3) In the case of group insurance, which is individually underwritten, is a present group certificate holder.

(u) "Pretext interview" means an interview whereby a person, in an

attempt to obtain information about a natural person, performs one or more of the following acts:

(1) Pretends to be someone he or she is not.

(2) Pretends to represent a person he or she is not in fact representing.

(3) Misrepresents the true purpose of the interview.

(4) Refuses to identify himself or herself upon request.

(v) "Privileged information" means any individually identifiable information that both:

(1) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual.

(2) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual. However, information otherwise meeting the requirements of this division shall nevertheless be considered "personal information" under this act if it is disclosed in violation of Section 791.13.

(w) "Residual market mechanism" means the California FAIR Plan Association, Chapter 10 (commencing with Section 10101) of Part 1 of Division 2, and the assigned risk plan, Chapter 1 (commencing with Section 11550) of Part 3 of Division 2.

(x) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(y) "Unauthorized insurer" means an insurance institution that has not been granted a certificate of authority by the director to transact the business of insurance in this state.

(z) "Commissioner" means the Insurance Commissioner.

791.03. No insurance institution, agent or insurance-support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction; provided, however, that a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily recognized privileged relationship with the person to whom the information relates for the purpose of investigating a claim where there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation or material nondisclosure in connection with a claim.

791.04. (a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided below:

(1) In the case of a written application for insurance, a notice shall be provided no later than:

(A) At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant, an insured under the policy, 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, an insured under the policy, or public records.

(2) In the case of a policy renewal, a notice shall be provided no later than the policy renewal date or the date upon which policy renewal is confirmed, except that no notice shall be required in connection with a policy renewal if either of the following applies:

(A) Personal information is collected only from the policyholder, an insured under the policy, or from public records.

(B) A notice meeting the requirements of this section has been given within the previous 24 months.

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder, an insured under the policy, or from public records or if a notice meeting the requirements of this section has been given within the previous 24 months.

(b) The notice required by subdivision (a) shall be in writing and shall state all of the following:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage.

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information.

(3) The types of disclosures identified in subdivisions (b), (c), (d), (e), (f), (i), (k), (l), and (n) of Section 791.13 and the circumstances under which the disclosures may be made without prior authorization, except that only those circumstances need be described which occur with such frequency as to indicate a general business practice.

(4) A description of the rights established under Sections 791.08 and 791.09 and the manner in which the rights may be exercised.

(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(c) In lieu of the notice prescribed in subdivision (b), the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder of the following:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage.

(2) Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization.

(3) A right of access and correction exists with respect to all personal information collected.

(4) The notice prescribed in subdivision (b) will be furnished to the applicant or policyholder upon request.

(d) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

791.05. An insurance institution or agent shall clearly specify those questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction.

791.06. Notwithstanding any other provision of law, no insurance institution, agent or insurance-support organization may utilize as its disclosure authorization form in connection with insurance transactions a form or statement which authorizes the disclosure of personal or privileged information about an individual to the insurance institution, agent, or insurance-support organization unless the form or statement:

(a) Is written in plain language.

(b) Is dated.

(c) Specifies the types of persons authorized to disclose information about the individual.

(d) Specifies the nature of the information authorized to be disclosed.

(e) Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to

whom the individual is authorizing information to be disclosed.

(f) Specifies the purposes for which the information is collected.

(g) Specifies the length of time the authorization shall remain valid, which shall be no longer than:

(1) In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits:

(A) Thirty months from the date the authorization is signed if the application or request involves life, health or disability insurance; or

(B) One year from the date the authorization is signed if the application or request involves property or casualty insurance.

(2) In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:

(A) The term of coverage of the policy if the claim is for a health insurance benefit; or

(B) The duration of the claim if the claim is not for a health insurance benefit; or

(C) The duration of all claims processing activity performed in connection with all claims for benefits made by any person entitled to benefits under a nonprofit hospital service contract.

(h) Advises the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

(i) This section shall not be construed to require any authorization for the receipt of personal or privileged information about an individual.

791.07. (a) No insurance institution, agent or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the insurance institution or agent informs the individual of the following:

(1) That he or she may request to be interviewed in connection with the preparation of the investigative consumer report, and

(2) That upon a request pursuant to Section 791.08, he or she is entitled to receive a copy of the investigative consumer report.

(b) If an investigative consumer report is to be prepared by an insurance institution or agent, the insurance institution or agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

(c) If an investigative consumer report is to be prepared by an insurance-support organization, the insurance institution or agent desiring such report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such interviews, if requested.

791.08. (a) If any individual, after proper identification, submits a written request to an insurance institution, agent or insurance-support organization for access to recorded personal information about the individual which is reasonably described by the individual and reasonably locatable and retrievable by the insurance institution, agent or insurance-support organization, the insurance institution, agent or insurance-support organization shall within 30 business days from the date such request is received:

(1) Inform the individual of the nature and substance of such recorded personal information in writing, by telephone or by other oral communication, whichever the insurance institution, agent or insurance-support organization prefers;

(2) Permit the individual to see and copy, in person, such recorded personal information pertaining to him or her or to obtain a copy of such recorded personal information by mail, whichever the individual prefers, unless such recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

(3) Disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, agent or insurance-support organization has disclosed such personal information within two years prior to such request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; and

(4) Provide the individual with a summary of the procedures by which he or she may request correction, amendment or deletion of recorded personal information.

(b) Any personal information provided pursuant to subdivision (a) above shall identify the source of the information if such source is

an institutional source.

(c) Medical record information supplied by a medical care institution or medical professional and requested under subdivision (a), together with the identity of the medical professional or medical care institution which provided such information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the individual prefers. Mental health record information shall be supplied directly to the individual, pursuant to this section, only with the approval of the qualified professional person with treatment responsibility for the condition to which the information relates. If it elects to disclose the information to a medical professional designated by the individual, the insurance institution, agent or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

(d) Except for personal information provided under Section 791.10, an insurance institution, agent or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

(e) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subdivision (a), an insurance institution, agent 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.

(f) The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subdivision shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(g) For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency".

791.09. (a) 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 insurance institution, agent or insurance-support organization shall either:

(1) Correct, amend or delete the portion of the recorded personal information in dispute; or

(2) Notify the individual of:

(A) Its refusal to make such correction, amendment or deletion.

(B) The reasons for the refusal.

(C) The individual's right to file a statement as provided in subdivision (c).

(b) If the insurance institution, agent or insurance-support organization corrects, amends or deletes recorded personal information in accordance with paragraph (1) of subdivision (a), the insurance institution, agent or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment or fact of deletion to:

(1) Any person specifically designated by the individual who may have, within the preceding two years, received such recorded personal information.

(2) Any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received such recorded personal information from the insurance institution within the preceding seven years; provided, however, that 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.

(3) Any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.

(c) Whenever an individual disagrees with an insurance institution's, agent's or insurance-support organization's refusal to correct, amend or delete recorded personal information, the individual shall be permitted to file with the insurance institution, agent or insurance-support organization:

(1) A concise statement setting forth what the individual thinks is the correct, relevant or fair information.

(2) A concise statement of the reasons why the individual disagrees with the insurance institution's, agent's or insurance-support organization's refusal to correct, amend or delete recorded personal information.

(d) In the event an individual files either statement as described in subdivision (c), the insurance institution, agent or support organization shall:

(1) File the statement 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 statement and have access to it.

(2) In any subsequent disclosure by the insurance institution, agent or support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the individual's statement along with the recorded personal information being disclosed.

(3) Furnish the statement to the persons and in the manner specified in subdivision (b).

(e) The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subdivision shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(f) For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency".

791.10. (a) In the event of an adverse underwriting decision the insurance institution or agent responsible for the decision shall:

(1) Either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such person that upon written request he or she may receive the specific reason or reasons in writing.

(2) Provide the applicant, policyholder or individual proposed for coverage with a summary of the rights established under subdivision (b) and Sections 791.08 and 791.09.

(b) Upon receipt of a written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within 21 business days from the date of receipt of such written request:

(1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to paragraph (1) of subdivision (a).

(2) The specific items of personal and privileged information that

support those reasons; provided, however:

(A) The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the commissioner, that the applicant, policyholder or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure.

(B) Specific items of medical record information supplied by a medical care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the individual prefers.

Mental health record information shall be supplied directly to the individual, pursuant to this subdivision, only with the approval of the qualified professional person with treatment responsibility for the condition to which the information relates.

(3) The names and addresses of the institutional sources that supplied the specific items of information given pursuant to paragraph (2) of subdivision (b); provided, however, that the identity of any medical professional or medical care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the individual prefers.

(c) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(d) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subdivision (a) may be given orally to the extent that such information is available.

791.11. No insurance institution, agent or insurance-support organization may seek information in connection with an insurance transaction concerning:

(a) Any previous adverse underwriting decision experienced by an individual, or

(b) Any previous insurance coverage obtained by an individual through a residual market mechanism, unless such inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

791.12. No insurance institution or agent may base an adverse underwriting decision in whole or in part on the following:

(a) On the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism; provided, however, an insurance institution or agent may base an adverse underwriting decision on further information obtained from an insurance institution or agent responsible for a previous adverse underwriting decision. The further information, when requested, shall create a conclusive presumption that the information is necessary to perform the requesting insurer's function in connection with an insurance transaction involving the individual and, when reasonably available, shall be furnished the requesting insurer and the individual, if applicable.

(b) On personal information received from an insurance-support organization whose primary source of information is insurance institutions; provided, however, an insurance institution or agent may base an adverse underwriting decision on further personal information obtained as the result of information received from an insurance-support organization.

(c) On the fact that an individual has previously inquired and received information about the scope or nature of coverage under a residential fire or property insurance policy, if the information is received from an insurance-support organization whose primary source of information is insurance institutions and the inquiry did not result in the filing of a claim.

791.13. An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(a) With the written authorization of the individual, and meets either of the conditions specified in paragraph (1) or (2):

(1) If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirement of Section 791.06.

(2) If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

(A) Dated;

(B) Signed by the individual.

(C) Obtained one year or less prior to the date a disclosure is sought pursuant to this section.

(b) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:

(1) To enable such person to perform a business, professional or insurance function for the disclosing insurance institution, agent, or insurance-support organization or insured and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(A) Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(B) Is reasonably necessary for such person to perform its function for the disclosing insurance institution, agent, or insurance-support organization.

(2) To enable such person to provide information to the disclosing insurance institution, agent or insurance-support organization for the purpose of:

(A) Determining an individual's eligibility for an insurance benefit or payment; or

(B) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction.

(c) To an insurance institution, agent, insurance-support organization or self-insurer, provided the information disclosed is limited to that which is reasonably necessary under either paragraph (1) or (2):

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or

(2) For either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual.

(d) To a medical-care institution or medical professional for the purpose of any of the following:

(1) Verifying insurance coverage or benefits.

(2) Informing an individual of a medical problem of which the individual may not be aware.

(3) Conducting operations or services audit, provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes.

(e) To an insurance regulatory authority; or

(f) To a law enforcement or other governmental authority pursuant to law.

(g) Otherwise permitted or required by law.

(h) In response to a facially valid administrative or judicial order, including a search warrant or subpoena.

(i) Made for the purpose of conducting actuarial or research studies, provided:

(1) No individual may be identified in any actuarial or research report.

(2) Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed.

(3) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization.

(j) 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 insurance institution, agent or insurance-support organization, provided:

(1) Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation.

(2) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization.

(k) To a person whose only use of such information will be in connection with the marketing of a product or service, provided:

(1) No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from such information is disclosed; or

(2) The individual has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed; and

(3) The person receiving such information agrees not to use it except in connection with the marketing of a product or service.

(l) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons.

(m) By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent.

(n) To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

(o) To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional.

(p) To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable.

(q) To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction.

(r) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance. The information disclosed shall be limited to that which is reasonably necessary to permit the person to protect his or her interest in the policy and shall be consistent with Article 5.5 (commencing with Section 770).

791.14. (a) The commissioner shall have power to examine and investigate into the affairs of every insurance institution or agent doing business in this state to determine whether the insurance institution or agent has been or is engaged in any conduct in violation of this article.

(b) The commissioner shall have the power to examine and investigate into the affairs of every insurance-support organization acting on behalf of an insurance institution or agent which either transacts business in this state or transacts business outside this state that has an effect on a person residing in this state in order to determine whether such insurance-support organization has been or is engaged in any conduct in violation of this article.

791.15. (a) Whenever the commissioner has reason to believe that an insurance institution, agent or insurance-support organization has been or is engaged in conduct in this state which violates this article, or if the commissioner believes that an insurance-support organization has been or is engaged in conduct outside this state which has an effect on a person residing in this state and which

violates this article, the commissioner shall issue and serve upon such insurance institution, agent or insurance-support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be not less than 30 days after the date of service.

(b) At the time and place fixed for such hearing the insurance institution, agent or insurance-support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the commissioner shall permit any adversely affected person to intervene, appear and be heard at such hearing by counsel or in person.

(c) At any hearing conducted pursuant to this section the commissioner may administer oaths, examine and cross-examine witnesses and receive oral and documentary evidence. The commissioner shall have the power to subpoena witnesses, compel their attendance and require the production of books, papers, records, correspondence and other documents which are relevant to the hearing. A stenographic record of the hearing shall be made upon the request of any party or at the discretion of the commissioner. If no stenographic record is made and if judicial review is sought, the commissioner shall prepare a statement of the evidence for use on review. Hearings conducted under this section shall be governed by the same rules of evidence and procedure applicable to administrative proceedings conducted under the laws of this state.

(d) Statements of charges, notice, orders and other processes of the commissioner under this article may be served by anyone duly authorized to act on behalf of the commissioner. Service of process may be completed in the manner provided by law for service of process in civil actions or by registered mail. A copy of the statement of charges, notice, order or other process shall be provided to the person or persons whose rights under this article have been allegedly violated. A verified return setting forth the manner of service, or return postcard receipt in the case of registered mail, shall be sufficient proof of service.

791.16. For the purpose of this article, an insurance-support organization transacting business outside this state which has an effect on a person residing in this state shall be deemed to have appointed the commissioner to accept service of process on its behalf, provided the commissioner causes a copy of such service to be mailed forthwith by registered mail to the insurance-support organization at its last known principal place of business. The

return postcard receipt for such mailing shall be sufficient proof that the same was properly mailed by the commissioner.

791.17. (a) If, after a hearing pursuant to Section 791.15, the commissioner determines that the insurance institution, agent or insurance-support organization charged has engaged in conduct or practices in violation of this article, the commissioner shall reduce his or her findings to writing and shall issue and cause to be served upon such insurance institution, agent or insurance-support organization a copy of such findings and an order requiring such insurance institution, agent or insurance-support organization to cease and desist from the conduct or practices constituting a violation of this article.

(b) If, after a hearing pursuant to Section 791.15, the commissioner determines that the insurance institution, agent or insurance-support organization charged has not engaged in conduct or practices in violation of this article, the commissioner shall prepare a written report which sets forth findings of fact and conclusions of law. Such report shall be served upon the insurance institution, agent or insurance-support organization charged and upon the person or persons, if any, whose rights under this article were allegedly violated.

(c) Until the expiration of the time allowed under Section 791.18 for filing a petition for review or until such petition is actually filed, whichever occurs first, the commissioner may modify or set aside any order or report issued under this section. After the expiration of the time allowed under Section 791.18 for filing a petition for review, if no such petition has been duly filed, the commissioner may, after notice and opportunity for hearing, alter, modify or set aside, in whole or in part, any order or report issued under this section whenever conditions of fact or law warrant such action or if the public interest so requires.

791.18. (a) Any person subject to an order of the commissioner under Section 779.17 or Section 791.20 or any person whose rights under this article were allegedly violated may obtain a review of any order or report of the commissioner by filing in a court of competent jurisdiction, within 30 days from the date of the service of such order or report, pursuant to Section 1094.5 of the Code of

Civil Procedure. The court shall have jurisdiction to make and enter a decree modifying, affirming or reversing any order or report of the commissioner, in whole or in part.

(b) An order or report issued by the commissioner under Section 791.17 shall become final:

(1) Upon the expiration of the time allowed for the filing of a petition for review, if no such petition has been duly filed; except that the commissioner may modify or set aside an order or report to the extent provided in subdivision (c) of Section 791.17; or

(2) Upon a final decision of the court if the court directs that the order or report of the commissioner be affirmed or the petition for review dismissed.

(c) No order or report of the commissioner under this article or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order or report from any liability under any law of this state.

791.19. Any person who violates a cease and desist order of the commissioner under Section 791.17 may, after notice and hearing and upon order of the commissioner, be subject to one or more of the following penalties, at the discretion of the commissioner:

(a) A monetary fine of not more than ten thousand dollars ($10,000) for each violation; or

(b) A monetary fine of not more than fifty thousand dollars ($50,000) if the commissioner finds that violations have occurred with such frequency as to constitute a general business practice; or

(c) Suspension or revocation of an insurance institution's or agent's license if the insurance institution or agent knew or reasonably should have known it was in violation of this article.

791.20. (a) If any insurance institution, agent or insurance-support organization fails to comply with Section 791.08, 791.09 or 791.10 with respect to the rights granted under those sections, any person whose rights are violated may apply to any court of competent jurisdiction, for appropriate equitable relief.

(b) An insurance institution, agent or insurance-support organization which discloses information in violation of Section 791.13 shall be liable for damages sustained by the individual about whom the information relates. However no individual shall be entitled to a monetary award which exceeds the actual damages

sustained by the individual as a result of a violation of Section 791.13.

(c) In any action brought pursuant to this section, the court may award the cost of the action and reasonable attorney's fees to the prevailing party.

(d) An action under this section shall be brought within two years from the date the alleged violation is or should have been discovered.

(e) Except as specifically provided in this section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of this act.

791.21. No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with this chapter, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent or insurance-support organization; provided, however, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

791.22. Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent or insurance-support organization under false pretenses shall be fined not more than ten thousand dollars ($10,000) or imprisoned for not more than one year, or both.

791.23. The rights granted under Sections 791.08, 791.09 and 791.13 shall take effect on October 1, 1981, regardless of the date of the collection or receipt of the information which is the subject of such sections. Nothing contained in subdivisions (k) and (l) of Section 791.13, or in any other provision of this article, shall in any way affect the provisions of Section 770.1.

791.26. Where an authorization from the individual was granted to a

nonprofit hospital service plan prior to October 1, 1981, such authorization shall be deemed to be in compliance with this article.

791.27. A disability insurer that provides coverage for hospital, medical, or surgical expenses shall not release any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan unless authorized to do so by the employee. An insurer that has, pursuant to an agreement, assumed the responsibility to pay compensation pursuant to Article 3 (commencing with Section 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall not be considered an employer for the purposes of this section. Nothing in this section prohibits a disability insurer from releasing relevant information described in this section for the purposes set forth in Chapter 12 (commencing with Section 1871) of Part 2 of Division 1.

INSURANCE CODE
SECTION 795-795.7

795. It is the purpose of this article to provide a means of more adequately meeting the needs of persons who are 65 years of age or older and their spouses for insurance coverage against financial loss from accident or disease through the combined resources and experience of a number of insurers; to make possible the fullest extension of such coverage by encouraging insurers to combine their resources and experience and to exercise their collective efforts in the development and offering of policies of such insurance to all such applicants at costs lower than those generally available through individual insurers; and to regulate the joint activities herein authorized in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), as amended.

795.1. Wherever used in this article, the following terms shall have the meanings hereinafter set forth or indicated, unless the

context otherwise requires:

(a) "Association" means a voluntary unincorporated association formed for the purpose of enabling co-operative action to provide disability insurance in accordance with this article in this or any other state having legislation enabling the issuance of insurance of the type provided in this article.

(b) "Insurer" means any insurance company which is authorized to transact disability insurance in this State.

(c) "Extended health insurance" means hospital, surgical and medical expense insurance provided by a policy issued as provided by this article.

795.2. Notwithstanding any other provision of this code or any other law which may be inconsistent herewith, any insurer may join with one or more other insurers to plan, develop, underwrite, and offer and provide to any person who is 65 years of age or older and to the spouse of such person, extended health insurance against financial loss from accident or disease, or both. Such insurance may be offered, issued and administered jointly by two or more insurers by a group policy issued to a policyholder through an association formed for the purpose of offering, selling, issuing and administering such insurance. The policyholder may be an association, a trustee, or any other person. Any such policy may provide, among other things, that the benefits payable thereunder are subject to reduction if the individual insured has any other coverage providing hospital, surgical or medical benefits whether on an indemnity basis or a provision of service basis resulting in such insured being eligible for more than 100 percent of covered expenses which he is required to pay, and any insurer issuing individual policies providing extended hospital, surgical or medical benefits to persons 65 years of age and older and their spouses may also use such a policy provision. A master group policy issued to an association or to a trustee or any person appointed by an association for the purpose of providing the insurances described in this article shall be another form of group disability insurance.

Any form of policy approved by the commissioner for an association shall be offered throughout California to all persons 65 and older and their spouses, and the coverage of any person insured under such a form of policy shall not be cancelable except for nonpayment of premiums unless the coverage of all persons insured under such form of policy is also canceled.

795.25. Any association, organized in accordance with this article, may offer, issue and administer a policy, or policies, designed to specifically meet the requirements of any federal or state program for provision of health care to segments of the population over 65 years of age. In any case where such a federal or state program is designed to also meet the health care needs of segments of the population under age 65, including, but without limitation, the health care needs of families with dependent children, the blind, the disabled, and the otherwise medically indigent, insurance under such policy or policies may be made available to beneficiaries of such program under age 65. Such an association may also perform administrative services in connection with any such program under contract with the federal government, the state, any agency of either, or any other entity.

795.3. Notwithstanding the provisions of Section 755.5 of this code, any person licensed to transact disability insurance as an insurance agent, insurance broker, insurance solicitor or life agent may transact extended health insurance and may be paid a commission thereon in accordance with commission schedules filed with the commissioner as required by Section 795.5 of this code.

795.4. Any association formed for the purposes of this article may hold title to property, may enter into contracts, and may limit the liability of its members to their respective pro rata shares of the liability of such association. Any such association may sue and be sued in its associate name and for such purpose only shall be treated as a domestic corporation. Service of process against such association, made upon a managing agent, any member thereof or any agent authorized by appointment to receive service of process, shall have the same force and effect as if such service had been made upon all members of the association. Such association's books and records shall also be subject to examination under the provisions of Sections 730-738, inclusive, either separately or concurrently with examination of any of its member insurers.

795.5. The forms of the policies, applications, certificates or other evidence of insurance coverage, commission schedules and applicable premium rates relating thereto shall be filed with the commissioner. No such policy, contract, certificate or other evidence of insurance, application or other form shall be sold, issued or used and no endorsement shall be attached to or printed or stamped thereon unless the form thereof shall have been approved by the commissioner or 30 days shall have expired after such filing without written notice from the commissioner of disapproval thereof. The commissioner shall disapprove the forms for such insurance if he finds that they are unjust, unfair, inequitable, misleading or deceptive or that the rates are by reasonable assumptions excessive in relation to the benefits provided. In determining whether such rates by reasonable assumptions are excessive in relation to the benefits provided, the commissioner shall give due consideration to past and prospective claim experience, within and outside this State, and to fluctuations in such claim experience, to a reasonable risk charge, to contribution to surplus and contingency funds, to past and prospective expenses, both within and outside this State, and to all other relevant factors within and outside this State including any differing operating methods of the insurers joining in the issue of the policy. In exercising the powers conferred upon him by this section, the commissioner shall not be bound by any other requirement of this code with respect to standard provisions to be included in disability policies or forms.

The commissioner may, after hearing upon written notice, withdraw an approval previously given, upon such grounds as in his opinion would authorize disapproval upon original submission thereof. Any such withdrawal of approval after hearing shall be by notice in writing specifying the ground thereof and shall be effective at the expiration of such period, not less than 90 days after the giving of notice of withdrawal, as the commissioner shall in such notice prescribe.

If and when a program of hospital, surgical and medical benefits is enacted by the federal government or the State of California, the extended health insurance benefits provided by policies issued under this article shall be adjusted to avoid any duplication of benefits offered by the federal or state programs and the premium rates applicable thereto shall be adjusted to conform with the adjusted benefits.

The association shall submit an annual report to the Insurance Commissioner which shall become public information and shall provide information as to the number of persons insured, the names of the insurers participating in the association with respect to insurance

offered under this article and the calendar year experience applicable to such insurance offered under this article, including premiums earned, claims paid during the calendar year, the amount of claims reserve established, administrative expenses, commissions, promotional expenses, taxes, contingency reserve, other expenses, and profit and loss for the year. The commissioner shall require the association to provide any and all information concerning the operations of the association deemed relevant by him for inclusion in the report.

795.6. The articles of association of any association formed in accordance with this article, all amendments and supplements thereto, a designation in writing of a resident of this State as agent for the service of process, and a list of insurers who are members of the association and all supplements thereto shall be filed with the commissioner.

The name of any association or any advertising or promotional material used in connection with extended health insurance to be sold, offered, or issued, pursuant to this article shall not be such as to mislead or deceive the public.

795.7. No act done, action taken or agreement made pursuant to the authority conferred by this article shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this State heretofore or hereafter enacted which does not specifically refer to insurance.

INSURANCE CODE
SECTION 796.01-796.04

796.01. Disability insurers and nonprofit hospital service plans shall, upon rejecting a claim from a health care provider or a patient, and upon their demand, disclose the specific rationale used in determining why the claim was rejected. Nothing in this section is intended to expand or restrict the ability of a health care provider or a patient from having health care coverage approved in advance of services.

796.02. Compensation of a person retained by a disability insurer to review claims for health care services shall not be based on either of the following:

(a) A percentage of the amount by which a claim is reduced for payment.

(b) The number of claims or the cost of services for which the person has denied authorization or payment.

796.03. This article does not apply to services or benefits provided pursuant to Medi-Cal, including services or benefits provided under Chapters 7 (commencing with Section 14000) and 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

796.04. A disability insurer that provides coverage for hospital, medical, or surgical expenses and a nonprofit hospital service plan that authorizes a specific type of treatment for services covered under a policyholder's contract or plan by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available or the terms and conditions of the contract as may be agreed upon between a policyholder, certificate holder, or trust, and the insurer.

INSURANCE CODE
SECTION 799-799.10

799. The purposes of this article are to establish standards for the performance by life and disability income insurers of their duty to avoid making or permitting unfair distinctions between individuals of the same class in the underwriting of life or disability income insurance for the risks of acquired immune deficiency syndrome (AIDS) and AIDS-related conditions (ARC); to establish mandatory and uniform minimum standards for assessing AIDS and ARC risks for

determining insurability which are deemed to be sufficiently reliable to be used for life and disability income insurance risk classification and underwriting purposes; to require the maintenance of strict confidentiality of personal information obtained through testing; and to require informed consent before any insurer tests for HIV.

799.01. As used in this article:

(a) "ELISA" test means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus.

(b) "Positive ELISA test" means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same specimen.

(c) "Western Blot Assay" means an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus.

(d) "Reactive Western Blot Assay" means a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

(e) "HIV antibody test" means an ELISA test or a Western Blot Assay, or both.

(f) "Life or disability income insurer" means an insurer licensed to transact life insurance or disability insurance in this state or a fraternal benefit society licensed in this state.

(g) "Certificate" means a certificate of group life insurance or group disability income insurance delivered in this state, regardless of the situs of the group master policy.

(h) "Policy" means an individual life insurance policy or individual disability income insurance policy delivered in this state or a certificate of life insurance benefits or disability income insurance benefits delivered in this state by a fraternal benefit society.

(i) "Disability income insurance" means insurance against loss of occupational earning capacity arising from injury, sickness, or disablement.

799.02. Notwithstanding subdivision (f) of Section 120980 of the Health and Safety Code or any other provisions of law, a life or disability income insurer may decline a life or disability income insurance application or enrollment request on the basis of a positive ELISA test followed by a positive Western Blot Assay performed by or at the direction of the insurer on the same specimen of the applicant.

This authorization applies only to policies, certificates, and applications for coverage (a) that are issued, delivered, or received on or after the effective date of the urgency statute amending this section enacted during the 1989 portion of the 1989-90 Regular Session and (b) the issuance or granting of which is otherwise contingent upon medical review for other diseases or medical conditions to be effective.

This article shall not be construed to prohibit an insurer from declining an application or enrollment request for insurance because the applicant has been diagnosed as having AIDS or ARC by a medical professional.

799.03. No insurer shall test for HIV or for the presence of antibodies to HIV for the purpose of determining insurability other than in accordance with the informed consent, counseling, and privacy protection provisions of this article and Article 6.6 (commencing with Section 791). Notwithstanding any other provision of law, this constitutes the exclusive requirements for counseling, informed consent, and privacy protection for that testing.

(a) An insurer that requests an applicant to take an HIV-related test shall obtain the applicant's written informed consent for the test. Written informed consent shall include a description of the test to be performed, including its purpose, potential uses, and limitations, the meaning of its results, procedures for notifying the applicant of the results, and the right to confidential treatment of the results. Prior to the applicant's execution of the consent, the insurer shall:

(1) Provide the applicant printed material describing HIV, its causes and symptoms, the manner in which it is spread, the test or tests used to detect HIV or the HIV antibody, and what a person can do whose test results are positive or negative.

(2) Provide the applicant a list of counseling resources available, where the applicant can obtain assistance in understanding

the meaning of the test and its results. The list may be provided from publicly available information.

(b) The insurer shall notify an applicant of a positive test result by notifying the applicant's designated physician. If the applicant tested has not given written consent authorizing a physician to receive the test results, the applicant shall be urged, at the time the applicant is informed of the positive test results, to contact a private physician, the county department of health, the State Department of Health Services, local medical societies, or alternative test sites for appropriate counseling.

(c) The commissioner shall develop and adopt standardized language for the informed consent disclosure form required by this section to be given to any applicant for life or disability income insurance who takes an HIV-related test.

799.04. A life or disability income insurer may not require an applicant to undergo an HIV antibody test unless the cost of the test is borne by the insurer.

799.05. No life or disability income insurer shall consider the marital status or known or suspected homosexuality or bisexuality of an applicant for life insurance or disability income insurance in determining whether to require an HIV antibody test of that applicant.

799.06. All underwriting activities undertaken by insurers pursuant to this article shall be subject to all applicable provisions of Article 6.6 (commencing with Section 791). On and after January 1, 1990, no application or enrollment request for life or disability income insurance shall contain a question pertaining to prior testing for HIV antibodies, unless the question is limited in scope to prior testing for the purpose of obtaining insurance.

799.07. If an applicant has had a positive ELISA test result or a positive Western Blot Assay or both, a life or disability income insurer shall not report a code to an insurance support organization as defined in Section 791.02 or another insurer unless a nonspecific

test result code is used which does not indicate that the individual was subject to testing related to the human immunodeficiency virus.

799.08. No policy or certificate shall limit benefits otherwise payable if loss is caused or contributed to by AIDS or ARC unless the insurer could have declined the application or enrollment request of the insured as provided in Section 799.02.

799.09. No life or disability income insurer shall require an HIV antibody test if the results of the test would be used exclusively or nonexclusively for the purpose of determining eligibility for hospital, medical, or surgical insurance coverage or eligibility for coverage under a nonprofit hospital service plan or health care service plan.

799.10. (a) This section shall apply to the disclosure of the results of HIV antibody tests requested by an insurer pursuant to this article and, notwithstanding the provisions of Section 120980 of the Health and Safety Code, Section 120980 of the Health and Safety Code does not apply to the disclosure of the results of HIV antibody tests conducted pursuant to this article.

(b) Any person who negligently discloses results of an HIV antibody test to any third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Section 1603.1 or 1603.3 of the Health and Safety Code, shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of an HIV antibody test to any third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Section 1603.1 or 1603.3 of the Health and Safety Code, shall be assessed a civil penalty in an amount not less than one thousand

dollars ($1,000) and not more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of an HIV antibody test to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Section 1603.1 or 1603.3 of the Health and Safety Code, that results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor punishable by imprisonment in the county jail for a period not to exceed one year, by a fine of not to exceed ten thousand dollars ($10,000), or by both that fine and imprisonment.

(e) Any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or psychological harm that is a proximate cause of the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) "Written authorization," as used in this section, applies only to the disclosure of test results by a person responsible for the care and treatment of the person subject to the test. Written authorization is required for each separate disclosure of the test results, and shall include to whom the disclosure would be made.

INSURANCE CODE
SECTION 800-804

800. This article shall not apply to:

(a) Insurers made exempt therefrom by other provisions of this code.

(b) Insurance upon the interests of common carriers engaged in interstate trade, or upon property in their custody.

(c) Insurance contracts executed without this state, but which during the term thereof temporarily cover subject matter within this state.

(d) Bid bonds issued by any admitted insurer in connection with any public or private contract.

801. The amendments made in any sections contained in this article by the Statutes of the 1969 Regular Session of the Legislature shall not repeal, rescind or affect the interpretation of Article 1.5 (commencing with Section 685) of Chapter 1 of Part 2 of Division 1 of, or Section 1750.5 of this code.

802. Any admitted insurer may, by means of temporary binders, execute contracts of insurance at offices outside this state upon subject matter located in this state if policies therefor are thereafter issued by it.

803. (a) No admitted insurer shall assume or reinsure the liabilities of a nonadmitted insurer upon subject matter located in this state for the purpose of circumventing the rate and form provisions of this code, or the nonadmitted insurer provisions in Chapter 6 (commencing with Section 1760) of Part 2, and their implementing regulations. Notwithstanding Section 804, if, after notice and hearing, the commissioner determines that a reinsurance agreement was entered into in violation of this section, then the insurer shall be subject to a fine not to exceed five thousand dollars ($5,000), for each such reinsurance agreement, and the commissioner may enter any other corrective order he or she deems necessary.

(b) The commissioner shall issue a bulletin to govern the reporting to the department by admitted insurers of their reinsurance transactions with nonadmitted insurers. The bulletin shall specify the types of reinsurance subject to reporting, the amounts which shall be reported, and the manner in which that information shall be reported. The bulletin shall require reporting of sufficient information to enable the department to evaluate compliance with subdivision (a).

804. Any insurer willfully violating any provision of this article is guilty of a misdemeanor and is punishable by a fine not exceeding one thousand dollars ($1,000) for each violation thereof, or the commissioner may suspend the certificate of authority of such insurer for the remainder of the term thereof.

INSURANCE CODE
SECTION 810

810. An admitted insurer, without first obtaining the written consent of the commissioner, shall not enter into any agreement or arrangement with any nonadmitted insurer by way of sale, reinsurance, merger, consolidation, assumption, or in any other manner which results in the admitted insurer ceasing to service in this state any group insurance contract or 10 or more individual insurance contracts entered into in this state or issued for delivery in this state insuring the life or person of any resident of this state or any property in this state.

Service as used in this section includes but is not limited to:

(a) Adjustment and payment of losses.

(b) Appropriate amendment of insurance contracts as called for therein to keep the coverage consistent with current conditions.

(c) Collection of premiums.

(d) Issuance of policies, certificates and other documents, in fulfillment of prior agreements.

(e) Returning unearned premiums.

(f) Payment of cash values.

No admitted insurer shall in whole or in part or in any manner so cease to so service such insurance business without such written consent from the commissioner unless it has by valid contract arranged for an admitted insurer to perform such servicing.

This section shall not affect or modify any of the provisions of this code relating to statement credit allowed for reinsurance.

Violation of this section constitutes a failure to comply with the laws of this state regarding the governmental control of insurers within the meaning of Section 701.

INSURANCE CODE
SECTION 815-816

815. No insurer shall pay any representative given discretion as to the settlement or adjustment of claims under life or disability policies, whether in direct negotiation with the claimant or in

supervision of the person negotiating, a compensation which in any way is contingent upon the amount of settlement of such claims.

816. No insurer shall pay any person given discretion as to settlement of claims under any policy of insurance, or surety bond, whether in direct negotiation with the claimant or in supervision of the person negotiating, a compensation which in any way is contingent upon the amount of settlement of such claims, except as in this section otherwise expressly provided.

This section shall apply equally to a single claim, a number of specified claims, an aggregate of claims during a specified period of time or an aggregate of claims under any contract, agreement or arrangement.

This section shall not affect the interpretation or provisions of Section 815.

The word "person" as used in this section includes, but is not limited to: employees, agents, brokers, representatives, general agents, managing general agents, surplus line brokers, insureds, coinsureds, adjusters and independent contractors but does not include attorneys in fact or other exclusive managers of an insurer.

This section does not apply to:

(a) Compensation of a producer, managing general agent, surplus line broker or general agent under any arrangement, agreement or contract whereby the producer or general agent is not granted discretion in the actual adjustment or settlement of any or all individual claims settled for an amount exceeding five hundred dollars ($500).

(b) A producer, managing general agent, surplus line broker or general agent who is compensated by a contingent commission arrangement based wholly or partly on underwriting results, unless the arrangement guarantees an agreed return to the insurer which may exceed the underwriting profit actually earned by the insurer on business written through the producer, managing general agent, surplus line broker or general agent.

(c) Contracts of reinsurance between insurers.

(d) An arrangement, schedule of charges, agreement or contract, express or implied, for the adjustment of claims under which the compensation for the services of the person making the adjustment (exclusive of reimbursement for actual expenses) consistently increases, in reasonable brackets, as the amount paid in settlement

of a claim increases.

An insurer which in any other jurisdiction is making payments which would be in violation of this section if made in respect to insurance business done in this state shall not be admitted to this state until it presents evidence satisfactory to the commissioner that it will not make such payments in this state and that it will within one year after admission to this state cease to make any such payments in any other jurisdiction and, within the same period, terminate any contract or arrangement under which such payments are to be paid. Failure to so cease such payments and to so terminate such contracts and arrangements within such period of one year shall constitute grounds for revocation of the insurer's certificate of authority.

INSURANCE CODE
SECTION 820-860

820. The terms used in this article shall be given the meanings herein set forth, but such meanings shall not, merely by reason of enactment in this article, govern the interpretation of any other provision of this code.

821. "Security" means every instrument commonly known by that term, except:

(a) Commercial paper when issued, given or acquired in a bona fide way in the ordinary course of legitimate business, trade or commerce.

(b) Promissory notes, whether secured or unsecured, if not offered to the public, and if not sold to an underwriter of the sale for the purpose of resale.

(c) Mortgage participation certificates issued under and in accordance with the provisions of Chapter 2, Part 6, Division 2.

(d) Policies of insurance issued by an insurer.

821.5. Without in any manner affecting the scope of the term "security" as set forth in section 821, and with the exceptions therein set forth, the following instruments are particularly

specified as securities within the meaning of that section: every stock, bond, note, treasury stock, debenture, evidence of indebtedness, certificate evidencing a contribution, certificate of interest or participation, certificate of interest in a profit sharing agreement, collateral trust certificate, any transferable share, investment contract, or beneficial interest in title to property, contracts or earnings.

822. Except as otherwise provided by this article, "sale" or "sell" means every disposition, or attempt or arrangement to dispose, of a security or interest in a security for value, whether done by direct or indirect means. A security is conclusively presumed to be sold for value if given with any purchase of any nature or if given as a bonus on account of a purchase. "Sale" or "sell" shall also mean a contract of sale, an exchange, any change in the rights, preferences, privileges or restrictions on outstanding securities, an attempt to sell, an option of sale, a solicitation of a sale, a subscription or an offer to sell directly or by an agent, or a circular letter, advertisement or otherwise.

823. (a) A privilege pertaining to a security giving the holder the privilege to convert such security into another security of the same insurer is not a sale of such other security.

(b) A right pertaining to a security and entitling the holder of such right to subscribe to another security of the same insurer is not a sale of such other security, but the sale of such other security upon the exercise of such right shall be subject to the provisions of this article.

824. "Broker" means every person, other than an agent, who in this state engages either wholly or in part in the business of (a) dealing in any security issued by others, (b) underwriting any issue of such securities, (c) purchasing such securities with the purpose of reselling them, or (d) offering such securities for sale to the public. No authority to act as a broker may be implied from an appointment executed by an insurer appointing an agent of that insurer.

825. "Agent" means every person employed or appointed by an insurer

or broker who, within this State and for a compensation, sells any security.

826. "Insurer" for the purposes of this article includes every organization organized for the purpose of assuming the risk of loss under contracts of insurance or reinsurance, and also includes any of the following organizations:

(a) An admitted insurer,

(b) A nonadmitted domestic insurer,

(c) A nonadmitted foreign insurer,

(d) A nonadmitted alien insurer,

(e) An underwritten title company, or an organization organized for the purpose of doing an underwritten title business, whether licensed or not, and

(f) An attorney in fact of a reciprocal or interinsurance exchange, whether it be admitted or not, or an organization organized for the purpose of acting as the attorney in fact of a reciprocal, or interinsurance exchange, whether the same be admitted or not.

"Insurer" shall not include, unless specified in subdivisions (a) through (f), inclusive, an organization, which though required to obtain a certificate or license from the commissioner, is organized or to be organized primarily for purposes other than assuming the risk of loss under contracts or agreements of insurance.

The amendments of this section by the Legislature at the 1965 Regular Session, except as they relate to underwritten title companies, attorneys in fact, and exclusive managers, shall be construed as a restatement and continuation of the law existing prior to such amendment. Every permit issued by the commissioner or the Commissioner of Corporations to an insurer as defined in this section prior to its amendment by the Legislature at 1965 Regular Session shall be valid and effective for all purposes stated therein, from the date of its issuance until the date of expiration stated therein.

Every permit issued by the commissioner under the authority of former subdivision (g) of this section from the date such subdivision became effective in 1965 until the effective date of the amendment to this section at the 1970 Regular Session of the Legislature shall be valid and effective for all purposes stated therein, from the date of its issuance until the expiration date specified therein.

827. An insurer shall not sell in this state, except upon a sale

for delinquent assessment made in accordance with the provisions of Section 423 of the Corporations Code, or offer for sale, negotiate for the sale of, or take subscriptions for any security of its own issue until it shall have first applied for and secured from the commissioner a permit authorizing it so to do.

827.3. (a) As used in this section, the term "insurer" means an insurer which is domestic and admitted.

(b) The transactions of an insurer set out in subdivisions (c) and (d) are exempt from Section 827 if they meet all of the following requirements:

(1) They are not accompanied by an advertisement and no selling expenses have been given, paid, or incurred in connection therewith.

(2) No consideration has been given, paid, or incurred in connection with them.

(3) Within 30 days after the transaction, the insurer notifies the commissioner in writing of its occurrence. The notice shall describe the transaction, including the transaction date, the number and par value of shares issued, and the purpose of the transaction. The notice shall be executed under penalty of perjury.

(c) Par value increases resulting from a transfer of gross paid-in surplus to capital.

(d) Shares issued or distributed by an insurer as dividends to existing holders of shares of the insurer, on a pro rata basis according to the shares previously held by each holder, provided the new shares are of the same class and par value and have the same rights, preferences, privileges, and restrictions as the outstanding shares.

(e) Any transfer of surplus to paid-up capital pursuant to subsection (d) shall not be deemed consideration for purposes of this section.

(f) Notwithstanding this section, the applicable notice provisions, contained in subdivision (e) of Section 1215.4, shall apply to those transactions set forth in subdivision (d).

827.5. The term "insurer" as used in this section shall not include domestic insurers as defined in Section 26.

The following transactions of an insurer described in subdivisions (a), (c), (d), and (f) of Section 826 shall be exempt from the

provisions of this article:

(a) Any negotiations or agreements prior to general solicitation for the approval of the shareholders of said insurer and subject to such approval, of a change in the rights, preferences, privileges or restrictions of or on outstanding securities or a merger, consolidation or sale of corporate assets in consideration of the issuance of securities.

(b) Any change in the rights, preferences, privileges, or restrictions of or on outstanding securities of such insurer, unless the holders of at least 25 percent of the outstanding shares or units of any class of securities which will be directly or indirectly affected substantially and adversely by such change have addresses in this state according to the records of such insurer; or

(c) Any exchange incident to a merger, a consolidation, an acquisition of outstanding stock, or a sale of corporate assets in consideration of the issuance of securities of another insurer or corporation, unless at least 25 percent of the outstanding shares of any class, the holders of which are to receive securities in the exchange of the surviving, consolidated, or purchasing corporation or insurer, are held by persons who have addresses in this state according to the records of such corporation or insurer of which they are shareholders.

(d) For the purposes of subdivision (b) and subdivision (c) of this section, (1) any securities held to the knowledge of the issuer in the names of a broker as defined in Section 824 or nominees of such broker and (2) any securities controlled by any one person who is not a resident of the State of California who controls directly or indirectly 50 percent or more of the outstanding securities of that class, shall not be considered outstanding. The determination of whether 25 percent of the outstanding securities are held by persons having addresses in this state, for the purposes of subdivision (b) and subdivision (c) of this section, shall be made as of the record date for the determination of the security holders entitled to vote on or consent to the action, if approval of such holders is required, or if not as of the date of directors' approval of such action.

(e) Any change (other than a stock split or reverse stock split) in the rights, preferences, privileges, or restrictions of or on outstanding shares, except the following if they materially and adversely affect any class of shareholders: (1) to add, change, or delete assessment provisions; (2) to change the rights to dividends thereon; (3) to change the redemption provisions; (4) to make them redeemable; (5) to change the amount payable on liquidation; (6) to change, add, or delete conversion rights; (7) to change, add, or delete voting rights; (8) to change preemptive rights; (9) to change,

add, or delete sinking fund provisions; (10) to rearrange the relative priorities of outstanding shares; (11) to impose, change, or delete restrictions upon the transfer of shares in the articles of incorporation or bylaws; (12) to change the right of shareholders with respect to the calling of special meetings of shareholders; or (13) to change, add, or delete any rights, preferences, privileges, or restrictions of, or on, the outstanding shares or memberships of a mutual water company or other corporation organized primarily to provide services or facilities to its shareholders or members.

(f) Any stock split or reverse stock split, except the following: (1) any stock split or reverse stock split if the corporation has more than one class of shares outstanding and the split would have a material effect on the proportionate interests of the respective classes as to voting, dividends or distributions; (2) any stock split of a stock which is traded in the market and its market price as of the date of directors' approval of the stock split adjusted to give effect to the split was less than two dollars ($2) per share; or (3) any reverse stock split if the corporation has the option of paying cash for any fractional shares created by such reverse split and as a result of such action the proportionate interests of the shareholders would be substantially altered. Any shares issued upon a stock split or reverse stock split exempted by this subdivision shall be subject to any conditions previously imposed by the commissioner applicable to the shares with respect to which they are issued.

(g) Any change in the rights of outstanding debt securities, except the following if they substantially and adversely affect any class of securities: (1) to change the rights to interest thereon; (2) to change their redemption provisions; (3) to make them redeemable; (4) to extend the maturity thereof or to change the amount payable thereon at maturity; (5) to change their voting rights; (6) to change their conversion rights; (7) to change sinking fund provisions; or (8) to make them subordinate to other indebtedness.

827.6. Any offer or sale of voting common stock by an insurer incorporated in this state shall be exempt from the provisions of this article if, immediately after the proposed sale and issuance, there will be only one class of stock of such insurer outstanding which is owned beneficially by no more than one domestic insurer, providing all of the following requirements have been met:

(1) All such stock shall be evidenced by certificates which have

been stamped or printed prominently on their face a legend in a form to be prescribed by rule of the commissioner restricting the transfer of such stock in such manner as the rule provides.

(2) The offer and sale of such stock is not accompanied by the publication of any advertisement, and no selling expenses have been given, paid, or incurred in connection therewith.

(3) The consideration to be received by the issuer for the stock to be issued shall consist of only cash or cancellation of indebtedness for money borrowed or both upon the initial organization of the issuer, provided all such stock is issued for the same price per share.

(4) No promotional consideration has been given, paid, or incurred in connection with such issuance. Promotional consideration means any consideration paid directly or indirectly to a person who, acting alone or in conjunction with one or more other persons, takes the initiative in founding and organizing the business or enterprise of the issuer, for services rendered in connection with such founding or organizing.

827.7. Where required by this article the commissioner is authorized to issue subscription and preorganization permits of and pertaining to insurers or proposed insurers. Applications for such permits shall set forth such of the matters described in Sections 834, 835, 836 and 837 as the commissioner deems appropriate or requires.

827.8. An offer or sale of voting common stock or preferred stock of and by a foreign or alien insurer to fire and casualty broker-agents, as defined in Section 33.5, shall be exempt from the requirements of this article if all of the following requirements are met:

(a) The sale shall not be made to more than 35 fire and casualty broker-agents in the State of California.

(b) Each fire and casualty broker-agent to whom an offer is made is an "accredited investor" as defined in Regulation D under the Federal Securities Act of 1933, as amended.

(c) Each fire and casualty broker-agent to whom an offer is made meets all of the following requirements:

(1) The broker-agent shall have been appointed by the admitted insurer for a period of at least one year and that admitted insurer

shall meet all of the following requirements:

(A) Be authorized to transact property and casualty insurance. For purposes of this section, property and casualty insurance means insurance falling within classes 2, 3, 7, 8, 10, 11, 12, 14, 15, 16, 18, and 20 under Section 100 except home protection contracts, as defined in Section 12740.

(B) Have at least four hundred million dollars ($400,000,000) of statutory capital and surplus.

(C) Hold a certificate of authority in good standing with this state and have no regulatory action relating to financial hazard or fraud against the company in the last three years from states, including this state, where the insurer is authorized as an admitted insurer to do business.

(D) Is currently reinsuring or has definite plans to reinsure business produced by that broker-agent with the same foreign or alien insurer offering securities to the broker-agent.

(2) The broker-agent generates five million dollars ($5,000,000) in premiums per year and plans on transferring or writing at least one million dollars ($1,000,000) per year with the admitted insurer.

(3) The broker-agent shall pay at least fifty thousand dollars ($50,000) for the securities purchased in the transaction but not in excess of five hundred thousand dollars ($500,000).

(4) The broker-agent shall have a net worth of at least five million dollars ($5,000,000).

(d) The offer and sale of stock is accompanied by the prospectus, private placement memorandum, together with any other information required pursuant to Regulation D of the Federal Securities Act of 1933.

(e) The consideration received by the issuer for the stock to be issued consists solely of cash.

(f) No promotional consideration or selling expenses have been given, paid, or incurred in connection with the issuance of stock, and the offer and sale of stock is not accompanied by the publication of any advertisement.

(g) All stock issued shall be evidenced by a certificate that shall have a notice printed prominently on its face restricting the transfer of the stock solely to the issuer or investors who have been shareholders of the issuer for at least three years and who are approved by at least 51 percent of the members of the board of directors of the issuer.

(h) The issuer of both the common and preferred stock shall be all of the following:

(1) A foreign or alien insurer that does not transact insurance

directly in California, but is solely a reinsurer.

(2) A reinsurer that only reinsures commercial lines property and casualty insurance, as specified in subparagraph (A) of paragraph (1) of subdivision (c).

828. Except in the case of a broker holding a broker's certificate issued by the commissioner under this code or by the Commissioner of Corporations under the Corporate Securities Act and then in effect, a person, desiring or proposing to sell a security to be issued by any insurer, shall not issue, circulate, or publish any advertisement, pamphlet, prospectus, or circular concerning any such security until the insurer secures from the commissioner a permit authorizing it to sell such security.

829. A person shall not issue, circulate, or publish any advertisement or writing concerning any security sold by him, unless either his name is subscribed thereto, and a true copy thereof is filed in the office of the commissioner at least one day prior to the issue, publication, or circulation, or the commissioner first authorizes or consents to the issuance, circulation or publication.

830. A person shall not issue, circulate, or publish any such advertisement or writing after receipt of notice in writing from the commissioner that, in his opinion, the same contains any statement that is false or misleading or otherwise likely to deceive a reader thereof.

831. Every security issued by any insurer without a permit of the commissioner authorizing the same in effect at the time of the issue, shall be void. Every security issued by any insurer under a permit of the commissioner shall be void unless its provisions conform to the provisions, if any, required by the permit.

831.1. Every security of a home protection company issued or authorized to be issued prior to December 31, 1978, shall be valid even though it has been issued without a permit of the commissioner authorizing the same if, at the time of the issue or authorization, the security was qualified or exempt from qualification under the Corporate Securities Law of 1968 (Title 4, Division 1 of the Corporations Code).

Any sale, transfer, hypothecation, or other distribution of a security whose issuance is validated by this section, whether such transaction takes place before or after the effective date of this section is not prohibited by the provisions of this article.

832. Every insurer that commits any of the following acts is guilty of a public offense and punishable by fine not exceeding ten thousand dollars:

(a) Selling or causing to be issued a security contrary to the provisions of this article or not in conformity with the permit of the commissioner.

(b) Applying any of the proceeds of sale of a security to any purpose other than as specified in the permit, or to a purpose specified in the permit, but in excess of the amount limited for that purpose.

833. Every person who commits any of the acts specified in this section is guilty of a public offense and punishable by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment in the state prison, or in a county jail not exceeding one year, or by both such fine and imprisonment.

(a) Knowingly authorizing, directing, aiding, causing, or assisting in causing the issuance, execution, or sale of, any security, in nonconformity with a permit of the commissioner then in effect and authorizing such issuance, or contrary to the provisions of this article.

(b) Knowingly making any false statement or representation in any application to the commissioner, or in any proceeding before him, or in any examination, audit, or investigation made by him, or by his authority.

(c) With knowledge of the falsity, causing to be filed in the office of the commissioner any false statement or representation concerning an insurer, the property which the insurer then holds or

proposes to acquire, the insurer's officers, the insurer's financial condition or other affairs, or the insurer's proposed plan of business.

(d) With knowledge of the falsity of any such statement or representation, causing any security to be issued, executed, or sold without first informing the commissioner of the falsity of such statement in writing.

(e) Directly or indirectly, knowingly causing or assisting in causing any part of the proceeds from the sale of any security to be applied to any purpose contrary to the provisions of the permit authorizing the issuance of such security, or to any purpose in excess of the amount specified in such permit for such purpose.

(f) Selling a security with knowledge that it has been issued or executed in violation of any of the provisions of this article.

(g) Causing a writing concerning a security to be issued, circulated, or published while having knowledge that such matter contains any statement that is false, misleading, or otherwise likely to deceive a reader thereof.

(h) In any respect, willfully violating or failing to comply with any of the provisions of this article.

(i) In any other respect, willfully violating or neglecting to comply with any part of an order or permit of the commissioner under the provisions of this article.

(j) Conspiring with one or more other persons to violate any permit or order issued by the commissioner, or any of the provisions of this article.

834. The application for a permit to issue or sell securities shall be verified as provided in the Code of Civil Procedure for the verification of pleadings, and shall be filed on 81/2 x 11 inch size paper in the office of the commissioner. In the application the applicant shall set forth:

(a) The names and addresses of its officers.

(b) The location of its office.

(c) An itemized account of its financial condition, including the amount and character of its assets and liabilities.

(d) A detailed statement of the plan upon which it proposes to transact business.

(e) A copy of any security it proposes to issue.

(f) A copy of any contract it proposes to make concerning the same.

(g) A copy of any prospectus or advertisement, or other description of such securities, then prepared by it for distribution

or publication.

(h) Such additional information concerning the company, its condition and affairs as the commissioner requires.

835. If the applicant is a partnership, unincorporated association, or joint stock company, it shall file with its application a copy of its articles of partnership or association, and all other papers pertaining to its organization.

836. If the applicant is a corporation, it shall file with its application a copy of all minutes of any proceedings of its directors, stockholders, or members, relating to or affecting the issue of such securities, and also a copy of its articles of incorporation, by-laws, and any amendments to either thereof.

837. If the applicant is a foreign corporation or association, it shall also file with its application:

(a) A certificate of the proper officer of the jurisdiction in which it is organized, executed not more than 30 days before the filing of such application, showing that the applicant is authorized to transact business in that jurisdiction.

(b) In such form as the commissioner prescribes, its written instrument, irrevocably appointing the commissioner and his successor in office its true and lawful attorney upon whom all process in any action or proceeding against it can be served. Such service shall have the same effect as if the applicant was a domestic insurer lawfully served with process in this State.

838. Upon the filing of such application, the commissioner shall examine it and the other papers and documents filed therewith. He may, if he deems it advisable, cause to be made a detailed examination, audit, and investigation of the applicant and its affairs.

838.5. Pursuant to this code, the commissioner has been and is

authorized, in the instance of an application for a permit to issue securities in exchange for one or more bona fide outstanding securities, claims or property interest, or partly in such exchange and partly for cash, to approve the terms and conditions of such issuance and exchange and the fairness of such terms and conditions, after a hearing upon the fairness of such terms and conditions, to which all persons to whom it is proposed to issue securities in such exchange shall have the right to appear.

839. The commissioner shall issue a permit if he finds that:

(a) The proposed plan of business of the applicant and the proposed issuance of securities are fair, just, and equitable.

(b) The applicant intends fairly and honestly to transact its business, and

(c) The securities the applicant proposes to issue and the methods to be used by it in issuing or disposing of them are such as, in his opinion, will not work a fraud upon the purchaser thereof, or upon policyholders or other security holders of applicant.

Otherwise, he shall deny the application and notify the applicant in writing of his decision.

839.1. (a) In any case where a domestic insurer is directly affected by the total transaction for some part of which the permit applied for is needed, and the commissioner in his discretion determines that reasonable grounds exist for contentions that such total transaction or any part thereof:

(1) Is a combination of capital, skill, or acts to create or carry out restrictions on or to prevent competition in the insurance business; or

(2) Is a combination (in the form of a trust or otherwise) in restraint of the insurance business; or

(3) Is an attempt to monopolize the insurance business; or

(4) Is a conspiracy to create any of the foregoing; or

(5) That such total transaction, or any part thereof, if consummated will create or result in any of the foregoing or will substantially lessen competition in the insurance business.

Then, in such event, the Insurance Commissioner may make findings with respect to whether such total transaction, or any part thereof, would or would not do or be any of the foregoing.

(b) In the event the Insurance Commissioner makes affirmative findings as provided in subdivision (a) of this section, he may deny

the permit applied for.

839.5. The commissioner shall not issue a permit for the sale of any securities of a domestic insurer in any case where he finds that the expense of organization, exclusive of attorney fees, accountant fees, and actuary fees, will exceed 12 percent of the total amount actually paid for the capital stock.

840. The commissioner may prescribe in the permit the amounts, considerations, terms, and conditions governing the issue and disposal of the securities and the permit authorizes such issue and disposal only in accordance with its provisions.

841. Every permit shall recite in bold type that the issuance thereof is permissive only and does not constitute a recommendation or endorsement of the securities permitted to be issued.

842. The commissioner may impose conditions requiring the deposit in escrow of securities and the impoundment of the proceeds from the sale thereof, limiting the expense in connection with the sale thereof, and otherwise requiring such method of dealing as he deems reasonable and either necessary or advisable to insure the disposition of the proceeds of such securities in the manner and for the purposes provided in the permit.

843. The commissioner may, from time to time and for cause, amend, alter or revoke any permit issued by him hereunder, or temporarily suspend the rights thereunder of the applicant. He also may establish such rules and regulations as are reasonable or necessary to carry out the purposes and provisions of this article.

In establishing any such rules and regulations the commissioner is expressly authorized, irrespective of the other provisions of this section or this article, to specify different and simplified forms

for both applications and permits where a foreign insurer, whether admitted or not, is seeking to sell or issue securities of its own issue to persons in this state and meets all the following standards:

(a) It has, prior to filing the application, made a filing with the Securities and Exchange Commission;

(b) It (or a predecessor) has been lawfully engaged in the insurance business for at least five years and currently is admitted to transact insurance in at least five states;

(c) It currently has admitted assets of at least five million dollars ($5,000,000); and

(d) It has, prior to filing the application, obtained a written permit or consent to issue such securities from the authority in its domiciliary state having jurisdiction over issuances of its securities and the statutory standards for obtaining such permit or consent are comparable to the like standards of this state.

844. Every insurer authorized by the commissioner to sell securities shall thereafter, at such times and in such form as he requires, make and file in his office a report, setting forth:

(a) The securities sold by it under the authority of any permit issued by him.

(b) The proceeds derived therefrom.

(c) The disposition of such proceeds.

(d) Such other information concerning its property, officers, or affairs, and relating to or affecting the value of such securities, as the commissioner requires.

845. (a) No person may sell or resell any security of a domestic, foreign, or alien insurer:

(1) As an insurer with respect to securities of its own issue without securing the permit of the commissioner as provided in this article.

(2) As an agent of such insurer except under authority of a certificate issued by the commissioner under this code.

(3) As a broker or as an agent for a broker except under authority of a certificate or license issued by the Commissioner of Corporations under the provisions of the Corporations Code and in full conformity with all provisions of the Corporations Code.

(b) Subdivision (a) shall not prohibit a bona fide owner of

securities of an insurer from selling or reselling such securities if:

(1) Such securities were originally issued under the authority of a permit of the commissioner and such sale or resale is made in conformity with the conditions, if any, in such permit effective at the time of such sale or resale; or

(2) Such securities were originally issued in a jurisdiction other than California in full conformity with the applicable laws, if any, governing such issuance in such jurisdiction.

A sale or resale of securities of an insurer by the owner of the securities which is made for the purpose of evading the provisions of this article requiring an insurer to secure a permit from the commissioner or for any other fraudulent purpose shall, however, be null and void and a violation of the criminal provisions of this article.

(c) Any sale or resale permitted by this section is subject to the stop power of the commissioner under Section 854 and the similar powers of the Commissioner of Corporations pursuant to the provisions of the Corporations Code.

(d) Any violation of this section is subject to the penalties provided in Section 833.

845.5. The certificate required by Section 845 to act as an agent of an insurer shall be secured as provided in Section 846 and shall expire on the first day of July after its issue, unless sooner suspended or revoked.

The permission granted by Section 845 to persons holding certificates or licenses issued by the Commissioner of Corporations does not affect the provisions of this article requiring that an insurer and that an agent appointed by an insurer secure a permit or certificate from the commissioner to issue, sell or resell securities and such issue, sale or resale and the advertising thereof is subject to the provisions of this article, nor does such section permit an owner of securities to sell or resell the same except in conformity with such section and this article.

846. To secure such certificate, the applicant shall make and file in the office of the commissioner an application therefor in writing, verified by or in behalf of the applicant. Such application shall set forth:

(a) The name and address of the applicant.

(b) 1. In the case of an applying corporation, association or joint stock company, the name and address of each of its managing officers and managing agents.

2. In the case of an applying partnership, the name and address of each of the partners.

(c) A succinct statement of facts showing possession of a good business reputation:

1. By the applicant.

2. In the case of an applicant corporation, association, or joint stock company, by its managing officers and managing agents.

3. In the case of an applicant partnership, by its members.

(d) If the applicant is a broker, the general plan and character of the business of the applicant.

(e) Such other information as the commissioner requires.

847. At the time of filing an application for a broker's certificate, the applicant shall file with the commissioner a bond for five thousand dollars, payable to the people of the State of California, for the use and benefit of any interested person, to be approved by the commissioner. The bond shall be conditioned upon the following conduct by the broker, the broker's agents, and employees:

(a) Strict compliance with the provisions of this article.

(b) Honest and faithful application of all funds received.

(c) Honest and faithful performance of all obligations and undertakings in the purchase or sale of securities.

(d) Payment of all damages suffered by any person damaged or defrauded by reason of the violation of any of the provisions of this article, or by reason of any fraud connected with or growing out of any transaction contemplated by the provisions of this article.

850. If the applicant is a foreign corporation or association, it shall file with its application:

(a) A copy of its articles of incorporation or association.

(b) A certificate of the proper officer of the jurisdiction in which it is organized, executed not more than thirty days before the filing of such application, showing that the applicant is authorized to transact business in that jurisdiction.

(c) In such form as the commissioner prescribes, its written

instrument irrevocably appointing the commissioner and his successor in office its true and lawful attorney upon whom all process in any action or proceeding against it, arising out of or founded upon the fraud of such applicant in the sale of securities within this State, or in any action upon any bond provided by this article, can be served. Such service shall have the same effect as if the applicant was a domestic corporation or association lawfully served with process in this State.

851. The commissioner shall examine such application, and shall make such further investigation of the applicant and its affairs as he deems advisable. He shall issue the certificate if, from such examination, the commissioner is satisfied that:

(a) The business reputation of the applicant and, in the case of a firm or corporation, its officers or members, is good.

(b) The sale of the securities proposed to be sold by it would not be unfair, unjust or inequitable to the purchasers thereof.

(c) Neither it nor its officers or members have violated any of the provisions of this article.

(d) Neither it nor its officers or members have engaged or are about to engage in any fraudulent transaction.

Otherwise, he shall deny the application and notify the applicant of his decision.

Where a hearing is held under this section the proceedings shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

852. The commissioner may at any time in accordance with the procedure provided in Section 1738 suspend or revoke any broker's or agent's certificate issued by him if he finds that the holder thereof is of bad business repute, or has violated any provision of this article, or has engaged, or is about to engage in any fraudulent transaction.

853. Every broker shall, at such times as the commissioner requires, make and file in the office of the commissioner a true and correct statement concerning any security sold or offered for sale by

the broker. The statement shall show:

(a) The name and location of the principal office of the issuer of such security.

(b) The names of the issuer's managing officers if it is a corporation, or of its members if it is a partnership.

(c) The issuer's assets, liabilities, and issued capital stock, at the close of its fiscal year then last ended, or at a later date.

(d) The issuer's gross income, expenses, and fixed charges for the year next preceding such date, or for such time as such issuer of such security has transacted business, if for less than one year.

(e) The approximate price at which the broker has sold or proposes to sell such security.

(f) Such other information, of which the broker has knowledge, as the commissioner requires.

854. After receipt of notice in writing from the commissioner, stating that the sale of a security would, in the commissioner's opinion, be unfair, unjust, or inequitable to the purchaser, no broker shall sell such security until and unless the commissioner in writing withdraws the objection.

855. All writings filed with the commissioner under this article shall be open to public inspection except where, in his judgment, the public welfare or the welfare of any insurer demands that any portion of such information be not made public. In such cases he may, in his discretion, withhold such information from public inspection for such time as in his judgment is necessary.

856. (a) The commissioner may at any time give or make public any information concerning any insurer, if in the commissioner's judgment, the giving or publishing of the information will be of public interest.

(b) The commissioner may at any time give or make public any information concerning securities purchased or sold within this state by an insurer, if in the commissioner's judgment, the giving or publishing of the information is in the public interest or it will tend to prevent the fraudulent purchase or sale of the securities.

857. The commissioner shall charge and collect the following fees:

(a) For filing an original or supplemental application, or any amendments thereto, for a permit to issue securities, one thousand seven hundred seventy dollars ($1,770) except for applications for a permit to issue securities evidencing any change in rights, preferences, privileges, or restrictions on outstanding securities, or for applications for a permit to issue securities evidencing only a share dividend or a share split.

(b) For filing an application for a permit to issue securities evidencing any change in the rights, preferences, privileges, or restrictions on outstanding securities, two hundred thirty-six dollars ($236).

(c) For filing an application for a permit to issue securities evidencing a share dividend or a share split, five hundred ninety dollars ($590).

(d) For filing an application for any other kind of permit, such as an application, for the issuance of a preorganizational or a negotiating permit, an application for a permit to issue options for securities, but not for the securities themselves, or any application for an amendment to an existing permit to issue securities, one hundred eighteen dollars ($118).

(e) An original or supplemental application shall not be amended after the permit sought thereby or by amendment thereto has been issued or denied.

859. The commissioner shall also collect the following fees:

(a) For filing any application for a broker's certificate, one hundred eighteen dollars ($118) for the first office or location plus fifty-eight dollars ($58) for each additional office or location.

(b) For filing any application for an agent's certificate, fifty-eight dollars ($58).

(c) For an examination, audit, or investigation, the actual amount of expenses reasonably incurred in the performance of the work, plus the following:

(1) If made by an employee of the commissioner, the actual amount of the compensation paid to such employee for that time.

(2) The amount of the usual cost to the state of typing, transcribing or otherwise preparing any written report of such examination, audit or investigation that may reasonably be needed in

the discharge of the commissioner's duties.

860. No fees shall be charged or collected for copies of papers, records, or official documents furnished to public officers for use in their official capacity or for the reports of the commissioner in the ordinary course of distribution.

INSURANCE CODE
SECTION 880-886

880. Except as provided in this article, every insurer shall conduct its business in this State in its own name.

881. The commissioner shall require the name or any changed name of every insurer (including reciprocal or interinsurance exchanges), every attorney in fact, every motor club and every underwritten title company to be submitted to him by written application and approved by him before such name is used in this state for business purposes. If approved, the commissioner shall issue his official certificate approving the name, and when appropriate, reserving the name for the following time periods, which shall commence on the date of the approval:

(1) One year where the applicant is newly formed, or where the application is filed on behalf of an entity to be formed, under the laws of this state.

(2) One hundred eighty days and during the pendency in good faith of an application for certificate of authority in the case of a foreign or alien applicant.

(3) Ninety days in the case of an admitted entity requesting authority to change the name under which it will conduct its business with the public in this state.

Except in the case where an applicant has already paid a fee on a pending application for admission, the commissioner shall collect a fifty-eight dollar ($58) fee for filing each application for name approval and reservation. An application for name approval may contain not more than three names in the order of applicant's preference and the commissioner's approval shall be limited to only

one name submitted by any one application.

The certificate of approval shall be attached to the articles of incorporation before the Secretary of State shall file such articles or any amended articles. The commissioner may reject any name so submitted when it is an interference with, or too similar to one already appropriated, or when it is likely to mislead the public in any respect. In the event of such a rejection, the applicant shall legally change its name to one approved by the commissioner or, if a foreign or alien insurer, may arrange to conduct any business it may do with the public in California under an approved name as an operating name, identifying itself under both its true name and operating name in the conduct of all official business with the commissioner.

Notwithstanding the provisions of Sections 1282 and 12221, the provisions of this section shall apply to reciprocal insurers, including their attorneys in fact, and shall apply to motor clubs, respectively.

881.1. Notwithstanding the provisions of Section 881 or any other provision of law, neither the commissioner or the Secretary of State shall reject a name proposed by an entity seeking admission as a home protection company if such name was used by such entity for conduct of a home protection or home warranty business in this state for at least one year prior to May 3, 1978. Every such name, upon the commissioner's determination of such use, shall be approved upon submission of application therefor.

881.3. Upon approval of an applicant's name by the commissioner, and the issuance of a certificate approving the same, the applicant may apply to the Secretary of State for the issuance of a certificate of reservation of corporate name for the same periods specified in Section 881.

881.5. If through inadvertance or otherwise a corporation does not comply with Section 881 of the Insurance Code, or with Sections 201.5, 202, 2105, 2106, 2106.5, and 2107 of the Corporations Code when any of such sections is applicable, any corporation lawfully engaged in the insurance business in this state may bring an action for judicial relief against such corporation by means of any remedy

afforded by law. Such action may be based upon any of the grounds by reason of which the commissioner could or would have denied application for approval of the corporate name of the noncomplying corporation. In such an action the court may order such corporate defendant to adopt a new name or an operating name, when permissible, acceptable to both the Secretary of State and the commissioner, by filing a certificate of amendment or by filing an amended statement and designation with the Secretary of State.

882. When two or more insurers propose to issue an underwriter's policy, each insurer shall first file an application with the commissioner for approval and registration of the name or title under which the policy is to be issued. The commissioner may reject any name submitted when it is an interference with, or too similar to, one already appropriated or when it is likely to mislead the public in any respect. In such case the application may be amended to submit another or other names.

The commissioner shall charge and collect in advance a fee of twenty-nine dollars ($29) from each insurer filing an application for approval and registration of such name or title, or for filing any amendment thereto.

882.5. (a) A home protection company proposing to issue a contract bearing the name of itself as well as another name which is the name of a person, persons, or organization of persons licensed pursuant to Part 1 (commencing with Section 10000) of Division 4 of the Business and Professions Code, or a franchised name therefor, shall first file an application with the commissioner for approval of the other name. The commissioner may reject any name so submitted when it is an interference with, or too similar to, one already appropriated or when it is likely to mislead the public in any respect. However, the name shall not be rejected, except pursuant to subdivision (b), if the name was used by the same entity for a similar offering in this state prior to May 3, 1978. In case of any rejection of a name pursuant to this subdivision, the application may be amended to submit another or other names.

(b) No such name shall be approved unless all power to transact home protection business (except as authorized in Section 771.1) and other powers specified by the commissioner by regulation, are specifically retained by the home protection company and the home protection contracts prominently disclose that fact.

The commissioner, pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, may adopt reasonable regulations to implement this section.

883. An underwriter's policy may be issued under a name thus registered and shall clearly show:

(a) The names of the insurers guaranteeing it.

(b) The severalty of the contract.

(c) The proportion of the premium to be paid to each insurer.

(d) The proportion of liability which each assumes.

884. Unless renewed, the approval and registration of all underwriters' names shall expire at 12:01 a.m. July 1st of each even-numbered year. Renewal may be secured by filing with the commissioner an application therefor, together with a fee of ten dollars ($10). Such an application shall be filed during the month of May preceding such July 1st. The commissioner shall furnish the application forms for such renewal. The commissioner shall, upon receipt of a proper renewal application and payment of the filing fee therefor, renew the approval and registration of the underwriter's name unless he finds that:

(a) The insurer has abandoned use of said underwriter's name;

(b) The insurer is actually using or publicizing the name in any manner after it has discontinued the issuance of underwriter's policies bearing such name;

(c) The insurer has used such underwriter's name in a manner which has resulted in misrepresentation or fraud;

(d) The insurer has used such underwriter's name in a manner which would violate any provision of law relating to the conduct of its business;

(e) The insurer has secured such underwriter's name through misrepresentation or concealment of material information; or

(f) Reasons exist which would warrant refusal of approval or registration if the same were being initially requested.

If the commissioner so finds he shall advise all insurers using said underwriter's name in writing that the renewal application is denied and set forth with particularity the reasons for the denial. Such denial shall be effective thirty (30) days after mailing of such advice to the insurer unless within such thirty (30) days the insurer requests a hearing. In this event the advice of denial shall

constitute the commissioner's opening pleading for the purpose of the hearing, which shall be deemed denied by the insurer. The insurer if it elects may within ten (10) days file additional written response. The hearing shall be noticed and commenced within a reasonable time. During said thirty (30) days, and, if request for hearing be filed until the termination of such proceeding, the insurer may continue the use of the underwriter's name and the issuance of policies thereunder provided timely renewal application has been filed and the filing fee paid.

885. The commissioner may at any time institute proceedings for the revocation of approval and registration of an underwriter's name upon any of the grounds set forth in Section 884 by following the procedure prescribed in that section.

886. Termination of approval and registration of an underwriter's name, whether through denial of a renewal application or revocation, shall have no effect on the validity or the retention in force to normal expiration of any underwriter's policies issued on or prior to the date of such termination with an effective date not more than sixty (60) days after its issue date provided that if any such policy is continuous in form it shall not be continued in force beyond its annual renewal date first occurring after such date of termination.

INSURANCE CODE
SECTION 900-925.4

900. On or before the first day of March of each year every insurer doing business in this State shall make and file with the commissioner, in triplicate, statements exhibiting its condition and affairs as of the thirty-first day of December then next preceding.

900.2. (a) All insurers doing business in this state shall have an annual audit by an independent certified public accountant. The

audit shall be conducted and the audit report prepared and filed in conformity with the Annual Audited Financial Reports instructions contained in the annual statement instructions as adopted from time to time by the National Association of Insurance Commissioners.

(b) The commissioner may grant a 30-day extension of the filing date upon a showing by the insurer and its independent certified public accountant of the reasons for requesting that extension and the determination by the commissioner of substantial cause for an extension. The request for an extension shall be submitted in writing not less than 20 days prior to the due date in sufficient detail to permit the commissioner to make an informed decision on the requested extension.

(c) The commissioner may promulgate regulations to further the purposes of this section.

900.5. The commissioner shall charge and collect one hundred eighteen dollars ($118) in advance as a fee for the first filing each year of a statement under this article. Only one such fee shall be charged or collected from any one insurer in any one calendar year.

900.7. The statements required by Section 900 shall be filed, in triplicate, by the insurer with the office of the department in Los Angeles. Upon receipt of the three copies, the commissioner shall ensure that one copy is maintained at the department's office in Los Angeles, one copy at the department's office in San Francisco, and one copy at the department's office in Sacramento.

900.8. The commissioner may decline to grant or renew or may suspend or revoke a certificate of authority of an insurer that knowingly files with the department a false financial statement.

900.9. Any officer, director, employee or agent of any insurer, who wilfully signs or files a false or untrue report or statement of the business, affairs, or condition of such insurer with intent to deceive any public officer, office, or board to which such insurer is

required by law to report, or which has authority by law to examine into its affairs or transactions, is guilty of a felony.

902. Insurers engaged in the business of compensation insurance shall, at such intervals as may be prescribed by the commissioner, file statements supplemental to such annual statements and covering such matters dealt with in such annual statements as the commissioner designates. Neither such supplemental report nor any synopsis thereof need be published.

903. The commissioner shall require statements and reports to be verified as follows: (a) If made by a domestic corporation, by the oaths of any two of the executive officers thereof. (b) If made by an individual or firm, by the oath of such individual or a member of the firm. (c) If made by a foreign insurer, by the oath of the principal executive officer thereof, or manager, residing within the United States.

903.5. In any case where an insurer is required by law to file with the commissioner statements or reports respecting its financial condition, income or disbursements, verified or signed by its designated officers, agents, or employees, the commissioner may accept and file the statement or report verified by affidavit of the president or vice president and the treasurer or secretary of such insurer, in lieu of the verification or signature otherwise prescribed by law.

904. In addition to the annual statement required to be filed pursuant to Section 900, each admitted insurer shall file an authorization for disclosure to the commissioner of financial records pertaining to such funds pursuant to Section 7473 of the Government Code, to be effective until the next such annual filing.

922. The guarantee by the Small Business Administrator that a surety shall not suffer loss as set forth in the Small Business

Investment Act of 1958, as amended, shall for all purposes and requirements under this code be deemed a contract of reinsurance between such surety and an authorized or admitted reinsurer irrespective of whether or not such guarantee contains all the provisions required of other reinsurance contracts.

922.1. The Legislature declares its intent that:

(a) In some instances, it is appropriate for the protection of insureds, insurers, and the public generally, that assuming insurers be required to provide security for the payment of their reinsurance obligations.

(b) Where such security is provided and upon the insolvency of the assuming insurer or initiation of receivership proceedings against it, the commissioner shall have the authority to determine whether it is in the best interest of insureds, claimants, and insurers to retain such security in the United States, to allow the filing of claims against the assuming insurer in the United States, and to have such claims valued in a United States proceeding subject to United States laws.

(c) In furtherance of the protection of insureds, insurers, and the public generally, the Legislature hereby states that these matters are fundamental to the business of insurance and hereby exercises its powers and privileges available pursuant to Sections 1011 and 1012 of Title 15 of the United States Code.

922.2. (a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability in accordance with Sections 922.4 and 922.5 only if the reinsurance contract contains provisions that provide, in substance, as follows:

(1) The reinsurer shall indemnify the ceding insurer for any portion of the risk it has assumed according to the terms and conditions contained in the reinsurance contract.

(2) In the event of insolvency and the appointment of a conservator, liquidator, or statutory successor of the ceding company, the portion of any risk or obligation assumed by the reinsurer shall be payable to the conservator, liquidator, or statutory successor on the basis of claims allowed against the insolvent company by any court of competent jurisdiction or by any conservator, liquidator, or statutory successor of the company having

authority to allow such claims, without diminution because of that insolvency, or because the conservator, liquidator, or statutory successor has failed to pay all or a portion of any claims. Payments by the reinsurer as set forth in this subdivision shall be made directly to the ceding insurer or to its conservator, liquidator, or statutory successor, except where the contract of insurance or reinsurance specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer.

The reinsurance contract may provide that the conservator, liquidator, or statutory successor of a ceding insurer shall give written notice of the pendency of a claim against the ceding insurer indicating the policy or bond reinsured, within a reasonable time after such claim is filed and the reinsurer may interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defense or defenses which it may deem available to the ceding insurer or its conservator, liquidator, or statutory successor. The expense thus incurred by the reinsurer shall be payable subject to court approval out of the estate of the insolvent ceding insurer as part of the expense of conservation or liquidation to the extent of a proportionate share of the benefit which may accrue to the ceding insurer in conservation or liquidation, solely as a result of the defense undertaken by the reinsurer.

(b) Payment pursuant to a reinsurance contract shall be made within a reasonable time with reasonable provision for verification in accordance with the terms of the reinsurance agreement. However, in no event shall the payments be beyond the period required by the National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual.

(c) The original insured or policyholder shall not have any rights against the reinsurer which are not specifically set forth in the contract of reinsurance, or in a specific agreement between the reinsurer and the original insured or policyholder.

922.3. Notwithstanding any other provision of law, credit for reinsurance, as either an asset or a deduction, shall not be allowed in any accounting or financial statement of the ceding insurer in respect to any so-called reinsurance contract unless, in such contract, the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance.

922.4. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subdivision (a), (b), (c), or (d). Credit shall be allowed under subdivision (a) or (b) only for cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. If meeting the requirements of subdivision (c), the requirements of subdivision (e) shall also be met.

(a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state unless the assuming insurer is the subject of a regulatory order or regulatory oversight by any state in which it is licensed based upon a commissioner's determination that the assuming insurer is in a hazardous financial condition.

(b) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state unless the assuming insurer is the subject of a regulatory order or regulatory oversight by any state in which it is licensed based upon a commissioner's determination that the assuming insurer is in a hazardous financial condition. An accredited reinsurer is one that does all of the following:

(A) Files with the commissioner evidence of its submission to this state's jurisdiction.

(B) Submits to this state's authority to examine its books and records.

(C) Designates the commissioner or a designated attorney in this state as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(D) Is licensed 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 to transact insurance or reinsurance in at least one state.

(E) Files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement and other financial information requested by the commissioner.

(F) Submits a statement, signed and verified by an officer of the assuming insurer to be true and correct, that discloses whether the assuming insurer or any affiliated person who owns or has a

controlling interest in the assuming insurer is currently known to be the subject of any of the following:

(i) Any order or proceeding regarding conservation, liquidation, or receivership.

(ii) Any order or proceeding regarding the revocation or suspension of a license or accreditation to transact insurance or reinsurance in any jurisdiction.

(iii) Any order or proceeding brought by an insurance regulator in any jurisdiction seeking to restrict or stop the assuming insurer from transacting insurance or reinsurance based upon a hazardous financial condition.

The assuming insurer shall provide the commissioner with copies of any orders or other documents initiating proceedings subject to disclosure under this paragraph. The statement shall affirm that no actions, proceedings, or orders subject to this subparagraph are outstanding against the assuming insurer or any affiliated person who owns or has a controlling interest in the assuming insurer, except as disclosed in the statement.

(G) Maintains a surplus as regards policyholders in an amount that is not less than twenty million dollars ($20,000,000) and whose accreditation has not been denied by the commissioner within 90 days of its submission or maintains a surplus as regards policyholders in an amount less than twenty million dollars ($20,000,000) and whose accreditation has been approved by the commissioner.

(2) The commissioner may deny or revoke an assuming insurer's accreditation if the assuming insurer does not meet all of the standards required of an accredited reinsurer, or if its accreditation would be hazardous to the policyholders of this state. In determining whether to deny or revoke accreditation, the commissioner may consider the qualifications of the assuming insurer with respect to all the following subjects:

(A) Its financial stability.

(B) The lawfulness and quality of its investments.

(C) The competency, character, and integrity of its management.

(D) The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer.

(E) Whether claims under its contracts are promptly and fairly adjusted and are promptly and fully paid in accordance with the law and the terms of the contracts.

(3) Credit shall not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing.

(4) The actual costs and expenses incurred by the department to review a reinsurer's request for accreditation and subsequent reviews

shall be charged to and collected from the requesting reinsurer. If the reinsurer fails to pay the actual costs and expenses promptly when due, the commissioner may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.

(c) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution as defined in subdivision (b) of Section 922.7 for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund the assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers or any other form required by the NAIC.

(2) Credit for reinsurance shall not be granted under this subdivision unless the form of the trust and any amendments to the trust have been approved by either:

(A) The commissioner of the state where the trust is domiciled.

(B) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

The trust and any trust amendments shall also be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. Notwithstanding the foregoing, nothing in this paragraph shall prevent the commissioner from disapproving the form of the trust if it is not in compliance with this state's laws and regulations.

(3) Credit for reinsurance shall not be granted under this subdivision unless the following requirements are met:

(A) The trust instrument shall provide that contested claims shall be valid, enforceable, and payable 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) The trust shall vest legal title to its assets in the trustees of the trust for the benefit of the grantor's United States ceding insurers, their assigns, and successors in interest.

(C) The trust and the assuming insurer shall be subject to examination as determined by the commissioner.

(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, shall have outstanding obligations due under the reinsurance agreements subject to the trust.

(E) No later than February 28 of each year, the trustees of the trust shall report to the commissioner in writing setting forth the

balance of 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 within the next 18 months.

(4) 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 ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000).

(B) In the case of a group including incorporated and individual unincorporated underwriters:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States 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 this article, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(iii) In addition to the trusts required in clauses (i) and (ii), the group shall maintain in trust a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(iv) 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.

(v) The group shall, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the group.

(C) In the case of a group of incorporated insurers under common administration, the group shall meet all of the following

requirements:

(i) Have continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation and be in good standing with its domiciliary regulator.

(ii) Demonstrate that individual insurer members maintain standards and financial conditions reasonably comparable to admitted insurers.

(iii) Maintain aggregate policyholders' surplus of at least ten billion dollars ($10,000,000,000).

(iv) Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group.

(v) In addition, maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for these liabilities. The commissioner shall have the authority to require additional amounts to be held in the trust as a condition for initial or continued accreditation if the commissioner determines that these additional amounts are required for the protection of ceding insurers.

(vi) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator, and financial statements for each underwriter member of the group prepared by its independent public accountant.

(5) The actual costs and expenses incurred by the department to review the trusts and subsequent amendments established or maintained pursuant to this subdivision shall be charged to and collected from the requesting reinsurer or group. If the reinsurer or group fails to pay the actual costs and expenses promptly when due, the commissioner may refuse to allow credit for reinsurance ceded to that reinsurer or group.

(d) Credit shall be allowed when the reinsurance ceded to an assuming insurer not meeting the requirements of subdivision (a), (b), or (c), but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(e) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subdivision (c) shall not be allowed unless the assuming insurer does both of the following:

(1) Submits to the jurisdiction of any court of competent jurisdiction in any state of the United States, complies with all requirements necessary to give such court jurisdiction, and abides by the final decision of the court or of any appellate court in the event of an appeal.

(2) Designates the commissioner or a designated attorney in this state as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

This subdivision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(f) If the assuming insurer does not meet the requirements of subdivision (a), (b), or (d), the credit permitted by subdivision (c) shall not be allowed unless the assuming insurer agrees in the trust agreement that notwithstanding any other provision in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (4) of subdivision (c), 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:

(1) 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 all of the assets of the trust fund.

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

(3) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(4) The grantor hereby waives any right otherwise available to it under United States law that is inconsistent with this provision.

922.5. (a) An asset or a deduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the

requirements of Section 922.4 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer to the extent of either of the following:

(1) The asset or deduction is not greater than the amount of funds held by the ceding insurer under a reinsurance contract with that assuming insurer as security for the payment of obligations thereunder and such funds are held in the United States under the exclusive control of the ceding insurer.

(2) The asset or deduction is not greater than the amount of funds held in a trust, satisfactory to the commissioner, on behalf of the ceding insurer under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder and is held in a qualified United States financial institution, as defined in subdivision (b) of Section 922.7, subject to withdrawal solely by the ceding insurer.

The security under this subdivision may be in the form of cash or securities authorized as general investments under Article 3 (commencing with Section 1170) of Chapter 2, or securities listed by the Securities Valuation Office of the NAIC, qualifying as admitted assets under this code and with liquidity meeting the requirements of Section 706.5.

(b) An asset or a deduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 922.4 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer to the extent that security is provided in the form of letters of credit, satisfactory to the commissioner, which shall be:

(1) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in subdivision (a) of Section 922.7, effective no later than December 31st in respect of the year for which filing is being made, and in the possession of the ceding insurer on or before the filing date of its annual statement.

(2) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation and 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.

922.6. (a) Unless credit for reinsurance or deduction from liability is disallowed pursuant to Section 922.3 or 923, credit for

reinsurance or deduction from liability shall be allowed a foreign ceding insurer to the extent credit has been allowed by the ceding insurer's state of domicile if either:

(1) The state of domicile is accredited by the NAIC.

(2) Credit or deduction from liability would be allowed under this statute if the foreign ceding insurer were domiciled in this state.

(b) Notwithstanding subdivision (a), credit for reinsurance or deduction from liability may be disallowed upon a finding by the commissioner that either the condition of the reinsurer, or the collateral or other security provided by the reinsurer, does not satisfy the credit for reinsurance requirements applicable to ceding insurers domiciled in this state.

922.7. (a) For purposes of subdivision (b) of Section 922.5, a "qualified United States financial institution" means an institution that complies with all of the following:

(1) Is organized or in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state thereof.

(2) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies.

(3) Has been determined by the commissioner, or, in the discretion of the commissioner, the Securities Valuation Office of the NAIC, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(b) A "qualified United States financial institution" means, for purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that is both:

(1) Organized, or in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers.

(2) Regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

922.8. (a) The commissioner, after notice, comment period, and a hearing if requested by more than 10 affected insurers, may issue a bulletin setting forth reasonable requirements for the allowance of reinsurance as an asset or deduction from liability consistent with Sections 922.4 to 922.6, inclusive, including the following:

(1) Filing requirements for an accredited assuming insurer.

(2) Accreditation requirements for an assuming insurer with less than a twenty million dollars ($20,000,000) surplus as regards policyholders.

(3) The definition of "liabilities" as used in Sections 922.4 and 922.5.

(4) Investment guidelines for trust funds established and maintained pursuant to subdivision (c) of Section 922.4.

(5) Definitions and required or permitted conditions for trust funds established and maintained pursuant to Section 922.5.

(6) Requirements of letters of credit established and maintained pursuant to Section 922.5.

(b) On or before January 1, 1998, the commissioner shall notify the Legislature that the bulletin has been promulgated so that the Legislature is able to ensure the commissioner's compliance with the requirements of this subdivision.

(c) The bulletin authorized by this section shall have the same force and effect, and may be enforced by the commissioner to the same extent and degree, as regulations issued by the commissioner until the time that the commissioner issues additional or amended regulations pursuant to subdivision (d).

(d) The commissioner shall adopt regulations implementing the provisions of this law, that shall supersede the bulletin authorized by this section, no later than December 31, 2001.

922.9. Sections 922.4 and 922.5 shall apply to all cessions on and after January 1, 1997, under reinsurance contracts that have had an inception, anniversary, or renewal date not less than six months after that date.

923. The commissioner shall require every insurer which is required to file an annual statement to use the annual statement blanks and instructions thereto adopted by the National Association of Insurance Commissioners. The statements shall be completed in conformity with the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners, to the extent that

the practices and procedures contained in the manual do not conflict with any other provision of this code. The commissioner may make changes from time to time in the form of the statements and reports as seem to him or her best adapted to elicit from the insurers a true exhibit of their condition. The commissioner shall notify each insurer of any changes from the National Association of Insurance Commissioners' annual statement blanks which the commissioner has determined pursuant to this section to be appropriate.

923.5. Each insurer transacting business in this state shall at all times maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims for which the insurer may be liable, and to provide for the expense of adjustment or settlement of losses and claims.

The reserves shall be computed in accordance with regulations made from time to time by the commissioner. The promulgation of the regulations by the commissioner, or any changes thereto or amendments thereof, shall be in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The commissioner shall make the regulations upon reasonable consideration of the ascertained experience and the character of such kinds of business for the purpose of adequately protecting the insured and securing the solvency of the insurer.

With respect to liability, common carrier liability, and compensation insurance, the regulations shall be consistent with Section 11558.

The commissioner may prescribe the manner and form of reporting pertinent information concerning the reserves provided for in this section.

This section shall not apply to life insurance, title insurance, disability insurance, mortgage insurance, or mortgage guaranty insurance.

924. The commissioner shall collect a late filing fee of three hundred thirty-six dollars ($336) from any admitted insurer that fails to make and file in the commissioner's office within the time prescribed by law any statements or stipulations required by this code. After the first month, the commissioner shall also collect a late filing fee of four hundred four dollars ($404) for each and every month or fractional part of a month thereafter that the insurer

continues to transact the business of insurance until those statements and stipulations are filed.

925. Upon request of the commissioner, and at intervals as prescribed by him or her, any insurer that appears to the commissioner to require immediate regulatory attention shall provide to the commissioner supplemental accounting, financial, and actuarial information. The commissioner may request that an insurer select and retain an independent certified public accountant, certified public accountant corporation, an actuary corporation, or an independent actuary satisfactory to the commissioner, if that person has not already been retained by the insurer, whenever the information supplied or likely to be supplied is not satisfactory or acceptable to the commissioner, or, whenever the person who would be responsible for that preparation of that information has previously provided information that was not satisfactory or acceptable to the commissioner. The commissioner may select or retain an independent certified public accountant, a certified public accountant corporation, an actuary corporation, or an independent actuary, if the insurer does not within a reasonable time make the selection as requested by the commissioner. If the information is prepared by an independent certified public accountant or independent actuary, or other independent professional financial corporation or person, the corporation or person shall examine and render an opinion upon that supplemental information.

925.1. (a) All supplemental information, work papers and other relevant documents of the independent certified public accountant, or independent actuary, or other independent professional financial person and the insurer relevant to information provided to the commissioner pursuant to Sections 925 to 925.2, inclusive, shall be made available by the insurer for review by the commissioner upon request at the insurer's office, at the commissioner's office, or any other reasonable place designated by the commissioner.

(b) All supplemental information, relevant work papers and other relevant documents of the certified public accountant or actuary shall be retained for a period of not less than five years from the date of the report. The certified public accountant or the actuary shall make that information available to the insurer upon the reasonable request of the commissioner made to the insurer, except

when that information is subject to the right against self-incrimination or other relevant privileges.

(c) Every insurer shall authorize, in writing, the independent certified public accountant, independent actuary, or other independent professional financial person retained or engaged by it to provide to the commissioner all information subject to Section 925 to 925.2, inclusive.

925.2. The commissioner may prescribe the subject matter and form of reporting supplemental information and the subject matter of opinions.

925.3. All supplemental information provided or made available to the commissioner pursuant to Sections 925 to 925.2, inclusive, including work papers and other relevant documents of the independent certified public accountants or, independent actuary or other independent professional financial person and the insurer relevant to that information, shall be received in confidence within the meaning of subdivision (d) of Section 6254 of the Government Code and exempt from the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Additionally, that information shall not be subject to subpoena or subpoena duces tecum.

925.4. Nothing contained herein shall be deemed in any manner to limit, restrict or abridge the powers of the commissioner to examine insurers, to inquire into their financial condition or to obtain supplemental information in accordance with any other provision of this code.

INSURANCE CODE
SECTION 928

928. (a) An admitted insurer shall not undertake any single risk or accept reinsurance on any single risk when its liability thereon in excess of the amount reinsured by reinsurance authorized for annual statement credit under this code exceeds 10 percent of its capital

and surplus as shown by its last statement on file in the office of the commissioner.

(b) This section shall apply to any class or classes of insurance specified in Chapter 1 (commencing with Section 100) of Part 1 of Division 1, except:

(1) Life, as defined in Section 101.

(2) Title, as defined in Section 104.

(3) Surety, as defined in Section 105.

(4) Mortgage Guaranty, as defined in Section 119.

(5) Financial Guaranty, as defined in Section 124.

INSURANCE CODE
SECTION 930-934

930. The provisions of this article shall apply to all domestic, foreign, and alien insurers doing business in this state.

931. (a) Each domestic, foreign, and alien insurer doing business in this state shall annually, on or before the first day of March of each year, file with the National Association of Insurance Commissioners a copy of its annual statement convention blank, along with any additional filings as prescribed by the commissioner for the preceding year. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners.

(b) Foreign insurers that are domiciled in a state which has a law substantially similar to subdivision (a) of this section shall be deemed in compliance with this section.

932. In the absence of actual malice, members of the National Association of Insurance Commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, National

Association of Insurance Commissioners' employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the commissioner under the authority of this article and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required herein.

933. All financial analysis ratios and examination synopses concerning insurers that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department.

934. The commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to file its annual statement with the National Association of Insurance Commissioners when due or within any extension of time which the commissioner, for good cause, may grant.

INSURANCE CODE
SECTION 939-956

939. Except as otherwise expressly provided, all deposits of securities with the commissioner shall be subject to the provisions of this article.

940. The commissioner shall accept and hold securities in trust for the policyholders or policyholders and creditors of an insurer and for their benefit, whenever (a) the law of another state or of a foreign country requires such a deposit with an officer of this state as a prerequisite to transacting insurance business in that state or country, or (b) the law of this state requires such a deposit with an officer of this state.

940.1. The commissioner shall require the payment of fifty-eight dollars ($58) in lawful money of the United States in advance for receiving and processing securities or deposit schedules for securities deposited pursuant to this article. An additional fee of twenty-nine dollars ($29) shall be payable for each withdrawal, substitution, or any other change in the securities comprising such deposit. There shall be no other or additional fee for attaching the commissioner's seal to a securities deposit schedule for a deposit under this article.

941. Such deposited securities shall not be estimated above their par value nor above their market value, except that preferred stock shall be estimated only at its market value.

942. The commissioner shall permit a deposit of those securities in the State Treasury, subject to the provisions of Sections 11715 and 11716, if applicable. The securities deposited with the State Treasurer shall be maintained in electronic book entry or certificate form as security for policyholders or policyholders and creditors of the insurer to whom they respectively belong. The state is responsible for the custody and safe return of any money or securities so deposited. The State Treasurer shall deposit any such moneys under the provisions of Sections 16370 and 16375 of the Government Code.

943. So long as the insurer continues solvent the commissioner shall permit it to collect the interest or dividends on the securities so deposited, and from time to time to withdraw any such securities on depositing other securities in the stead of those to be withdrawn. Such new securities shall be of the same value as those withdrawn and of the character mentioned in this article.

944. Securities deposited under the provisions of this article shall not be withdrawn from the State treasury except upon the written order of the insurer making the deposits, with the

endorsement of the commissioner thereon, or upon the order of some court of competent jurisdiction.

945. If the deposit is of mortgages, it shall be accompanied either by full abstracts of title with the fees for examination of title, or by policies of title insurance or certificates of title issued by an admitted title insurer. The fees for appraisal of the property shall be paid by the insurer making the deposit. In any case where he ascertains that the expense thereof would not be unreasonable or such as to make the deposit impracticable, the commissioner may require a policy of title insurance or a guaranty that the abstract is correct and that it shows title to be in the proper parties, issued by a corporation authorized to issue such policies or guaranties in the State in which the security or some part thereof is located.

946. If the deposit is of stocks or bonds, it shall be accompanied by the fees necessary for the appraisal thereof, except as otherwise provided by Article 3, Chapter 1, Part 2, Division 1, of this code.

948. Whenever an insurer has deposited with the commissioner the requisite security, in conformity with the requirements of this article, the commissioner shall issue to such insurer, under his official seal, a certificate of such deposit for each State or country requiring such certificate. Such certificate shall state the items and amount of securities so deposited, and their value.

949. The commissioner shall require the payment of twenty-nine dollars ($29) in lawful money of the United States, in advance, as a fee for each certificate issued pursuant to this article.

950. Whenever such a depositing insurer has paid, canceled, or reinsured all its unexpired policies outstanding in this State, and all its liabilities under such policies are extinguished, or assumed

by other responsible insurers, it may apply to the commissioner for return of its deposit. Such application shall be in writing and verified. If on such application, and from an examination of the books of the insurer and of its officers under oath, the commissioner is satisfied that all of its policies are so paid, canceled, extinguished, or reinsured, he shall deliver up to the insurer the securities deposited.

951. Pending such examination the securities requested to be withdrawn may continue subject to withdrawal and substitution as provided by section 943.

952. Whenever the laws of any other state or country, by reason of which Section 940 is brought into force, are repealed and abrogated, then any deposit with the commissioner under and by reason of that section shall be delivered up to the depositing insurer.

953. Whenever a domestic insurer deposits securities with an officer of this State, in order to enable it to do business in another State pursuant to the laws of such other State, if such insurer thereafter ceases to do business in such other State and files conclusive evidence that all policies written in such other State have expired or been paid, canceled or reinsured, the securities shall on demand be returned to the depositing insurer.

954. The commissioner shall make an annual examination of the securities received by him from each insurer. If it appears at any time that the securities deposited by any such insurer amount to less than the sum required for the purposes for which the deposit was made, he shall notify the insurer thereof. Unless the deficiency is made up within thirty days after the notice, the commissioner shall revoke the insurer's certificate of authority, countermand all the certificates issued to the insurer under this article, and give notice thereof to the officers of the several States to whom the certificate has been transmitted.

955. All appraisal fees collected by the commissioner under the

provisions of this article shall be paid into the State treasury in trust and withdrawn as provided by law for withdrawal of trust funds from the State treasury.

956. An account or accounts in one or more banks or savings and loan associations the accounts of which are insured by an agency or instrumentality of the federal government shall be accepted as securities comprising any part of any deposit made with the commissioner.

INSURANCE CODE
SECTION 980-989

980. As used in this article, "liability" includes liability for losses reported, expenses, taxes, and all other indebtedness not included in those categories.

984. Any mortgage insurer or any mortgage guaranty insurer is insolvent whenever provision for its liabilities and for unearned income would, after exhausting its required insurance surplus, impair its capital paid in so as to reduce it below two hundred fifty thousand dollars ($250,000) or below 75 percent of the aggregate par value of its issued capital stock.

985. (a) On or after January 1, 1970, as used in this article and in subdivision (i) of Section 1011, "insolvency" means either of the following:

(1) Any impairment of minimum "paid-in capital" or "capital paid in," as defined in Section 36, required in the aggregate of an insurer by the provisions of this code for the class, or classes, of insurance that it transacts anywhere.

(2) An inability of the insurer to meet its financial obligations when they are due.

(b) On or after January 1, 1970, an insurer cannot escape the condition of insolvency by being able to provide for all its

liabilities and for reinsurance of all outstanding risks. An insurer must also be possessed of additional assets equivalent to such aggregate "paid-in capital" or "capital paid in" required by this code after making provision for all such liabilities and for such reinsurance.

(c) On or after October 1, 1967, as used in this code provision for reinsurance of all outstanding risks and "gross premiums without any deduction, received and receivable upon all unexpired risks" means the greater of: (1) the aggregate amount of actual unearned premiums, or (2) the amount reasonably estimated as being required to reinsure in a solvent admitted insurer the unexpired terms of the risks represented by all outstanding policies.

(d) On or after October 1, 1967, an insurer must make provision for reinsurance of the outstanding risk on policies that provide premiums are fully earned at inception and on policies that for any other reason do not provide for a return premium to the insured on cancellation prior to expiration.

(e) On or after October 1, 1967, the commissioner shall prescribe standards for reasonably estimating the amount required to reinsure that will provide adequate safeguards for the policyholders, creditors and the public.

(f) On or after October 1, 1967, this section shall not be applicable to life, title, mortgage or mortgage guaranty insurers.

(g) In the application of this section to disability insurance, as defined in Section 106, reserves for unearned premiums and amounts reasonably estimated as required to reinsure outstanding risks shall be determined in accordance with the provisions of Section 997.

985.5. In the case of the insolvency of an admitted insurer, the commissioner shall prepare a report, which shall be a public record, with respect to the causes and factors which contributed to that insolvency. The report shall be submitted to the Governor and to the Legislature no later than one year from the date of the insolvency.

985.6. The costs incurred in investigating and preparing the report required by Section 985.5 shall be an expense of administration within the meaning of paragraph (1) of subdivision (a) of Section 1033.

986. A life insurer issuing policies on a reserve basis is insolvent whenever its assets are exceeded by the total of the following: (1) the amount necessary to provide for its liabilities; (2) the amount of paid-in capital, as defined in Section 36, required by the provisions of Sections 10510, 10511, and 10512; (3) the amount necessary to provide for reinsurance of all its outstanding risks at the following rates:

(a) In the case of contracts issued in a foreign country, upon the lives of residents thereof, by a domestic insurer authorized to and doing business in that foreign country, the rates shall be in accordance with the standard of mortality approved by the commissioner, as provided by law.

(b) In the case of group insurance, at the rates required by law for valuation thereof.

(c) In the case of all other outstanding risks written prior to January 1, 1892, at the rates based upon the American Experience Table of Mortality with interest at the rate of 41/2 percent per annum.

(d) In the case of all its other outstanding risks written from and after December 31, 1891, up to and including December 31, 1907, at rates based upon the Combined Experience or Actuaries' Table of Mortality with interest at the rate of 4 percent per annum.

(e) In the case of all its other outstanding risks written from and after December 31, 1907, and prior to the operative date as to such risks of Article 3a (commencing with Section 10159.1), Chapter 1, Part 2, Division 2, at rates based upon the American Experience Table of Mortality with interest at the rate of 31/2 percent per annum, and, where applicable, in accordance with Section 10486.9.

(f) In the case of contracts of disability insurance, as defined in Section 106, according to the standards provided in Section 997.

(g) In the case of all other risks, according to the standards provided in Article 3a (commencing with Section 10489.1), Chapter 5, Part 2, Division 2.

987. A title insurer is insolvent whenever provision for its liabilities would, after exhausting its required surplus, so far impair its capital paid in as to reduce it below two hundred fifty thousand dollars ($250,000), or below 75 percent of the aggregate par value of its issued capital stock.

988. (a) As used in this section:

(1) "Impaired" means a financial situation in which the assets of an insurer are less than the sum of the insurer's minimum required capital, minimum required surplus and all liabilities as determined in accordance with the requirements for the preparation and filing of the annual statement of an insurer.

(2) "Chief executive officer" means the person, irrespective of title, designated by the board of directors or trustees of an insurer as the person charged with the responsibility of administering and implementing the insurer's policies and procedures.

(b) Whenever an insurer is impaired, its chief executive officer shall immediately notify the commissioner, in writing of that impairment and shall also immediately notify in writing all of the board of directors or trustees of the insurer. Any officer, director, or trustee of an insurer shall notify the person serving as chief executive officer of the impairment of the insurer in the event the officer, director, or trustee knows or has reason to know that the insurer is impaired.

(c) Any person who violates this section shall, upon conviction thereof, be fined not more than fifty thousand dollars ($50,000) or be imprisoned in the county jail for not more than one year, or both.

989. Any person who does any of the following is guilty of a misdemeanor punishable by not more than one year in county jail:

(a) Conceals any property belonging to an insurer.

(b) Transfers or conceals in contemplation of a state insolvency proceeding his or her own property or property belonging to an insurer.

(c) Conceals, destroys, mutilates, alters or makes a false entry in any document which affects or relates to the property of an insurer or withholds any such document from a receiver, trustee or other officer of a court entitled to its possession.

INSURANCE CODE
SECTION 995-995.7

995. (a) As used in this article, "contingent compensation

arrangement" means an arrangement having as its purpose the payment of a variable commission by the insurer, depending on the overall operating profit on the insurance business produced and handled by the payee, with other provisions of the arrangement auxiliary or incidental to such purpose.

(b) As used in this article, "retrospective commission arrangement" means an arrangement having as its purpose the retention by the insurer of a fixed proportion of the gross premiums, or gross premiums plus policy fees with the balance of the premiums, or premiums plus policy fees, retained by the producer of the business, who assumes to pay therefrom all losses, all subordinate commissions, loss adjustment expenses and his profit, if any, with other provisions of the arrangement auxiliary or incidental to such purpose.

(c) The phrases defined in subdivisions (a) and (b) of this section shall not be deemed to include a contingent commission arrangement of a producer, managing general agent, surplus line broker, or general agent based wholly or partly on underwriting results, unless the arrangement guarantees an agreed return to the insurer which may exceed the underwriting profit actually earned by the insurer on business written through the producer, managing general agent, surplus line broker, or general agent.

(d) As used in this article, "policy fee" means any sum specified in the policy as paid, or payable, in addition to the specified premium, as a consideration for the policy; and does not include expenses customarily charged to the insured which are not recited in the policy.

(e) This article shall apply only to automobile and automobile liability insurance.

995.1. An agent, broker, surplus line broker, general agent or other person operating under a contingent or retrospective compensation arrangement with any insurer shall promptly notify the insurer of every policy claim against the insurer of which he has knowledge with sufficient particulars to enable the insurer to establish an adequate claim reserve. Every insurer so notified of a policy claim or receiving independent knowledge of any policy claim shall promptly make a record thereof and establish a claim reserve for the same.

If the commissioner has reason to believe such agent, broker, general agent or other person is not so notifying the insurer, he shall give the insurer seven days written notice of such belief and

if the insurer does not correct the situation within seven days thereafter he may examine such agent, broker, general agent or other person at the expense of the insurer.

In the case of any arrangement whereby the producer receives from the insurer an initial percentage commission to be augmented if loss ratios or profits are more favorable than a stated standard, the insurer shall establish a contingent commission reserve for the amount, if any, which will become due to the producer because of such favorable loss ratios or profits.

Notwithstanding any provision of the contingent or retrospective arrangement, such claims and contingent commission reserves shall be a liability of the insurer.

Nothing contained in this section is intended to prohibit reasonable arrangements between a managing general agent, surplus line broker or general agent and an insurer which provide (a) for the amount of claim reserve to be recommended by the managing general agent, surplus line broker or general agent to the insurer, without particulars other than those needed by the insurer to establish the claim reserve on its books, or (b) for the handling of claim reserves on smaller claims of not more than two thousand dollars ($2,000) each on a bulk or group basis, upon recommendation of the amount by the managing general agent, surplus line broker or general agent, or (c) for the handling of losses not exceeding five hundred dollars ($500) each by the managing general agent, surplus line broker or general agent without establishment of claim reserves, or (d) for the reporting of losses and recommended reserves by the managing general agent, surplus line broker, or general agent on a monthly basis.

995.2. An insurer shall not claim as an asset by reason of any provision of a contingent or retrospective compensation arrangement, any account due from the other party pursuant to such an arrangement in an amount in excess of the money actually held by such party in a trusteed bank account for such insurer, unless such party is solvent without giving effect to any contingent or retrospective compensation not specifically acknowledged in writing by the insurer as settled in amount and payable in cash, or usable as an absolute offset against the insurer, within 90 days.

If the commissioner has reason to doubt the solvency of any person dealing with an insurer under a contingent or retrospective commission arrangement, he may examine him at the expense of the insurer.

Nothing contained in this section is intended to modify any

provision contained in Section 1735 of this code.

995.3. Every person operating under a retrospective or contingent compensation arrangement with any insurer shall report to the insurer within a reasonable time, and policy by policy, the full premium charge including any policy fee made to the insured and the amount of premium and policy fee, if any, collected from the insured in respect to each such policy. Such reporting need not be policy by policy in a case where such arrangement covers only policies which are all uniform in coverage, uniform as to premium and such premium is not over ten dollars ($10) annually.

If the commissioner has reason to believe any such person is not complying with this section, he shall give the insurer seven days written notice of such belief and if the insurer does not correct the situation within seven days thereafter, he may examine such person at the expense of the insurer.

Nothing contained in this section is intended to prohibit or invalidate use of the bordereau method of accounting or accounting by transmission of computer data by a managing general agent, surplus line broker, or general agent, nor to require him to report premium collections to an insurer where the managing general agent, surplus line broker, or general agent is liable to pay the insurer bordereau or accounting balances in full whether collected or not.

995.4. An insurer, notwithstanding the provisions of any contingent or retrospective compensation arrangement with any person, shall maintain as a liability, as part of its unearned premium reserve the unearned portion of all premium charges made to insureds without deduction for uncollected charges.

995.5. An insurer, notwithstanding the provisions of any contingent or retrospective compensation arrangement with any person, shall report and pay the premium tax liability set forth in the Revenue and Taxation Code on the basis that it has received the full premium charge including policy fees made to the insureds under policies less return premiums as permitted by law.

995.6. The provisions of Sections 995.1, 995.2, and 995.3 permitting the commissioner, in certain situations, to examine a person operating under a contingent or retrospective commission arrangement with an insurer at the expense of the insurer, and the other provisions of this article, shall not prevent the insurer from making a contract in advance with such person that in such event the person will reimburse the insurer for such expense. If in the course of examining such person the commissioner finds such person also operates under such contingent or retrospective commission arrangements with other insurers, he may prorate the expense of examination on an equitable basis among all the insurers so dealing with the person.

995.7. The purposes of Section 816 and the provisions of this article are to promote the solvency of insurers and the producers dealing with them under contracts, arrangements and practices therein described; to protect the public from unjustifiable claims practices and the inconvenience, hardship and possible loss attendant upon the insolvency of any of the insurers or persons described therein; and to prevent any frauds or mistakes which may arise from any of the contracts, arrangements or practices described therein. In furtherance of these purposes the commissioner shall at least 90 days prior to charging any person with a violation of Section 816 or the provisions of this article make reasonable rules and regulations clarifying or defining any word, term or phrase used in Section 816 or in this article, including establishment of detailed standards to determine solvency as that word is used in Section 995.2. Such rules and regulations shall be adopted, amended or repealed in accordance with the procedures provided in Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code.

INSURANCE CODE
SECTION 997

997. (a) For statement purposes as defined in Article 10 (commencing with Section 900), for insolvency calculations as defined in Article 13 (commencing with Section 980), and for the valuation

of the liabilities of insurers for all other purposes, every admitted insurer shall maintain an active life reserve which shall place a sound value on its liabilities under all disability policies and which shall not be less than the reserve according to the standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than the pro rata gross unearned premium reserve for the policies. The promulgation of the regulations by the commissioner or any changes or amendments thereof shall be in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Subdivisions (b), (c), and (d) shall control the amounts of reserves and liabilities, other than for specific claim losses, upon all individual disability policies until the effective date of regulations issued by the commissioner as provided in the next preceding paragraph. The regulations, in lieu of subdivisions (b), (c), and (d), shall control the amounts of the reserves and liabilities during the time the regulations continue in force. In the event the regulations shall cease to be in effect, the reserves and liabilities again shall be controlled by subdivisions (b), (c), and (d) during the time no such regulations shall be in force.

(b) Every admitted insurer which issues one or more of the following three types of individual disability policies shall maintain a reserve not less than the minimum reserve required under this subdivision:

(1) Policies which are guaranteed renewable for life or to a specified age at guaranteed premium rates.

(2) Policies which are guaranteed renewable for life or to a specified age but under which the insurer has reserved the right to change the scale of premiums.

(3) Policies, other than those described in paragraph (1) of subdivision (c), in which the insurer has reserved the right to cancel or to refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

During the period within which the renewability of the policy is guaranteed or the insurer's right to cancel the policy or to refuse renewal thereof is limited, the minimum reserve shall be an amount computed on the basis of two-year preliminary term tabular mean reserves employing the following assumptions:

Mortality and Interest: those assumptions specified in Article 3 (commencing with Section 10478) and Article 3a (commencing with Section 10489.1) of Chapter 5 of Part 2 of Division 2, for the

determination of minimum policy reserve liabilities for ordinary life insurance.

Morbidity or other contingency: any tables adopted by the National Association of Insurance Commissioners, or its successor, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for use in valuing individual disability insurance policies, or any modification of these tables approved by the commissioner, or any tables based upon individual insurer's own experience and approved by the commissioner.

For each benefit, each company shall establish reserves that place a sound value on the liabilities for the benefit.

These mean reserves shall be diminished or offset by appropriate credit for the valuation net deferred premiums. In no event, however, shall the aggregate reserves for all policies valued on the mean reserve basis, diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under the policies.

Negative reserves for any benefit may be offset against positive reserves for other benefits in the same individual or family policy, but if all benefits of the policy collectively develop a negative reserve, credit shall not be taken for the amount.

(c) Every admitted insurer which issues one or more of the following types of individual disability policies shall maintain the minimum unearned premium reserve required under this subdivision:

(1) Selected group disability policies issued under or subject to an agreement that, except for stated reasons, the insurer will not cancel or refuse to renew the coverage of individual insureds prior to a specified age unless all coverage under the same group is terminated.

(2) Any type of individual disability policy not included in one of the three types described in subdivision (b) and not included in paragraph (1) of this subdivision.

The minimum unearned premium reserve shall be the pro rata unearned portion of gross premiums in force and, subject to the limitations contained in Sections 922.2 to 922.8, inclusive, shall be reduced by premiums paid or credited for risks reinsured in solvent insurers.

(d) Provided the reserve on all policies to which the method or basis is applied is not less in the aggregate than the required amount determined according to the applicable standards specified in subdivisions (b) and (c), an insurer may use any reasonable assumptions as to the interest rate, mortality rates or the rates of morbidity or other contingency, and may introduce an assumption as to the voluntary termination of policies. Also, subject to the

preceding conditions, the insurer may employ methods other than the methods stated in subdivisions (b) and (c) in determining a sound value of its liabilities under such policies, including, but not limited to, any of the following:

(1) The use of midterminal reserves in addition to either the gross pro rata unearned premium reserves described in subdivision (c) or the net pro rata unearned premium reserve.

(2) Optional use of either the level premium, the one-year preliminary term or the two-year preliminary term method.

(3) Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expense.

(4) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity.

(5) The computation of the reserve for one policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued.

(6) The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

For statement purposes the net reserve liability for active lives may be shown as the mean reserve with offsetting asset items for net unpaid and deferred premiums or it may be shown as the excess of the mean reserve over the amount of net unpaid and deferred premiums, or, regardless of the underlying method of calculation, it may be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

INSURANCE CODE
SECTION 1010-1062

1010. The provisions of this article shall apply to all persons subject to examination by the commissioner, or purporting to do insurance business in this State, or in the process of organization with intent to do such business therein, or from whom the commissioner's certificate of authority is required for the transaction of business, or whose certificate of authority is revoked or suspended.

1011. The superior court of the county in which the principal

office of a person described in Section 1010 is located shall, upon the filing by the commissioner of the verified application showing any of the following conditions hereinafter enumerated to exist, issue its order vesting title to all of the assets of that person, wheresoever situated, in the commissioner or his or her successor in office, in his official capacity as such, and direct the commissioner forthwith to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business of said person, or so much thereof as to the commissioner may seem appropriate, and enjoining said person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until the further order of said court:

(a) That such person has refused to submit its books, papers, accounts, or affairs to the reasonable inspection of the commissioner or his or her deputy or examiner.

(b) That such person has neglected or refused to observe an order of the commissioner to make good within the time prescribed by law any deficiency in its capital if it is a stock corporation, or in its reserve if it is a mutual insurer.

(c) That such person, without first obtaining the consent in writing of the commissioner, has transferred, or attempted to transfer, substantially its entire property or business or, without such consent, has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(d) That such person is found, after an examination, to be in such condition that its further transaction of business will be hazardous to its policyholders, or creditors, or to the public.

(e) That such person has violated its charter or any law of the state.

(f) That any officer of such person refuses to be examined under oath, touching its affairs.

(g) That any officer or attorney in fact of such person has embezzled, sequestered, or wrongfully diverted any of the assets of such person.

(h) That a domestic insurer does not comply with the requirements for the issuance to it of a certificate of authority, or that its certificate of authority has been revoked; or

(i) That the last report of examination of any person to whom the provisions of this article apply shows such person to be insolvent within the meaning of Article 13 (commencing with Section 980), Chapter 1, Part 2, Division 1; or if a reciprocal or interinsurance

exchange, within the applicable provisions of Section 1370.2, 1370.4, 1371, or 1372; or if a life insurer, within the applicable provisions of Sections 10510 and 10511.

1011.5. The consent described in Section 1011(c) shall be obtained by filing an application with the commissioner in a form to be prescribed by him accompanied by such additional information concerning the insurer, its condition and affairs as the commissioner requires.

A fee of two thousand six hundred fifty-five dollars ($2,655) shall be paid to the commissioner for the filing of the application.

1012. Said order shall continue in force and effect until, on the application either of the commissioner or of such person, it shall, after a full hearing, appear to said court that the ground for said order directing the commissioner to take title and possession does not exist or has been removed and that said person can properly resume title and possession of its property and the conduct of its business.

1013. Whenever it appears to the commissioner that any of the conditions set forth in section 1011 exist or that irreparable loss and injury to the property and business of a person specified in section 1010 has occurred or may occur unless the commissioner so act immediately, the commissioner, without notice and before applying to the court for any order, forthwith shall take possession of the property, business, books, records and accounts of such person, and of the offices and premises occupied by it for the transaction of its business, and retain possession subject to the order of the court. Any person having possession of and refusing to deliver any of the books, records or assets of a person against whom a seizure order has been issued by the commissioner, shall be guilty of a misdemeanor and punishable by fine not exceeding one thousand dollars or imprisonment not exceeding one year, or both such fine and imprisonment.

1014. Whenever the commissioner makes any seizure as provided in section 1013, it shall, on the demand of the commissioner, be the duty of the sheriff of any county of this State, and of the police department of any municipal corporation therein, to furnish him with such deputies, patrolmen or officers as may be necessary to assist the commissioner in making and enforcing any such seizure.

1015. Immediately after such seizure, the commissioner shall institute a proceeding as provided for in section 1011 and thereafter shall proceed in accordance with the provisions of this article.

1016. If at any time after the issuance of an order under section 1011, or if at the time of instituting any proceeding under this article, it shall appear to the commissioner that it would be futile to proceed as conservator with the conduct of the business of such person, he may apply to the court for an order to liquidate and wind up the business of said person. Upon a full hearing of such application, the court may make an order directing the winding up and liquidation of the business of such person by the commissioner, as liquidator, for the purpose of carrying out the order to liquidate and wind up the business of such person.

1017. (a) In the commissioner's application for an order for the liquidation of a domestic corporation, or at any time thereafter, the commissioner may apply for, and the court shall make, an order dissolving the corporation.

(b) At any time during a proceeding for the liquidation of a domestic corporation authorized under Section 1016, the commissioner may apply for, and the court shall make, an order to permit the commissioner to sell the charter and license of that corporation while continuing to administer and distribute the remaining assets according to the provisions of this article. The order shall provide that the liabilities of the domestic corporation may not be transferred with the charter and license. In continuing the administration and distribution of assets the commissioner need not establish a liquidating trust or other, similar entity.

1018. The recording in the office of a county recorder of any county in the State of an order entered pursuant to section 1011, 1016 or 1017 shall impart the same notice that would be imparted by the recordation of a deed, bill of sale or other evidence of title duly executed by such person.

1019. Upon the issuance of an order of liquidation under section 1016, the rights and liabilities of any such person and of creditors, policyholders, shareholders and members, and all other persons interested in its assets, including the State of California, shall, unless otherwise directed by the court, be fixed as of the date of the entry of the order in the office of the clerk of the county wherein the application was made.

1020. Upon the issuance of an order either under Section 1011 or 1016, or at any time thereafter, the court shall issue such other injunctions or orders as may be deemed necessary to prevent any or all of the following occurrences:

(a) Interference with the commissioner or the proceeding.

(b) Waste of assets of such person.

(c) The institution or prosecution of any actions or proceedings.

(d) The obtaining of preferences, judgments, attachments, or other liens against such person or its assets.

(e) The making of any levy against any such person or its assets.

(f) The sale or deed for nonpayment of taxes or assessments levied by any taxing agency of property:

(1) Owned by such person.

(2) Upon which such person holds an encumbrance.

(3) Upon which such person has prior thereto commenced an action to foreclose any deed of trust or mortgage or has exercised the power of sale under any trust deed or mortgage which sale or foreclosure proceedings have not yet been completed or upon which no trustee's deed or judgment of court or sheriff's certificate of sale has been issued. "Taxing agency" as used in this section has the meaning ascribed to it by Section 121 of the Revenue and Taxation Code. The injunctions or orders authorized by this subdivision may be modified, dissolved or rescinded by the court on motion of the commissioner,

the State Controller, the person charged with the collection of taxes or assessments on such property, or any person beneficially interested in the property. The recording in the office of the county recorder of any county in the State of an order or injunction issued pursuant to this section, shall constitute service of such order or injunction upon any taxing agency with respect to property or interests therein located in such county.

(g) Any managing general agent or attorney in fact from withholding from the commissioner any books, records, accounts, documents or other writing relating to the business of such person; provided, however, that, if by contract or otherwise any of the same are the property of such an agent or attorney, the same shall be returned when no longer necessary to the commissioner or at any time the court after notice and hearing shall so direct.

1021. (a) Upon the making of an order to liquidate the business of such person, the commissioner shall publish notice to its policyholders, creditors, shareholders, and all other persons interested in its assets. The order and the notice shall require claimants to file their claims with the commissioner, together with proper proofs thereof, within six months to one year, at the commissioner's discretion, after the date of first publication of such notice, in the manner specified in this article.

(b) The time period specified in subdivision (a) shall not apply to the California Insurance Guarantee Association or the California Life and Health Insurance Guarantee Association provided it files with the commissioner a notice of possible claim within such six-month period and files actual claim or claims within such periods of time as may be permitted by order of court.

(c) Notwithstanding the provisions of subdivision (a), both of the following apply:

(1) If the commissioner determines that the business subject to liquidation order possesses, or is likely to possess, insufficient assets to permit significant distribution to a person interested in those assets, the commissioner may decline to handle a claim submitted pursuant to subdivision (a), as long as the notice requirements of subdivision (a) and Section 1022 are observed.

(2) If the commissioner reasonably determines that the business subject to liquidation order possesses, or is likely to possess, insufficient assets to permit significant distribution of funds to pay the expenses of administration under this article, as provided in paragraph (1) of subdivision (a) of Section 1033, the commissioner

may decline to continue, and may abandon, the insolvency proceeding upon providing notice pursuant to subdivision (a) and Section 1022.

1022. Such notice shall be published in a newspaper of general circulation, published in the county in which the proceeding is pending, and in the Counties of Alameda, Los Angeles, Sacramento, San Diego, San Francisco, and Santa Clara, not less than once a week for four successive weeks. A copy of the notice, accompanied by an affidavit of due publication, including a statement of the date of first publication, shall be filed with the clerk of the court.

1023. A claim must set forth, under oath, on the form prescribed by the commissioner:

(a) The particulars thereof, and the consideration therefor.

(b) Whether said claim is secured or unsecured, and, if secured, the nature and amount of such security.

(c) The payments, if any, made thereon.

(d) That the sum claimed is justly owing from such person to the claimant.

(e) That there is no offset to the claim.

(f) Such other data or supporting documents as the commissioner requires.

1024. Unless such claim is filed in the manner and within the time provided in section 1021, it shall not be entitled to filing or allowance, and no action may be maintained thereon. In the liquidation, pursuant to the provisions of this article, of any domestic insurer which has issued policies insuring the lives of persons, the commissioner shall, within thirty days after the last day set for the filing of claims, make a list of the persons who have not filed proofs of claim with him and to whom, according to the books of said insurer, there are amounts owing under such policies, and he shall set opposite the name of each person the amount so owing to such person. Each person whose name shall appear upon said list shall be deemed to have duly filed, prior to the last day set for the filing of claims, a claim for the amount set opposite his name on said list.

1025. Claims founded upon unliquidated or undetermined demands must be filed within the time limit provided in this article for the filing of claims, but claims founded upon such demands shall not share in any distribution to creditors of a person proceeded against under section 1016 until such claims have been definitely determined, proved and allowed. Thereafter, such claims shall share ratably with other claims of the same class in all subsequent distributions.

An unliquidated or undetermined claim or demand within the meaning of this article shall be deemed to be any such claim or demand upon which a right of action has accrued at the date of the order of liquidation and upon which the liability has not been determined or the amount thereof liquidated.

1025.5. Notwithstanding the provisions of Sections 1021 to 1025, inclusive, the commissioner may, in lieu of requiring claimants to file separate claims:

(a) File a claim himself or herself on behalf of all claimants for return premiums.

(b) Permit any assignee of the right of the insured to a return premium by virtue of a valid assignment, as security or otherwise, made prior to an order under Section 1011 or a seizure under Section 1013, whichever is earlier in time in the particular case, to file one claim as assignee on behalf of all insureds having assigned rights to the assignee, which shall set forth such information as may be required under Section 1023.

(c) Permit the California Insurance Guarantee Association under subdivision (b) of Section 1063.4, or the California Life and Health Insurance Guarantee Association under paragraph (1) of subdivision (m) of Section 1067.07 to file one claim, for its association, combining all assigned claims and setting forth the information that the commissioner may require under Section 1023.

1026. Whenever any person has a cause of action against an insured and such cause is covered by a liability policy, such person, if the insurer is adjudged insolvent, may file a claim in the liquidation proceeding even if the claim is undetermined or unliquidated.

1026.1. Where a claim arising out of a policy of insurance has been filed by a third party and approved by the liquidator and such claim has subsequently been paid or satisfied, either wholly or in part, by the transfer of anything of value, either voluntarily or by process, from the insured of the person in liquidation to such third party, then upon the filing with the liquidator of proof of the making and value of such transfer, to the extent and in the manner required by the liquidator, the insured shall be subrogated to the rights of the third party claimant to the extent that the claim has been satisfied and discharged, but the rights of the insured shall not exceed the face value of such claim and if the insured has theretofore filed a claim covering the same subject matter, he is entitled to only one recovery.

1027. A claim by a third party founded upon an insurance policy may be allowed by the liquidator without requiring such claim to be reduced to judgment, provided it can be reasonably inferred from the proof presented that the claimant would be able to obtain a judgment upon his cause of action against the insured and that such judgment would represent a liability of the person in liquidation under the policy of insurance upon which such claim is founded.

In the event several claims founded upon one policy or bond are filed, and the aggregate amount of such claims exceeds the liability limit of said policy or bond, and one or more of such claims is unliquidated and undetermined, then all of such claims shall be deemed unliquidated and undetermined; provided, however, that should one or more of said claims become determined and proved within the time provided in this article, the liquidator, upon any distribution to creditors, shall impound the distribution percentage of the face amount of said claim or claims so determined and proved, not exceeding the policy or bond limit, and upon such claim or claims becoming liquidated as to amount, the liquidator shall release to such claimant the distribution percentage of the final liquidated value of such claims out of the funds so impounded.

1028. A judgment taken by default, or by collusion, against an insured shall not be considered as evidence, in the liquidation proceeding, either of the liability of such insured to such claimant upon such cause of action or of the amount of damages to which such

claimant is entitled.

1029. A claim of a secured claimant shall not be allowed in a sum greater than the excess over the value of the security of the amount for which the claim would be allowable if unsecured, unless the claimant surrenders the security to the liquidator. Upon such surrender the claim may be allowed in the full amount for which it is valued.

1030. The value of the security to be credited upon such claim shall be determined by an appraiser appointed by the liquidator and approved by the court. Such claimant shall elect to accept the security or to release it to the liquidator.

1030.5. (a) The liquidator may require, as a condition of payment of the final liquidation dividend to a lender, or his assignee, who has filed a claim for an unearned premium as an assignee of the insured for valuable consideration, that such assignee of the insured shall assign to the liquidator all his right, title, and interest in any unsatisfied debt of the insured to such assignee, pertaining to policies of the insolvent insurer, remaining unpaid after crediting the final liquidation dividend, if the amount of such unsatisfied debt is less than one hundred dollars and one cent ($100.01).

The liquidator may also require, as condition precedent, the delivery to him of all the documents giving rise to such debt.

The liquidator, in his sole discretion, may determine whether or not it will be feasible to attempt to collect any such assigned debt. If he determines not to pursue collection of any such debt, he shall file a declaration to that effect with the liquidation court and be relieved of any further responsibility in respect to such debt.

(b) As used in this section, "insured" means a natural person who purchased insurance from the insolvent insurer for personal, family, or household purposes.

1030.6. In any proceeding under this article, no agent shall be liable to the liquidator or conservator for unearned premiums uncollected by the agent, or unearned commissions uncollected by the agent, arising from an insolvency of an insurer.

1031. Mutual debts or mutual credits, whether arising out of one or more contracts between the person in liquidation under Section 1016 and any other person, shall be set off and the balance only shall be allowed or paid, except with respect to any of the following obligations as described in subdivisions (a) to (d), inclusive:

(a) The obligation of the person in liquidation to such other person does not entitle such other person claiming such set-off to share as a claimant in the assets of the person in liquidation.

(b) The obligation of the person in liquidation to the other person was purchased by, or transferred to, the other person.

(c) The obligation of the other person to the person in liquidation is to pay an assessment levied against the other person or to pay a balance upon a subscription for shares of the capital stock of the person in liquidation.

(d) The obligations between the other person and the person in liquidation arise from business where either the person in liquidation or the other person has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations.

Notwithstanding the foregoing, a set-off of amounts due on obligations arising from those contracts shall be allowed if the balance arises from contracts that were entered into, renewed, or extended with the express written approval of the commissioner.

1032. When a claim is rejected by the commissioner, written notice of rejection shall be given by mail, addressed to the claimant at the address set forth in his claim. Within thirty days after the mailing of the notice the claimant may apply to the court in which the liquidation proceeding is pending for an order to show cause why the claim should not be allowed.

1033. (a) Claims allowed in a proceeding under this article shall be given preference in the following order:

(1) Expense of administration.

(2) All claims of the California Insurance Guarantee Association or the California Life and Health Insurance Guarantee Association, and associations or entities performing a similar function in other states, together with claims for refund of unearned premiums and all claims under insurance and annuity policies or contracts, including funding agreements, of an insolvent insurer that are not covered claims.

The following claims are excluded from this priority:

(A) Any obligations of the insolvent insurer arising out of any reinsurance contracts, as well as obligations incurred after the expiration date of the policy or after the insurance policy has been replaced by the insured or canceled at the insured's request, or after the policy has been canceled by the California Insurance Guarantee Association, the California Life and Health Insurance Guarantee Association, or another association or entity performing a similar function in another state.

(B) Any obligations to insurers, insurance pools, or underwriting associations, and their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

(C) Any amount awarded as punitive or exemplary damages, and any damages in excess of the liability limits of the policies or contracts that represent damages for contractual bad faith.

(D) Any amount that is a surplus deposit of a subscriber as defined in Section 1374.1.

(E) Any judgments against or obligations or liabilities of the insolvent insurer otherwise arising from alleged or proven torts, and any default, collusive, or stipulated judgment against either the insured or the person subject to proceedings under this article, as well as any judgment taken in violation of Section 1020. Nothing in this subparagraph shall prohibit the commissioner from considering the underlying claims as a claim entitled to priority under this section, provided that the claimant shall provide to the commissioner a written election that the judgment shall in all things be disregarded in determining the liability for and valuation of the underlying claim.

(F) Any loss adjustment expenses, including adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, bond premiums, expert witness fees, and other claims of a similar nature incurred prior to the appointment of a liquidator.

(G) Claims arising from any self-insured program of the insurer,

including employee life, health and annuity plans, and self-funded employee benefit plans, however denominated, as well as claims arising from a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended, a minimum premium group insurance plan, a stop-loss group insurance plan, or an administrative services-only plan.

(H) Any portion of a policy or contract to the extent that it provides experience rating credits or refunds, dividends, or for the payment of fees or allowances to any person, including the policyholder or contractholder, in connection with the service to or administration of the policy or contract.

(I) Any annuity issued by a charitable organization for which the person subject to these proceedings did not have or utilize a certificate of authority to issue the policy or contract.

(3) Claims having preference by the laws of the United States.

(4) Unpaid charges due under the provisions of Section 736.

(5) Taxes due to the State of California.

(6) Claims having preference by the laws of this state.

(7) Claims of creditors not included in paragraphs (1) to (6), inclusive.

(8) Certificates of contribution, surplus notes, or similar obligations, and premium refunds on assessable policies.

(9) The interests of shareholders or other owners in any residual value in the estate.

(b) (1) Every claim allowed under a separate account policy, contract, or agreement providing, in effect, that the assets allocated to the separate account are not chargeable with liabilities arising out of any other business of the insurer, shall be satisfied out of the assets properly allocated to and maintained in the separate account, excluding amounts allocated or transferred to the separate account by the insurer pursuant to subdivision (b) of Section 10506, equal to the reserves maintained in the separate account for the policies, contracts, or agreements. No liabilities of the insurer arising out of any other business of the insurer shall be satisfied from assets properly allocated to and maintained in a separate account except (A) from amounts allocated or transferred to the separate account pursuant to subdivision (b) of Section 10506 and (B) from any assets allocated to the separate account that exceed the reserves under the separate account policies, contracts, or agreements. For the purposes of this subdivision, "separate account policies, contracts, or agreements" means any policies, contracts, or agreements that provide for separate accounts as contemplated by Section 10506, 10506.3, 10506.4, or 10541. Any valid and allowed

claim for contractual benefits that cannot be satisfied out of the assets properly allocated to and maintained in a separate account for obligations authorized by subdivision (a) of Section 10506.3 shall be included as a claim against the general account within paragraph (2) of subdivision (a). Any valid and allowed claim against the general account for contractual benefits under an obligation authorized by Section 10506.4 shall be included as a claim within paragraph (2) of subdivision (a).

(2) Notwithstanding any other provision of law, to the extent that any assets of a life insurer, other than those assets properly allocated to, and maintained in, a separate account, have been used to fund or pay any expenses, taxes, or policyholder benefits that are attributable to a separate account policy, contract, or agreement that should have been paid by a separate account prior to the commencement of delinquency proceedings, then upon the commencement of delinquency proceedings, the separate accounts that benefited from this payment or funding shall first be used to repay or reimburse the company's general assets or account for any unreimbursed net sums due at the commencement of delinquency proceedings prior to the application of the separate account assets to the satisfaction of liabilities of the corresponding separate account policies, contracts, and agreements.

(c) Upon the issuance of an order appointing a conservator or liquidator for any person under either Section 1011 or 1016 or both these sections, the lien of taxes due to the State of California imposed by Article 4 (commencing with Section 12491) of Chapter 4 of Part 7 of Division 2 of the Revenue and Taxation Code shall become subordinate to the reasonable administrative expenses of the proceeding under the order.

(d) The following definitions are for purposes of this section only and shall not be used to determine coverage under the California Life and Health Insurance Guarantee Association Act (Article 14.7 (commencing with Section 1067)):

(1) "Funding agreements" means those agreements authorized to be delivered or issued pursuant to Section 10541.

(2) "Annuity" means only those annuity contracts, including period-certain annuities issued by a life insurer, that require for their lawful issuance a certificate of authority from the commissioner, and excludes without limitation all instruments for which the commissioner's certificate of authority is not required, such as promissory notes, installment loans, negotiable instruments, mortgages, and debentures.

(3) Reinsurance contracts shall not be included as insurance or annuity policies or contracts, or funding agreements. However, any

insurance or annuity policy or contract, including any funding agreement, that is assumed by an insurer under an assumption reinsurance agreement pursuant to a plan of liquidation, rehabilitation, or reorganization shall, unless the plan provided otherwise, be deemed to retain the issue date of the original insurance or annuity policy or contract, or funding agreement that is assumed.

(e) The provisions of this section are severable. If any portion of this section is held invalid or is preempted by federal law, the remainder of the section and its application shall not be affected. Specifically, should any of paragraphs (1) to (6), inclusive, of subdivision (a) be held to be invalid or preempted by federal law, the claims included within the invalid paragraph shall be included within paragraph (7) of subdivision (a), and the remaining paragraphs shall not be affected thereby.

(f) No payment shall be made to any creditor in paragraphs (8) or (9) of subdivision (a), unless all claims in paragraphs (3) to (7), inclusive, of subdivision (a) have been paid in full, together with interest at the legal rate of the date of the order commencing the proceeding or the date on which the claim became liquidated, whichever date is later. In proceedings involving life insurance companies, no payment shall be made for any claim in paragraph (7), (8), or (9) of subdivision (a) unless and until all claims in paragraph (1) of subdivision (a) have been paid in full, together with interest at the legal rate, all claims in paragraph (2) of subdivision (a) have been paid the full value of the policy or contract upon which the claim is based, as of the time of distribution to claimants, and all claims in paragraphs (3) to (6), inclusive, of subdivision (a) have been paid in full, together with interest at the legal rate from the date of the order commencing the proceeding. Notwithstanding the provisions of this subdivision, no payment of interest shall be made to any insurance guaranty association that receives early access disbursements from the estate pursuant to Section 1035.5.

1034. (a) A preference is a transfer of any of the property of the person proceeded against to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the person proceeded against within one year before the filing of a petition for liquidation pursuant to Section 1016, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. The

following transactions shall be among those that may be considered a preference:

(1) A transfer of property of the person proceeded against.

(2) The creation of a lien on the property of the person proceeded against.

(3) The entry of a judgment against the person proceeded against.

(4) The transfers or other payments by the person proceeded against pursuant to subdivision (f) of Section 10506 in support of guarantees contemplated by Section 10506.4.

(b) If a liquidation order is entered pursuant to Section 1016 while the person proceeded against is already subject to a conservation order, then the transfers described in subdivision (a) shall be deemed preferences if made or suffered within one year before the filing of the successful petition for conservation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(c) Any preference may be avoided by the liquidator if any of the following is applicable:

(1) The transfer was made within four months before the filing of the petition.

(2) The creditor receiving the transfer or to be benefited thereby or his or her agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the person proceeded against was insolvent or was about to become insolvent.

(3) The creditor receiving the transfer was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the person proceeded against to an officer, whether or not the person held that position, or any shareholder holding directly or indirectly more than 5 percent of any class of any equity security issued by the person proceeded against, or any other person, firm, corporation, association, or aggregation of persons with whom the person proceeded against did not deal at arm's length.

(d) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, the purchaser or lienor shall have a lien upon the property to the extent of the consideration actually given. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

1034.1. (a) Every transfer made or suffered and every obligation incurred by a person proceeded against within one year prior to the filing of a successful petition for conservation or liquidation under this article is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors.

(b) A transfer made or an obligation incurred by a person proceeded against under this article, which is fraudulent under this section, may be avoided by the commissioner, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for that transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the commissioner shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the person proceeded against could obtain rights superior to the rights of the transferee.

(3) A transfer that creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subdivision apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Every person receiving any property from the person proceeded against or any benefit thereof that is a fraudulent transfer under subdivision (a) shall be personally liable therefor and shall be bound to account to the commissioner.

(d) Any transaction of the person proceeded against with a

reinsurer shall be subject to avoidance by the commissioner under subdivision (b) if both of the following are applicable:

(1) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release.

(2) Any part of the transaction took place within one year prior to the date of filing of the petition through which the conservation or liquidation was commenced.

The commissioner may avoid the transaction at any time within two years after the effective date of the transaction. If the transaction is so avoided, the parties shall be returned to their respective position as if the transaction had not occurred, and the commissioner may enforce the reinsurance contract as it existed prior to the transfer.

1035. (a) In any proceeding under this article, the commissioner may appoint and employ under his or her hand and official seal, special deputy commissioners, as his or her agents, and to employ clerks and assistants and to give to each of them those powers that he or she deems necessary. Upon appointing or employing special deputy commissioners, clerks, or assistants, the commissioner shall notify the Chair of the Joint Budget Committee of the Legislature, by letter, of the action. The costs of employing special deputy commissioners, clerks, and assistants appointed to carry out this article, and all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of that person under this article, shall be fixed by the commissioner, subject to the approval of the court, and shall be paid out of the assets of that person to the department. In the event the property of that person does not contain cash or liquid assets sufficient to defray the cost of the services required to be performed under the terms of this article, the commissioner may at any time or from time to time pay the cost of those services out of the appropriation for the maintenance of the department, but not out of the assets of other estates. Any amounts so paid shall be deemed expenses of administration and shall be repaid to the fund out of the first available moneys in the estate.

(b) Any person appointed by the commissioner to serve in the capacity of chief executive officer of the department's Conservation

and Liquidation Office shall be subject to confirmation by the Senate.

1035.2. (a) The officers and employees of the Conservation and Liquidation Office are subject to all conflict-of-interest provisions and financial disclosure requirements that would apply if they were employees of the department.

(b) (1) Prior to February 1, 2002, the department shall determine, pursuant to the provisions of Section 19990 of the Government Code, those activities of the officers and employees of the Conservation and Liquidation Office that are inconsistent, incompatible, or in conflict with their duties as officers or employees of that office.

(2) Prior to February 1, 2002, the department shall adopt and promulgate a Conflict of Interest Code pursuant to the provisions of Article 3 (commencing with Section 87300) of Chapter 7 of Title 9 of the Government Code, pertaining to the officers and employees of the Conservation and Liquidation Office. The Conflict of Interest Code and any other regulations necessary to implement this section shall be promulgated by the department as emergency regulations.

(c) The provisions of Chapter 7 (commencing with Section 87100) of Title 9 of the Government Code shall apply to a person who contracts with the Conservation and Liquidation Office to the same extent as would apply if that person were entering into the same or similar contractual relationship with the department.

(d) The department shall ensure that the officers and employees of the Conservation and Liquidation Office and persons who contract with that office comply with all provisions of this section.

1035.5. Notwithstanding the provisions of Article 14 (commencing with Section 1010), with regard only to those insurers subject to this article:

(a) Within 120 days of the issuance of an order directing the winding up and liquidation of the business of an insolvent insurer under Section 1016, the commissioner shall make application to the court for approval of a proposal to disburse the insurer's assets, from time to time as such assets become available, to the California Insurance Guarantee Association, or the California Life and Health Insurance Guarantee Association, and to any entity or person performing a similar function in another state.

(b) The proposal shall at least include the following provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors (to the extent of the value of the security held) and claims falling within the priorities established in paragraphs (1) to (4), inclusive, of subdivision (a) of Section 1033.

(2) Disbursement of the assets marshaled to date and subsequent disbursements of assets as they become available.

(3) Equitable allocation of disbursements to each of the associations entitled thereto.

(4) The securing by the commissioner from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the commissioner such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in paragraphs (1) to (5), inclusive, of subdivision (a) of Section 1033 in accordance with the priorities. No bond shall be required of any association.

(5) A full report to be made by the association to the commissioner accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on the assets, and any other matter as the court may direct.

(c) The commissioner's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made by the associations for which such associations could assert a claim against the commissioner, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of the claim payments made or to be made by the associations, then disbursements shall be in the amount of available assets. The reserves of the insolvent insurer on the date of the order of liquidation shall be used for purposes of determining the pro rata allocation of funds among eligible associations.

(d) The commissioner shall offset the amount disbursed to any entity or person performing a function in any other state similar to that function performed by the California Insurance Guarantee Association, or the California Life and Health Insurance Guarantee Association, by the amount of any statutory deposit, premiums, or any other asset of the insolvent insurer held in that state.

(e) Notice of such application shall be given to the associations in and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first-class postage prepaid, at least 30 days prior to submission of such application to the court. Action on the application may be taken by the court provided the above

required notice has been given and provided further that the commissioner's proposal complies with paragraphs (1) and (4) of subdivision (b).

1036. Notwithstanding any other provision of law, the provisions of Article 4 (commencing with Section 11040) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, pertaining to legal services, shall apply in the institution and prosecution of all insurance delinquency proceedings under this code. The compensation of any counsel outside of California state service who is employed pursuant to these provisions to represent the commissioner as receiver shall be fixed by the commissioner, subject to the approval of the court. Compensation of counsel representing the commissioner as receiver shall be paid from the assets of the person against whom the commissioner has proceeded under this article. It is the intent of the Legislature and the Legislature finds it is in the best interest of the people of the State of California that the Attorney General and the Insurance Commissioner consult and cooperate in regard to utilizing agency counsel of the Department of Insurance as the commissioner's legal counsel in delinquency proceedings, judicial and otherwise, to the extent appropriate and consistent with the interests of the parties beneficially interested in those proceedings and if that use would result in the savings of costs to the parties beneficially interested in those proceedings.

1037. Upon taking possession of the property and business of any person in any proceeding under this article, the commissioner, exclusively and except as otherwise expressly provided by this article, either as conservator or liquidator:

(a) Shall have authority to collect all moneys due that person, and to do such other acts as are necessary or expedient to collect, conserve, or protect its assets, property, and business, and to carry on and conduct the business and affairs of that person or so much thereof as to him or her may seem appropriate.

(b) Shall collect all debts due and claims belonging to that person, and shall have the authority to sell, compound, compromise, or assign, for the purpose of collection upon such terms and conditions as the commissioner deems best, any bad or doubtful debts.

(c) Shall have authority to compound, compromise or in any other

manner negotiate settlements of claims against that person upon such terms and conditions as the commissioner shall deem to be most advantageous to the estate of the person being administered or liquidated or otherwise dealt with under this article.

(d) Shall have authority without notice, to acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any real or personal property of that person at its reasonable market value, or, in cases other than acquisition, sale, or transfer on the basis of reasonable market value, upon such terms and conditions as the commissioner may deem proper. However, no transaction involving real or personal property shall be made where the market value of the property involved exceeds the sum of twenty thousand dollars ($20,000) without first obtaining permission of the court, and then only in accordance with any terms that court may prescribe.

(e) Shall have authority to transfer to a trustee or trustees, under a voting trust agreement, the stock of an insurer heretofore or hereafter issued to the commissioner as conservator or as liquidator in connection with a rehabilitation or reinsurance agreement, or any other proceeding under this article. This voting trust agreement shall confer upon the trustee or trustees the right to vote or otherwise represent that stock, and shall not be irrevocable for a period of more than 21 years.

(f) May, for the purpose of executing and performing any of the powers and authority conferred upon the commissioner under this article, in the name of the person affected by the proceeding or in the commissioner's own name, prosecute and defend any and all suits and other legal proceedings, and execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary and proper to effectuate any sale of any real and personal property or other transaction in connection with the administration, liquidation, or other disposition of the assets of the person affected by that proceeding; and any deed or other instrument executed pursuant to the authority hereby given shall be valid and effectual for all purposes as though it had been executed by the person affected by any proceeding under this article or by its officers pursuant to the direction of its governing board or authority. In cases where any real property sold by the commissioner under this article is located in a county other than the county wherein the proceeding is pending, the commissioner shall cause a certified copy of the order of his or her appointment, or order authorizing or ratifying the sale, to be filed in the office of the county recorder of the county in which that property is located.

(g) Shall have authority to invest and reinvest, in such manner as

the commissioner may deem suitable for the best interests of the creditors of that person, such portions of the funds and assets of that person in his or her possession as do not exceed the amount of the reserves required by law to be maintained by that person as reserves for life insurance policies, annuity contracts, supplementary agreements incidental to life business, and reserves for noncancellable disability policies, and which funds and assets are not immediately distributable to creditors. However, no investment or reinvestment shall be made which exceeds the sum of one hundred thousand dollars ($100,000) without first obtaining permission of the court, and then only in accordance with any terms that court may prescribe. That permission shall not be required for any investment or reinvestment of those funds or assets in funds administered by the Treasurer.

The enumeration, in this article, of the duties, powers and authority of the commissioner in proceedings under this article shall not be construed as a limitation upon the commissioner, nor shall it exclude in any manner his or her right to perform and to do such other acts not herein specifically enumerated, or otherwise provided for, which the commissioner may deem necessary or expedient for the accomplishment or in aid of the purpose of such proceedings.

1038. Any application under section 1011 or 1016 shall be served upon the person named in such application in the manner prescribed by law for personal service of summons or as provided by section 1039.

1039. In lieu of the service required by section 1038, service may, upon application to said court, be made in such manner as the court directs whenever it is satisfactorily shown by affidavit (a) in the case of a corporation, that the officers of the corporation upon whom service is required to be made as above provided, have departed from the State or keep themselves concealed therein with intent to avoid the service, or, (b) in the case of a Lloyd's association or interinsurance exchange, that the individual attorney in fact or the officers of the corporate attorney in fact can not be served because of such departure or concealment, or, (c) in the case of a natural person, that the natural person upon whom service is required to be made as above provided, has departed from the State or keeps himself concealed therein with intent to avoid the service.

1040. At any time after an order is made under section 1011 or 1016, the commissioner may remove the principal office of the person proceeded against to the City and County of San Francisco or to the city of Los Angeles. In event of such removal, the court wherein the proceeding was commenced shall, upon the application of the commissioner, direct its clerk to transmit all of the papers filed therein with such clerk to the clerk of the City and County of San Francisco or of the county of Los Angeles as the case may require. The proceeding shall thereafter be conducted in the same manner as though it had been commenced in the county to which it had been transferred.

1041. The commissioner shall be the custodian of all moneys collected by him or her or coming into his or her possession in the course of any proceeding under this article, but the commissioner may deposit those moneys, or any part thereof, without court approval in a bank which is a member of the Federal Deposit Insurance Corporation (FDIC), so long as the total deposit did not exceed those federal insurance limits; in a centralized State Treasury system bank account; or in funds administered by the Treasurer.

Provided further, any money which is deposited by the commissioner pursuant to this section, which the commissioner determines is available for investment, may be invested or reinvested by the Treasurer in any of the securities which are described in Article 1 (commencing with Section 16430) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code, or placed in a bank as provided in Chapter 4 (commencing with Section 16500) of Part 2 of Division 4 of Title 2 of the Government Code, and handled in the same manner as money in the State Treasury. Any increment which is received from that investment or reinvestment or deposit shall be remitted to the commissioner for allocation, upon a proper and equitable basis, to each estate participating in the investment, reinvestment, or deposit and deposited and disbursed as provided in Section 1037. The Treasurer may deduct from that remittance an amount equal to the reasonable costs incurred in carrying out this section or may bill the commissioner for those costs and the commissioner shall pay those costs from money which is collected pursuant to this chapter.

1042. The commissioner and a special deputy commissioner appointed pursuant to section 1035 shall have the power to subpoena witnesses and examine them under oath upon any subject relating to the affairs and business of any person affected by proceedings under this article. The penalties provided in Chapter II, Title III, Part IV of the Code of Civil Procedure shall apply to any witness who fails or refuses to appear in accordance with such subpoena, or to testify in connection therewith.

1043. In any proceeding under this article, the commissioner, as conservator or as liquidator, may, subject to the approval of said court, and subject to such liens as may be necessary mutualize or reinsure the business of such person, or enter into rehabilitation agreements. No commissioner who acts as conservator of such person or who mutualizes, merges or reinsures the business of such person or who enters into rehabilitation agreements affecting such person, and no deputy commissioner who has participated in the administration of the affairs of such person for the commissioner as conservator shall for a period of two years from and after the effective date of such mutualization, reinsurance or rehabilitation become an officer or director of, or serve as an officer or director of, or serve in any position of gain or profit in, any company formed in whole or in part of the assets or funds, or any part of the assets or funds of such mutualized, merged, reinsured or rehabilitated person.

Every person violating this provision is guilty of a public offense and shall be punished by imprisonment in the state prison, or in the county jail not exceeding one year, or by a fine not exceeding ten thousand dollars ($10,000), or by both such fine and imprisonment.

Such rehabilitation or reinsurance agreements shall provide that, subsequent to the date thereof and for such period of time as the commissioner may determine, no investment or reinvestment of the assets of the person rehabilitated or reinsured shall be made without first obtaining the written approval of the commissioner.

Every party to such agreement, and every director, officer, agent and employee of such person, and every other person who knowingly in violation thereof directs or aids or assists in causing to be made an investment or reinvestment of any of said assets without first having obtained the written approval of the commissioner, or who makes such investment or reinvestment in nonconformity with the written approval of the commissioner then in effect authorizing such investment or reinvestment, is guilty of a public offense and shall

be punished by imprisonment in the state prison, or in the county jail or by a fine not exceeding ten thousand dollars ($10,000), or by both such fine and imprisonment.

1044. In connection with a rehabilitation agreement under section 1043, which affects a life insurer, and in an agreement made for the reinsurance of the business of a life insurer under said section, there may be included in such rehabilitation or reinsurance agreement a provision for, and the commissioner shall have authority to impose and declare, a moratorium against the provisions of the life insurance policies therein involved calling for the making of loans on the security of such policies and for the payment of money upon the surrender of such policies, such moratorium to continue for such period and to such extent as may be directed by said court.

1045. If at any time after the issuance of an order under section 1011 affecting a life insurer issuing nonassessable policies on a reserve basis and organized with a capital stock evidenced by shares thereof it shall appear to the commissioner that the purposes of section 1011 can be best attained by the mutualization of such life insurer, the commissioner may formulate a plan for the mutualization of such insurer.

1046. Said mutualization plan shall include provisions for:

(a) The acquisition by such insurer of all outstanding shares of its capital stock at a price and upon terms and conditions to be fixed as hereinafter provided.

(b) The retirement of said shares of stock when acquired by such insurer.

(c) The amendment of the charter of such insurer so as to enable it to transact its business as a mutual insurer issuing nonassessable policies on a reserve basis.

(d) The manner in which and the time within which, after mutualization is effected, matured and maturing claims against such insurer shall be paid to the lawful holders thereof.

(e) The submission of said mutualization plan to the policyholders of such insurer under such procedure as shall be set forth in the plan or prescribed by said court, for their approval or rejection.

(f) Notice to the shareholders of such insurer, in such manner and at such time after the approval of said mutualization plan by said policyholders, as the court may direct.

1047. Said mutualization plan may include provisions:

(a) Imposing a moratorium against the provisions of the life insurance policies issued by such insurer and then in force calling for the making of loans on the security of such policies and for the payment of money upon the surrender of such policies, for a period and to an extent to be named in such provisions imposing such moratorium, and subject to extension, change or prior termination only upon the written approval of the commissioner.

(b) Imposing liens upon, or otherwise adjusting, the policies of the insurer so as to create or make available the minimum paid-in capital required of such an insurer to be admitted and such additional paid-in capital as will be reasonably sufficient to enable such insurer to carry on its business.

No lien or adjustment of such insurer's policies shall be made or imposed which has the effect of creating or making available for distribution to the shareholders of such insurer assets otherwise unavailable therefor.

(c) Regulating and adjusting the respective rights of holders of policies of different classes to participate in the profits or savings which may be made by such insurer when mutualized.

(d) Regulating the manner in which and the time at which the shareholders of such insurer shall be compensated for their proprietary interest, then existing, in the assets of such insurer other than goodwill.

(e) Regulating the manner in which the shareholders of such insurer shall be compensated for their proprietary interest in the goodwill, if then existing, of such insurer; provided, however, that no shareholder shall be compensated for his proprietary interest in such goodwill while any moratorium imposed under subdivision (a) of this section is in effect, nor while any lien imposed under subdivision (b) of this section exists, nor until all other indebtedness of such insurer existing at the time of mutualization has been fully paid and discharged or full provision made for its payment, nor otherwise than out of surplus earnings.

(f) Regulating such other matters as may, in the opinion of the commissioner, require regulation in the interest of expediency or otherwise.

1048. Upon formulation of said mutualization plan the commissioner shall submit the same to said court with his application for an order of said court directing the commissioner to submit said mutualization plan to the persons named in subdivision (e) of section 1046, under such procedure as shall be set forth in the plan or prescribed by said court, for their approval or rejection, and the court shall issue such order.

1049. Each policyholder of such insurer shall be entitled to one vote, regardless of the amount for which, or the number of policies under which, he is insured. Such mutualization plan shall be deemed approved by the said policyholders if a majority of the policyholders voting for and against it shall have approved it, and shall be deemed rejected if a majority of the policyholders voting for and against it shall have rejected it. In the event that said plan of mutualization is rejected by the policyholders of such insurer, the commissioner shall certify the fact of such rejection to said court, whereupon he may proceed further as hereinbefore provided in this article.

1050. In the event that said plan of mutualization is approved by said policyholders, the commissioner shall certify to the said court the fact of such approval and the number of votes cast for and against such mutualization plan. Said court shall thereupon issue its order directing the commissioner to give notice, as provided in said mutualization plan or as the court may otherwise prescribe, to the shareholders of such insurer of the approval of said mutualization plan by said policyholders. Said order shall direct the commissioner to transmit to each such shareholder by mail addressed to his address as it appears upon the records of such insurer, a true copy of said order and of said mutualization plan approved by said policyholders, and shall fix a time, not less than thirty nor more than sixty days from the date of such order, within which any such shareholder may file with said court a petition for the disapproval of said mutualization plan or for its modification in such manner as shall be set forth in such petition, and within which any such shareholder and the commissioner may file with said court a petition for the appointment of one or more appraisers to appraise the value of the then outstanding shares of capital stock of such insurer.

1051. After the expiration of the time fixed in the order provided for in section 1050, and upon the filing of such petition, said court shall direct notice of a hearing of said petitions to be given to the commissioner and to such petitioners as are shareholders of such insurer. At such hearing, all petitions for the disapproval and all petitions for the modification of said mutualization plan shall be given precedence over all petitions for the appointment of one or more appraisers. Upon hearing of all such petitions for the disapproval and for the modification of said mutualization plan, said court shall either approve said mutualization plan or disapprove it or modify it in such manner and to such extent, not inconsistent with the provisions of this article, as to said court shall seem appropriate. In the event of the disapproval of said mutualization plan the court shall deny all petitions for the appointment of one or more appraisers. In the event of the approval or modification of said mutualization plan, the court shall, upon hearing of the petitions for the appointment of appraisers, appoint one or more appraisers, who shall appraise the then outstanding shares of the capital stock of such insurer, without regard to any appreciation or depreciation arising out of said mutualization plan as so approved or modified. Such appraisement shall fix the reasonable value of such shares of capital stock, including the goodwill, if any, of such insurer, and shall state the value, if any, assigned to such goodwill; and if the appraisers shall have found that such insurer has no goodwill, such finding shall be stated. Such appraisement, when confirmed by said court, shall be final and conclusive.

1052. Thereupon the commissioner shall:

(a) Pay to each of such shareholders or his assignee or nominee, upon surrender of the shares held by such shareholder, the value of said shares so ascertained; subject, however, to the restrictions of subdivisions (d) and (e) of section 1047, and subject, also, to the terms and conditions of the mutualization plan as approved or modified.

(b) Appoint, with the approval of the court, the requisite number of directors in whom shall thereafter be vested the control and management of the assets and business of such insurer until their successors shall have been elected and qualified.

(c) Transfer, upon the order of said court, to the appropriate officers appointed by such directors, the property, real and

personal, and the books, records, accounts and papers of such insurer; provided, however, that the commissioner may retain, as a deposit, so much of such property as he deems necessary to defray additional costs and expenses incurred or to be incurred in connection with any proceeding under this article affecting such property or business.

1053. Immediately upon the appointment of the directors as provided in subdivision (b) of section 1052, the directors theretofore holding office shall cease to hold office, and all rights of the shareholders of such insurer to vote at any meeting of such insurer shall absolutely cease and such shareholders shall retain only such interest in such corporation or in the property or assets therof as shall be provided in said mutualization plan, and such insurer shall thereupon be and become a mutual life insurer under such corporate name as may have been set forth in its charter, as amended, to be conducted not for profit, but solely for the mutual benefit, ratably, of all its policyholders, and shall, upon issuance to it by the commissioner of a certificate of authority, have power to issue nonassessable policies on a reserve basis subject to all provisions of law applicable to incorporated life insurers issuing nonassessable policies on a reserve basis, but shall be exempt from the provisions of Chapter 7, Part 2, Division 2 of this code.

1054. Such insurer, after mutualization, shall be a continuation of the original insurer, and such mutualization shall not affect existing suits, rights or contracts except as provided in said mutualization plan as approved. Such insurer, after mutualization, shall exercise all the rights and powers and perform all the duties conferred or imposed by law upon insurers writing the classes of insurance written by it, and to protect rights and contracts existing prior to mutualization, subject to the effect of said mutualization plan.

1055. The commissioner shall exercise the powers and discharge the duties, concerning any insurer so mutualized, that are applicable to domestic insurers issuing policies of the same class. He shall issue a certificate of authority to transact the proper classes of insurance in this State to any insurer so mutualized which is solvent under Article 13, Chapter 1, Part 2, Division 1 of this code and

which has fully complied with the laws of this State.

1056. All costs and expenses connected with proceedings for the mutualization of such insurer shall be paid by the commissioner out of the funds of such insurer, whether or not mutualized, subject to the approval of said court.

1056.5. Whenever money or other property is payable to any claimant out of the assets of any person under the provisions of Sections 1021 to 1033, but such person cannot be located or for any other reason the payment of such money or other property to such person cannot be made, although assets are available for such payment, such money or other property shall be deposited in the State Treasury by the commissioner. Such deposits shall be deemed to have been received under the provisions of Chapter 7 (commencing with Section 1500) of Title 10 of Part 3 of the Code of Civil Procedure, and shall be subject to claim or other disposition as provided in said Chapter 7 (commencing with Section 1500) of Title 10. The commissioner may pay over the money or other property held by him to the persons respectively entitled thereto at any time prior to such deposit, upon being furnished satisfactory evidence of their right to the same.

1057. In all proceedings under this article, the commissioner shall be deemed to be a trustee for the benefit of all creditors and other persons interested in the estate of the person against whom the proceedings are pending.

1058. In any proceeding pending under the provisions of this article, the court in which such proceeding is pending shall have jurisdiction to hear and determine, in such proceeding, all actions or proceedings then pending or thereafter instituted by or against the person affected by a proceeding under this article.

1059. The commissioner, in the performance of any of his duties under this article, shall be deemed to be a public officer acting in his official capacity on behalf of the State, and the provisions of

Chapter 2, Division 7, Title 1 of the Government Code shall apply to him.

1060. The commissioner shall transmit to the Governor an annual report showing:

(a) The names of the persons proceeded against under this article.

(b) Whether such persons have resumed business or have been liquidated or have been mutualized.

(c) Such other facts as will acquaint the Governor, the policyholders, creditors, shareholders and the public with his proceedings under this article.

1061. In verification of the matters set forth in Section 1060 of this code, the Department of Finance shall, at least every two years or more often if requested by the commissioner, examine the commissioner's books and accounts relating to all proceedings under this article and Article 8 (commencing with Section 12550), Chapter 2, Part 6, Division 2 of this code, and shall file a report of each such examination with the court in which the respective proceeding is pending and shall furnish the commissioner a certified copy of each such report. The expense of examining the books and accounts of the commissioner as conservator or liquidator under this article or under Article 8 (commencing with Section 12550), Chapter 2, Part 6 of Division 2 of this code shall be paid out of the support appropriation for the Department of Insurance current at the date of billing for such expense and shall, upon order of the court or courts before which the proceedings under said articles are pending, be ratably reimbursed to such appropriation out of the assets of the estates administered by the commissioner as conservator or liquidator under this article or under Article 8 (commencing with Section 12550), Chapter 2, Part 6 of Division 2 of this code.

1062. In the event of the entry of an order under Section 1011 or 1016 of this article affecting any person having members, subscribers or policyholders, hereinafter referred to as "members" who are liable for assessment by law or by the provisions of their policies or contracts, and in which the termination of the policy or contract does not relieve the member from such liability, where the

commissioner in his discretion decides that an assessment would be in order, the liability of such members shall be determined, and the assessment therefor levied in the following manner:

1. Within one year from the date of the entry of the order under the provisions of Section 1011 or 1016 of this article, the commissioner shall make a report to the court setting forth: (a) the reasonable value of the assets of such person; (b) its probable liabilities, including reasonable costs of liquidation; and (c) the probable necessary assessment, if any, to pay all claims in full.

2. Upon the basis of such report, including any amendments thereof, the court shall determine the basis for calculating the liability of each member, subscriber or policyholder and shall order the commissioner to determine the amount of liability of each of the members.

3. Thereafter the commissioner shall give notice to each member, subscriber or policyholder of the amount of his liability by inclosing notice thereof in a sealed envelope, addressed and mailed, postage prepaid, to each member, subscriber or policyholder at his last known address as the same appears upon the books of the insurer.

4. Not less than 20 days after the mailing of said notice, as provided in paragraph 3 of this section, the commissioner shall report to the court the names of the members, subscribers or policyholders who have failed to pay their assessment in accordance with said notice, whereupon the court shall issue an order directing each of said members, subscribers or policyholders to appear in said court and show cause in the proceedings pending against such person, why he should not be held liable to pay such assessment, and why the commissioner should not have judgment therefor.

5. The commissioner shall cause a notice of such order setting forth a brief summary of the contents thereof: (a) to be published in such manner as shall be directed by the court; and (b) to be inclosed in a sealed envelope, addressed and mailed by registered mail with return receipt requested, postage prepaid, to each of said members whose liability for assessment remains unpaid, at his last known address, at least 20 days before the return day of such order to show cause.

6. On the return day of such order to show cause, (a) if such member shall not appear and serve verified objections on the commissioner, the court shall make an order adjudicating that such member is liable for the amount of such assessment, and that the commissioner may have a judgment against such member therefor; (b) if such member shall appear and serve verified objections upon the commissioner, there shall be a full hearing before the court, and if

the court affirms his liability to pay the whole or some part of said assessment, the commissioner may have judgment therefor.

7. A judgment upon any such order, shall have the same force and effect, and may be entered and may be appealed from as if it were a judgment in an original action brought in the court in which the proceeding is pending.

INSURANCE CODE
SECTION 1063-1063.16

1063. (a) Within 60 days after the original effective date of this article, all insurers, including reciprocal insurers, admitted to transact insurance in this state of any or all of the following classes only in accordance with the provisions of Chapter 1 (commencing with Section 100) of Part 1 of this division: fire (see Section 102), marine (see Section 103), plate glass (see Section 107), liability (see Section 108), workers' compensation (see Section 109), common carrier liability (see Section 110), boiler and machinery (see Section 111), burglary (see Section 112), sprinkler (see Section 114), team and vehicle (see Section 115), automobile (see Section 116), aircraft (see Section 118), and miscellaneous (see Section 120), shall establish the California Insurance Guarantee Association (the association); provided, however, this article shall not apply to the following classes or kinds of insurance: life and annuity (see Section 101), title (see Section 104), fidelity or surety including fidelity or surety bonds, or any other bonding obligations (see Section 105), disability or health (see Section 106), credit (see Section 113), mortgage (see Section 117), mortgage guaranty, insolvency or legal (see Section 119), financial guaranty or other forms of insurance offering protection against investment risks (see Section 124), the ocean marine portion of any marine insurance or ocean marine coverage under any insurance policy including the following: the Jones Act (46 U.S.C. Sec. 688), the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sec. 901 et seq.), or any other similar federal statutory enactment, or any endorsement or policy affording protection and indemnity coverage, or reinsurance as defined in Section 620, or fraternal fire insurance written by associations organized and operating under Sections 9080 to 9103, inclusive. Any insurer admitted to transact only those classes or kinds of insurance excluded from this article shall not be

a member insurer of the association. Each insurer admitted to transact a class of insurance included in this article, including the State Compensation Insurance Fund, as a condition of its authority to transact insurance in this state, shall participate in the association whether established voluntarily or by order of the commissioner after the elapse of 60 days following the original effective date of this article in accordance with rules to be established as provided in this article. It shall be the purpose of the association to provide for each member insurer insolvency insurance as defined in Section 119.5.

(b) The association shall be managed by a board of governors, composed of nine member insurers, each of which shall be appointed by the commissioner to serve initially for terms of one, two, or three years and thereafter for three-year terms so that three terms shall expire each year on December 31, and shall continue in office until his or her successor shall be appointed and qualified. At least five members of the board shall be domestic insurers. At least three of the members shall be stock insurers, and at least three shall be nonstock insurers. The nine members shall be representative, as nearly as possible, of the classes of insurance and of the kinds of insurers covered by this article. In case of a vacancy for any reason on the board, the commissioner shall appoint a member insurer to fill the unexpired term. In addition to the nine member insurers, the membership of the board shall also include one public member appointed by the President pro Tempore of the Senate, one public member appointed by the Speaker of the Assembly, one business member appointed by the commissioner, and one labor member appointed by the commissioner.

(c) The association shall adopt a plan of operations, and any amendments thereto, not inconsistent with the provisions of this article, necessary to assure the fair, reasonable, and equitable manner of administering the association, and to provide for other matters as are necessary or advisable to implement the provisions of this article. The plan of operations and any amendments thereto shall be subject to prior written approval by the commissioner. All members of the association shall adhere to the plan of operation.

(d) If for any reason the association fails to adopt a suitable plan of operation within 90 days following the original effective date of this article, or if at any time thereafter the association fails to adopt suitable amendments to the plan of operation, the commissioner shall after hearing adopt and promulgate reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. These rules shall continue in force until modified by the commissioner after hearing or superseded by a plan of operation,

adopted by the association and approved by the commissioner.

(e) In accordance with its plan of operation, the association may designate one or more of its members as a servicing facility, but a member may decline this designation. Each servicing facility shall be reimbursed by the association for all reasonable expenses it incurs and for all payments it makes on behalf of the association. Each servicing facility shall have authority to perform any functions of the association that the board of governors lawfully may delegate to it and to do so on behalf of and in the name of the association. The designation of servicing facilities shall be subject to the approval of the commissioner.

(f) The association shall have authority to borrow funds when necessary to effectuate the provisions of this article, and may provide in its plan of operations for any of the following:

(1) The issuance of notes, bonds, or debentures, or the establishment of a special purpose trust or other entity, solely for the purpose of facilitating a financing.

(2) The securing of that borrowing or those notes, bonds, or debentures by pledging or granting liens or mortgages, or by otherwise encumbering its real or personal property, including, but not limited to, premiums levied under Section 1063.5.

(g) The association, either in its own name or through servicing facilities, may be sued and may use the courts to assert or defend any rights the association may have by virtue of this article as reasonably necessary to fully effectuate the provisions thereof.

(h) The association shall have the right to intervene as a party in any proceeding instituted pursuant to Section 1016 wherein liquidation of a member insurer as defined in Section 1063.1 is sought.

(i) (1) The association shall have an annual audit of its financial condition conducted by an independent certified public accountant. The audit shall be conducted, to the extent possible, in accordance with generally accepted auditing standards (GAAS) and the report of the audit shall be submitted to the commissioner.

(2) The association shall annually audit at least one-third of the service companies retained by the association to adjust claims of insolvent insurers. The audits shall (A) assure that all covered claims are being investigated, adjusted, and paid in accordance with customary industry standards and practices and all applicable statutes, rules and regulations, and (B) examine the management and supervisory systems overseeing the claims functions. The audits shall be conducted by the association or an independent auditor, provided that the three largest service companies, as measured by the number of claims processed for the association during the previous

three fiscal years, shall be audited by an independent auditor at least once every three years. The association shall implement systems to retain independent auditing firms for the purpose of this paragraph, provided that no one firm is designated or utilized as an exclusive provider. Audits conducted pursuant to this paragraph shall be submitted annually to the commissioner for review.

(j) The commissioner shall examine the association to the same extent as, and in accordance with, the requirements of Article 4 (commencing with Section 730) of Chapter 1 of Part 2 of Division 2, which sets forth the examination requirements applicable to admitted insurers. A copy of the examination report shall be filed with the Chairpersons of the Senate and Assembly Committees on Insurance no later than December 31 of the year the report is completed.

1063.1. As used in this article:

(a) "Member insurer" means an insurer required to be a member of the association in accordance with subdivision (a) of Section 1063, except and to the extent that the insurer is participating in an insolvency program adopted by the United States government.

(b) "Insolvent insurer" means a member insurer against which an order of liquidation or receivership with a finding of insolvency has been entered by a court of competent jurisdiction.

(c) (1) "Covered claims" means the obligations of an insolvent insurer, including the obligation for unearned premiums, (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; (iii) which are presented as a claim to the liquidator in this state or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings; (iv) which were incurred prior to the date coverage under the policy terminated and prior to, on, or within 30 days after the date the liquidator was appointed; (v) for which the assets of the insolvent insurer are insufficient to discharge in full; (vi) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state; and (vii) in the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

(2) "Covered claims" also include the obligations assumed by an assuming insurer from a ceding insurer where the assuming insurer

subsequently becomes an insolvent insurer if, at the time of the insolvency of the assuming insurer, the ceding insurer is no longer admitted to transact business in this state. Both the assuming insurer and the ceding insurer shall have been member insurers at the time the assumption was made. "Covered claims" under this paragraph shall be required to satisfy the requirements of subparagraphs (i) to (vii), inclusive, of paragraph (1), except for the requirement that the claims be against policies of the insolvent insurer. The association shall have a right to recover any deposit, bond, or other assets that may have been required to be posted by the ceding company to the extent of covered claim payments and shall be subrogated to any rights the policyholders may have against the ceding insurer.

(3) "Covered claims" does not include obligations arising from the following:

(i) Life, annuity, health, or disability insurance.

(ii) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(iii) Fidelity or surety insurance including fidelity or surety bonds, or any other bonding obligations.

(iv) Credit insurance.

(v) Title insurance.

(vi) Ocean marine insurance or ocean marine coverage under any insurance policy including claims arising from the following: the Jones Act (46 U.S.C.A. Sec. 688), the Longshore and Harbor Workers' Compensation Act (33 U.S.C.A. Sec. 901 et seq.), or any other similar federal statutory enactment, or any endorsement or policy affording protection and indemnity coverage.

(vii) Any claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers' compensation policy issued pursuant to subdivision (c) of Section 3702.8 of the Labor Code that covers all or any part of workers' compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.

(4) "Covered claims" does not include any obligations of the insolvent insurer arising out of any reinsurance contracts, nor any obligations incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured or canceled at the insured's request, or after the insurance policy has been canceled by the association as provided in this chapter, or after the insurance policy has been canceled by the liquidator, nor any obligations to any state or to the federal government.

(5) "Covered claims" does not include any obligations to insurers,

insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

An insurer, insurance pool, or underwriting association may not maintain, in its own name or in the name of its insured, any claim or legal action against the insured of the insolvent insurer for contribution, indemnity or by way of subrogation, except insofar as, and to the extent only, that the claim exceeds the policy limits of the insolvent insurer's policy. In those claims or legal actions, the insured of the insolvent insurer is entitled to a credit or setoff in the amount of the policy limits of the insolvent insurer's policy, or in the amount of the limits remaining, where those limits have been diminished by the payment of other claims.

(6) "Covered claims," except in cases involving a claim for workers' compensation benefits or for unearned premiums, does not include any claim in an amount of one hundred dollars ($100) or less, nor that portion of any claim that is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer.

(7) "Covered claims" does not include that portion of any claim, other than a claim for workers' compensation benefits, that is in excess of five hundred thousand dollars ($500,000).

(8) "Covered claims" does not include any amount awarded as punitive or exemplary damages, nor any amount awarded by the Workers' Compensation Appeals Board pursuant to Section 5814 or 5814.5 because payment of compensation was unreasonably delayed or refused by the insolvent insurer.

(9) "Covered claims" does not include (i) any claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured nor (ii) any claim by any person other than the original claimant under the insurance policy in his or her own name, his or her assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into prior to insolvency, his or her executor, administrator, guardian or other personal representative or trustee in bankruptcy and does not include any claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

(10) "Covered claims" does not include any obligations arising out of the issuance of an insurance policy written by the separate division of the State Compensation Insurance Fund pursuant to Sections 11802 and 11803.

(11) "Covered claims" does not include any obligations of the insolvent insurer arising from any policy or contract of insurance

issued or renewed prior to the insolvent insurer's admission to transact insurance in the State of California.

(12) "Covered claims" does not include surplus deposits of subscribers as defined in Section 1374.1.

(d) "Admitted to transact insurance in this state" means an insurer possessing a valid certificate of authority issued by the department.

(e) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(f) "Control" 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 other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is 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 showing that control does not in fact exist.

(g) "Claimant" means any insured making a first party claim or any person instituting a liability claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(h) "Ocean marine insurance" includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance such as hull and machinery, marine builders' risks, and marine protection and indemnity. Those perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person.

(i) "Unearned premium" means that portion of a premium that had not been earned because of the cancellation of the insolvent insurer's policy and is that premium remaining for the unexpired term of the insolvent insurer's policy. "Unearned premium" does not include any

amount sought as return of a premium under any policy providing retroactive insurance of a known loss or return of a premium under any retrospectively rated policy or a policy subject to a contingent surcharge or any policy in which the final determination of the premium cost is computed after expiration of the policy and is calculated on the basis of actual loss experience during the policy period.

1063.2. (a) The association shall pay and discharge covered claims and in connection therewith pay for or furnish loss adjustment services and defenses of claimants when required by policy provisions. It may do so either directly by itself or through a servicing facility or through a contract for reinsurance and assumption of liabilities by one or more member insurers or through a contract with the liquidator, upon terms satisfactory to the association and to the liquidator, under which payments on covered claims would be made by the liquidator using funds provided by the association.

(b) The association shall be a party in interest in all proceedings involving a covered claim, and shall have the same rights as the insolvent insurer would have had if not in liquidation, including, but not limited to, the right to: (1) appear, defend, and appeal a claim in a court of competent jurisdiction; (2) receive notice of, investigate, adjust, compromise, settle, and pay a covered claim; and (3) investigate, handle, and deny a noncovered claim. The association shall have no cause of action against the insureds of the insolvent insurer for any sums it has paid out, except as provided by this article.

(c) (1) If damages against uninsured motorists are recoverable by the claimant from his or her own insurer, the applicable limits of the uninsured motorists coverage shall be a credit against a covered claim payable under this article. Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first-party claim for damage to property with a permanent location, he or she shall seek recovery first from the association of the permanent location of the property, and if it is a workers' compensation claim, he or she shall seek recovery first from the association of the residence of the claimant. Any recovery under this article shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent. A member insurer may recover in

subrogation from the association only one-half of any amount paid by such insurer under uninsured motorist coverage for bodily injury or wrongful death (and nothing for a payment for anything else), in those cases where the injured person insured by such an insurer has proceeded under his or her uninsured motorist coverage on the ground that the tort feasor is uninsured as a result of the insolvency of his or her liability insurer (an insolvent insurer as defined in this article), provided that such member insurer shall waive all rights of subrogation against such tortfeasor. Any amount paid a claimant in excess of the amount authorized by this section may be recovered by action brought by the association.

(2) Any claimant having collision coverage on a loss which is covered by the insolvent company's liability policy shall first proceed against his or her collision carrier. Neither that claimant nor the collision carrier, if it is a member of the association, shall have the right to sue or continue a suit against the insured of the insolvent insurance company for such collision damage.

(d) The association shall have the right to recover from any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this article the amount of any covered claim and allocated claims expense paid on behalf of that person pursuant to this article.

(e) Any person having a claim or legal right of recovery under any governmental insurance or guaranty program which is also a covered claim, shall be required to first exhaust his or her right under the program. Any amount payable on a covered claim shall be reduced by the amount of any recovery under the program.

(f) "Covered claims" for unearned premium by lenders under insurance premium finance agreements as defined in Section 673 shall be computed as of the earliest cancellation date of the policy pursuant to Section 673 or subdivision (g) of this section.

(g) "Covered claims" shall not include any judgments against or obligations or liabilities of the insolvent insurer or the commissioner, as liquidator, or otherwise resulting from alleged or proven torts, nor shall any default judgment or stipulated judgment against the insolvent insurer, or against the insured of the insolvent insurer, be binding against the association.

(h) "Covered claims" shall not include any loss adjustment expenses, including adjustment fees and expenses, attorney fees and expenses, court costs, interest, and bond premiums, incurred prior to the appointment of a liquidator.

1063.3. To aid in the detection and prevention of member insurer insolvencies:

(a) The board may, upon majority vote, make recommendations to the commissioner on matters pertaining to regulation for solvency.

(b) The board may prepare a report on the history and causes of any member insurer insolvency in which the association was obligated to pay covered claims, based on the information available to the association, and submit that report along with any recommendations resulting therefrom to the commissioner.

1063.4. (a) Insureds entitled to the protection of this article shall cooperate with the association in accordance with their policies in the same manner as they would have been required to cooperate with their insurer if it were not in liquidation and shall be deemed to have assigned to the association any right to make claim against the liquidator for a refund of unearned premium for the period of coverage provided by the association beginning on the date of the order of liquidation to the date of expiration or cancellation.

(b) Any insured or claimant entitled to the benefits of this article who elects to proceed under this article shall be deemed to have assigned to the association his or her rights against the estate of the insolvent insurer.

1063.5. Each time an insurer becomes insolvent then, to the extent necessary to secure funds for the association for payment of covered claims of that insolvent insurer and also for payment of reasonable costs of adjusting the claims, the association shall collect premium payments from its member insurers sufficient to discharge its obligations. The association shall allocate its claim payments and costs, incurred or estimated to be incurred, to one or more of the following categories: (a) workers' compensation claims; (b) homeowners' claims, and automobile claims, which shall include: automobile material damage, automobile liability (both personal injury and death and property damage), medical payments and uninsured motorist claims; and (c) claims other than workers' compensation, homeowners', and automobile, as above defined. Separate premium payments shall be required for each category. The premium payments for each category shall be used to pay the claims and costs allocated

to that category. The rate of premium charged shall be a uniform percentage of net direct written premium in the preceding calendar year applicable to that category. The rate of premium charges to each member in the appropriate categories shall initially be based on the written premium of each insurer as shown in the latest year's annual financial statement on file with the commissioner. The initial premium shall be adjusted by applying the same rate of premium charge as initially used to each insurer's written premium as shown on the annual statement for the second year following the year in which the initial premium charge is made. The difference between the initial premium charge and the adjusted premium charge shall be charged or credited to each member insurer by the association as soon as practical after the filing of the annual statements of the member insurers with the commissioner for the year on which the adjusted premium is based. In the case of an insurer that was a member insurer when the initial premium charge was made and that paid the initial assessment but is no longer a member insurer at the time of the adjusted premium charge by reason of its insolvency or its withdrawal from the state and surrender of its certificate of authority to transact insurance in this state, any credit accruing to that insurer shall be refunded to it by the association. "Net direct written premiums" shall mean the amount of gross premiums, less return premiums, received in that calendar year upon business done in this state, other than premiums received for reinsurance. In cases of a dispute as to the amount of the net direct written premium between the association and one of its members the written decision of the commissioner shall be final. The premium charged to any member insurer for any of the three categories or a category established by the association shall not be more than 2 percent of the net direct premium written in that category in this state by that member per year, starting on January 1, 2003, until December 31, 2007, and thereafter shall be one percent per year. The association may exempt or defer, in whole or in part, the premium charge of any member insurer, if the premium charge would cause the member insurer's financial statement to reflect an amount of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders by the company whose premium charge was deferred. Deferred premium charges shall be paid when the payment will not reduce capital or surplus below required minimums. These payments shall be credited against future premium charges to those companies receiving larger premium charges by virtue of the deferment. After all covered claims of the

insolvent insurer and expenses of administration have been paid, any unused premiums and any reimbursements or claims dividends from the liquidator remaining in any category shall be retained by the association and applied to reduce future premium charges in the appropriate category. However, an insurer which ceases to be a member of the association, other than an insurer that has become insolvent or has withdrawn from the state and has surrendered its certificate of authority following an initial assessment that is entitled to a refund based upon an adjusted assessment as provided above in this section, shall have no right to a refund of any premium previously remitted to the association. The commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer which fails to pay a premium when due and after demand has been made.

Interest at a rate equal to the current federal reserve discount rate plus 21/2 percent per annum shall be added to the premium of any member insurer which fails to submit the premium requested by the association within 30 days after the mailing request. However, in no event shall the interest rate exceed the legal maximum.

1063.6. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in the state shall, subject to waiver by the association in specific cases involving covered claims and subject to waiver by the commissioner as to matters that are not covered claims, be stayed for 60 days from the date that an order of liquidation or an order of receivership with a finding of insolvency has been entered by a superior court in this state or by a court in the state of domicile of the insurer, and an additional time thereafter as may be determined necessary by the court to permit proper defense or conduct of all pending causes of action by the association or the commissioner, as applicable. The stay as to matters to which the insolvent insurer is a party shall be superseded by and when an injunction or stay order is entered by the court in this state having jurisdiction of the liquidation or the ancillary liquidation.

The liquidator, receiver, or statutory successor of an insolvent member insurer shall permit reasonable access by the association to the insolvent insurer's records as is necessary for the association to carry out its duties with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the association with copies of these records upon the reasonable request of the association and at the expense of the association.

1063.7. When a liquidator, domiciliary or ancillary, is appointed in this state for any member insurer, the liquidator shall promptly give notice of his or her appointment and a brief description of the contents of this article and of the nature and functions of the association by prepaid first-class mail, to: (a) all persons known or reasonably expected to have or be interested in claims against the insurer, at the last known address within this state; (b) all insureds of the insurer, at the last known address within this state, accompanied by a notice of the date of termination of insurance; and (c) the board of governors of the association. Such notice may, but need not be, combined with the notice provided for in Section 1021. In the situations where notice is being provided by an ancillary liquidator, notice is only required to the extent information is available to provide the notice. The ancillary liquidator may also rely on the notice provided by the domiciliary liquidator to satisfy the notice requirements of this section. The liquidator may also require that producers of record of the insurer give prompt written notice of the same information, by first-class mail, to their insureds at the last known address within this state. The liquidator shall also promptly publish such notice in a newspaper of general circulation in the county where the insurer had its principal office in this state not less than once per week, for four weeks, and by publication elsewhere in this state as the court shall direct.

1063.8. Notwithstanding any other provision of law, the association shall be exempt from all license fees, income, franchise, privilege, property, or occupation taxes levied or assessed by this state, any municipality, county, or other political subdivision of this state. The rules of the commissioner promulgated pursuant to this article may exempt the association from: filing an annual statement, maintaining minimum required capital, paying any fees or reimbursements, or meeting any other requirement or doing any other thing required by this code or other laws relating to insurance.

1063.9. (a) The operation of the association shall at all times be subject to the regulation of the commissioner. The commissioner, or

any deputy or examiner, or any person whom the commissioner shall appoint, shall have the power of visitation and examination into the affairs of the association and free access to all books, papers, and documents that relate to the business of the association, may summon and qualify witnesses under oath, and may examine officers, agents or employees, or any other person having knowledge of the affairs, transactions, or conditions of the association.

(b) Any member insurer aggrieved by any action or decision of the association may appeal to the commissioner within 30 days after the action or decision of the association and after exhaustion of administrative remedies may seek court relief as provided in Section 12940.

1063.10. All orders or decisions of the commissioner made pursuant to Chapter 1347, Statutes of 1969 (of which this article is a part) and the provisions thereof as amended from time to time, shall be subject to judicial review as provided in Section 12940.

1063.11. The commissioner may, upon notice and opportunity for all interested parties to be heard, issue such rules, regulations and orders as may be necessary to carry out the provisions of this article. Such rules and regulations shall be adopted, amended or repealed in accordance with Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code.

1063.12. (a) The association, its member insurers, and its officers, directors, agents or employees of the association, or its member insurers, shall under no circumstances be liable for any sum in excess of the amount of covered claims of the insolvent insurer, as defined under subdivision (c) of Section 1063.1 of this article and the costs of administration and the costs of loss adjustment, investigation and defenses relating to claims thereunder.

(b) Any person or member made a party to any action, suit or proceeding because such person or member served on the board of governors or on a committee or was an officer or employee of the association shall be held harmless and be indemnified by the association against all liability and costs (including the amounts of judgments, settlements, fines or penalties) and expenses incurred in connection with such action, suit or proceeding; provided, however,

such indemnification shall not be provided on any matter in which the person or member shall be finally adjudged in any such action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of his office.

(c) The costs and expenses of such indemnification shall be prorated and paid for by the members in the same manner as provided in the plan of operations for the proration of premiums.

(d) The provisions of this section shall not be construed as creating any right in any third person, and shall be applicable only as between the association and its member insurers and its officers, directors, agents, or employees of the association or its member insurers.

1063.13. No member insurer of the association shall engage in the unlawful trade practice defined and condemned in subdivision (g) of Section 790.03.

1063.14. (a) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain provisions whereby each member insurer is required to recoup over a reasonable length of time a sum reasonably calculated to recoup the assessments paid by the member insurer under this article by way of a surcharge on premiums charged for insurance policies to which this article applies. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

(b) The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The association shall determine the rate of the surcharge and the collection period for each category and these shall be mandatory for all member insurers of the association who write business in those categories. Member insurers who collect surcharges in excess of premiums paid pursuant to Section 1063.5 for an insolvent insurer shall remit the excess to the association as an additional premium within 30 days after the association has determined the amount of the excess recoupment and given notice to the member of that amount. The excess shall be applied to reduce future premium charges in the appropriate category.

(c) The plan of operation may permit a member insurer to omit collection of the surcharge from its insureds when the expense of

collecting the surcharge would exceed the amount of the surcharge. However, nothing in this section shall relieve the member insurer of its obligation to recoup the amount of surcharge otherwise collectible.

1063.145. The statement of the amount of surcharge required to be provided under subdivision (b) of Section 1063.14 shall include a description of, and purpose for, the California Insurance Guarantee Association, as follows:

Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" with an amount will be displayed on your premium notice."

1063.15. In any workers' compensation matter the association shall have the same period of time within which to act or to exercise a right as is accorded to the insurer by the Labor Code, and those time periods shall be tolled against the association until 45 days after the appointment of a domiciliary or receiver.

1063.16. The association, to the extent it determines necessary or desirable, may request the department to issue bonds pursuant to Article 14.25 (commencing with Section 1063.50) to provide funds to pay covered claims of insolvent insurers. The association may act as agent of the department to collect premium payments levied by the department on its member insurers. If the association borrows the proceeds of the bonds from the department, the association may assess an additional premium, not to exceed 2 percent of the net direct premium written by the member insurer, to be applied exclusively to the repayment of the loan. The revenue received from the additional premium shall be pledged to the repayment of the loan and shall be used exclusively for that purpose until the bonds have been paid or provision for the payment of them has been made.

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1063.50. The California Insurance Guarantee Association is authorized to pay and discharge certain claims of insolvent insurers as defined in Section 1063.1 through the collection of premiums from its members, which amounts are limited by law and take time to assess and collect. If a natural disaster such as a major earthquake or fire were to occur in California, California's housing stock could be adversely affected and there could be an immediate need for large sums of money to pay covered claims of insolvent insurers. This article provides for the ability of the department to issue bonds to more expeditiously and effectively provide for the payment of covered claims that arise as a result of a natural disaster. The bonds are to be paid from the premiums assessed by the department or by CIGA for those purposes. It is a public purpose and in the best interest of the public health, safety, and general welfare of the residents of this state to provide for the issuance of bonds by the department to pay claimants and policyholders having covered claims against insolvent insurers operating in this state.

1063.51. (a) The terms "member insurer," "insolvent insurer," and "covered claims" have the meanings assigned those terms in Section 1063.1.

(b) "CIGA" means the California Insurance Guarantee Association, established pursuant to Article 14.2 (commencing with Section 1063).

(c) "Commissioner" means the Insurance Commissioner.

(d) "Board" means the board of governors of CIGA.

(e) "Department" means the Department of Insurance.

(f) "Insurance Assessment Bond Fund" is the fund created pursuant to Section 1063.52.

(g) "Insurance assessments" means the premiums collected by the department or by CIGA pursuant to Section 1063.5, 1063.53, or 1063.54.

1063.52. The Insurance Assessment Bond Fund is hereby created in

the State Treasury. Proceeds from the sale of bonds issued pursuant to this article and insurance assessments to repay bonds issued pursuant to this article shall be deposited in the Insurance Assessment Bond Fund.

All money in the fund is hereby continuously appropriated to the department for the exclusive purpose of carrying out the purposes of this part, and, notwithstanding the provisions of Chapter 2 (commencing with Section 12850) of Part 2.5 of Division 3 of Title 2 of the Government Code or the provisions of Article 2 (commencing with Section 13320) of Chapter 3 of Part 3 of Division 3 of Title 2 of the Government Code, or the provisions of Sections 11032 and 11033 of the Government Code, application of the fund shall not be subject to the supervision or budgetary approval of any other officer or division of state government. The department may pledge any or all of the moneys in the fund as security for payment of the principal of, and interest and redemption premiums, if any, on, bonds issued pursuant to this article, and, for that purpose or as necessary or convenient to the accomplishment of any other purpose under this article, may divide the fund into separate accounts.

1063.53. (a) In the event a natural disaster such as an earthquake or fire results in covered claim obligations currently payable and owed by the association in excess of its capacity to pay from current funds and current premium assessments allowable under Section 1063.5, and upon a declaration of emergency by the Governor or the President of the United States, the board, in its sole discretion, may by resolution request the department to issue bonds pursuant to this article to provide funds for the payment of covered claims and expenses related thereto. Should the bonds be issued, the department shall have the authority to levy upon member insurers insurance assessments in the amount necessary to pay the principal of and interest on the bonds, and to meet other requirements established by agreements relating to the bonds. The department may enter into an agreement with CIGA for CIGA to act as agent for the department to collect the assessments.

The department may assume the obligation to pay the covered claims of insolvent insurers for the purpose of paying the claims with the proceeds of the bonds. The obligation of the department to pay claims shall be a limited obligation payable only our of the proceeds of the bonds. The department shall enter into an agreement with CIGA for CIGA to act as agent of the department to adjust and administer the payment of the claims. Premium payments collected

pursuant to this authority may only be used for servicing the bond obligations provided for in this section and may be pledged for that purpose. Premium assessments made pursuant to this section shall also be subject to the surcharge provisions in Sections 1063.14 and 1063.145.

(b) In addition to the premium assessments provided for in this section, the board in its discretion and subject to other obligations of the association, may utilize current funds of the association, premium assessments made under Section 1063.5, and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.

1063.54. Notwithstanding any other provision of law, the department, in accordance with this article and at the request of the board pursuant to Section 1063.53 may issue bonds in order to provide for the payment of covered claims of insolvent insurers or in order to make loans to CIGA, which moneys CIGA is hereby authorized to borrow, to provide for the payment of covered claims of insolvent insurers. For this purpose, the department or CIGA may levy upon member insurers insurance assessments in the amounts necessary to pay the principal of and interest on the bonds and to meet other requirements established by agreements relating to the bonds. The department shall enter into an agreement with CIGA for CIGA to act as agent for the department to collect the assessments. The department may assume the obligation to pay the covered claims of insolvent insurers for the purpose of paying the claims with the proceeds of the bonds. The obligation of the department to pay claims shall be a limited obligation payable only out of the proceeds of the bonds. The department shall enter into an agreement with CIGA for CIGA to act as agent of the department to adjust and administer the payment of claims. The total bonded indebtedness authorized pursuant to this article shall not exceed the level that can be supported by the revenues dedicated to retiring the bonds.

1063.55. The bonds shall be authorized by order of the commissioner, shall be in the form, shall bear the date or dates, and shall mature at the time or times as the order or the indenture authorized by the order may provide, except that no bond shall mature more than 20 years from the date of its issue. The bonds may

be issued as serial bonds or as term bonds, or as a combination thereof, and, notwithstanding any other provision of law, the amount of principal of, or interest on, bonds maturing at each date of maturity need not be equal. The bonds shall bear interest at the rate or rates, variable or fixed or a combination thereof, be in the denominations, be in the form, either coupon or registered, carry the registration privileges, be executed in the manner, be payable in the medium of payment at the place or places within or without the state, be subject to the terms of redemption, and contain the terms and conditions as the order or indenture may provide. The bonds shall be sold at public or private sale by the Treasurer at, above, or below the principal amount thereof, on the terms and conditions and for the consideration in the medium of payment that the Treasurer shall determine prior to the sale.

1063.56. Upon receipt of an order of the commissioner authorizing the issuance of bonds, the Treasurer shall provide for their preparation in accordance with the order. The bonds authorized to be issued shall be sold by the Treasurer, at public sale or at private sale, as directed by the order. In the case of a public sale, (a) the bonds shall be sold by the Treasurer at such times as may be fixed by him or her, and upon such notice as he or she may deem to be advisable, upon sealed bids, to the bidder whose bid will result in the lowest net interest cost on account of the bonds, and (b) if no bids are received, or if the Treasurer determines that the bids are not satisfactory, the Treasurer may reject all bids received, if any, and either readvertise or sell the bonds at private sale.

1063.57. The department may provide for the issuance of refunding bonds for the purpose of refunding any bonds then outstanding which have been issued under the provisions of this article, including the payment of any redemption premium thereon and any interest accrued or to accrue to the date of redemption of those bonds. The issuance of the obligations, the maturities and other details thereof, the rights of the holders thereof, and the rights, duties, and obligations of the department in respect of the same shall be governed by the provisions of this article that relate to the issuance of bonds, insofar as those provisions may be appropriate therefor.

1063.58. Refunding bonds issued as provided in Section 1063.57 may be sold, or exchanged for outstanding bonds issued under this article and, if sold, the proceeds thereof may be applied, in addition to any other authorized purposes, to the purchase, redemption, or payment of the outstanding bonds. Pending the application of the proceeds of the refunding bonds, with any other available moneys, (a) to the payment of the principal, accrued interest, and any redemption premium on the bonds being refunded, (b) to the payment of any interest on those refunding bonds, or (c) to any expenses incurred in connection with the refunding, the proceeds may be invested in obligations permitted under the bond resolution authorizing the issuance of refunding bonds.

1063.59. The Treasurer or any other person executing the notes or bonds shall not be subject to any personal liability or accountability by reason of the issuance thereof.

1063.60. The department may issue negotiable bond anticipation notes and may refund those notes from time to time. Bond anticipation notes may be paid from the proceeds of sale of the bonds of the department in anticipation of which they were issued. Bond anticipation notes and agreements relating thereto and the order or orders authorizing those notes and agreements may contain any provisions, conditions, or limitations that a bond, agreement relating thereto, or bond order of the department may contain.

1063.61. The state does hereby pledge to and agree with the holders of any bonds issued under this article that the state will not limit or alter the rights hereby vested in the department to fulfill the terms of any agreements made with the holders thereof or in any way impair the rights and remedies of those holders until the bonds, together with the interest thereon, with interest on any unpaid installments of interest, and all costs and expenses in connection with any action or proceeding by or on behalf of those holders, are fully met and discharged. The department is authorized to include

this pledge and agreement of the state in any agreement with the holders of the notes or bonds.

1063.62. Bonds issued under this article shall be legal investments in which all public officers and public bodies of this state, its political subdivisions, all municipalities and municipal subdivisions, all insurance companies and associations and other persons carrying on an insurance business, all banks, bankers, banking institutions, including savings and loan associations, building and loan associations, trust companies, savings banks and savings associations, investment companies and other persons carrying on a banking business, all administrators, guardians, conservators, executors, trustees and other fiduciaries, and all other persons whatsoever who are now or may hereafter be authorized to invest in bonds or in other obligations of the state, may properly and legally invest funds, including capital, in their control or belonging to them. The bonds may be used by those private financial institutions, persons, or associations as security for public deposits. The bonds are also hereby made securities which may properly and legally be deposited with and received by all public officers and bodies of the state or any agency or political subdivision of the state and all municipalities and public corporations for any purpose for which the deposit of bonds or other obligations of the state is now or may hereafter be authorized by law, including deposits to secure public funds.

1063.63. All or any part of the revenues from the insurance assessments or from loan repayments by CIGA may be pledged by the department to secure the repayment of any bonds issued under this article and to pay costs incurred in the issuance or administration of the bonds. Any pledge made to secure the bonds shall be valid and binding from the time the pledge is made. The revenues pledged and thereafter received by the department or by any trustee, depository or custodian shall be deposited in a separate account and shall be immediately subject to the lien of the pledge without any physical delivery thereof or further act, and the lien of the pledge shall be valid and binding against all parties having claims of any kind in tort, contract, or otherwise against the department, CIGA, or the trustee, depository, or custodian, irrespective of whether the parties have notice thereof. The indenture or agreement by which the pledge is created need not be recorded. All of those insurance

assessments, to the extent so pledged, are hereby continuously appropriated for that purpose.

1063.64. The department and CIGA are each authorized to enter into those contracts or agreements with those banks, insurers, or other financial institutions that it determines are necessary or desirable to improve the security and marketability of the bonds issued under this article. Those contracts or agreements may contain an obligation to reimburse, with interest, any of those banks, insurers, or other financial institutions for advances used to pay the purchase price of, or principal or interest on, the bonds. Any such reimbursement obligation shall be payable solely from, and may be secured by a pledge of, the revenues derived from the insurance assessments levied for that purpose or from loan repayments by CIGA.

1063.65. The bonds shall not be, and shall state on their face that they are not, general obligations of the department or of the state or any political subdivision thereof, but are limited obligations of the state.

Bonds issued under the provisions of this article shall not be deemed to constitute a debt or liability or general obligation of the state or any political subdivision thereof other than as provided in this article and shall be payable solely from funds herein provided therefor. All of the bonds and any prospectus or other printed representation of the department concerning the bonds shall contain on the face thereof a statement to the following effect: "Neither the faith and credit nor the taxing power of the State of California is pledged to the payment of the principal of, or interest on, this bond."

The issuance of bonds under the provisions of this article shall not directly or indirectly or contingently obligate the state or any political subdivision thereof to levy or to pledge any form of taxation whatever therefor or to make any appropriation for their payment.

1063.66. Bonds issued by the department pursuant to this article, their transfer and the income therefrom, shall be free from taxation of every kind by the state and every city or county or other

political subdivision of the state, except inheritance and gift taxes.

1063.67. The department is authorized and empowered to employ financial consultants, advisers, legal counsel, and accountants as may be necessary in its judgment in connection with the issuance and sale of any bonds or other obligations of the department. Payment for these services may be made out of the proceeds of the sale of the bonds or other obligations. The department may delegate to the Treasurer the employment of those professionals.

1063.68. The provisions of Section 10295 and Sections 10335 to 10382, inclusive, of the Public Contract Code shall not apply to agreements entered into by the department or Treasurer in connection with the obtaining of financing.

INSURANCE CODE
SECTION 1063.70-1063.77

1063.70. The California Insurance Guarantee Association is authorized to pay and discharge certain claims of insolvent insurers as defined in Section 1063.1 through the collection of premiums from its members, which amounts are limited by law and take time to assess and collect. This article provides for the ability of CIGA to request the issuance of bonds by the California Infrastructure and Economic Development Bank pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code to more expeditiously and effectively provide for the payment of covered claims that arise as a result of the insolvencies of insurance companies providing workers' compensation insurance. The bonds are to be paid from the special bond assessments assessed by CIGA for those purposes and the other funds provided pursuant to Section 1063.74. Special bond assessments to repay bonds issued for payment of workers compensation benefits shall be assessed, to the extent necessary, for the claims category. It is a public purpose and in the best interest of the public health, safety, and general welfare of the residents of this state to provide for the issuance of

bonds to pay claimants and policyholders having covered claims against insolvent insurers operating in this state.

1063.71. (a) The terms "member insurer," "insolvent insurer," and "covered claims" have the meanings assigned those terms in Section 1063.1.

(b) The terms "CIGA," "commissioner," "board," and "department" have the meanings assigned those terms in Section 1063.51.

(c) "Bank" means the California Infrastructure and Economic Development Bank created pursuant to Article 1 (commencing with Section 63020) of Chapter 2, Division 1 of Title 6.7 of the Government Code.

(d) "Bonds" means bonds issued by the Bank pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code to provide funds for the payment of the covered claims and the adjusting and defense expenses relating to those claims that are issued at the request of the board pursuant to Section 1063.73.

(e) "Collateral" means the special bond assessments, the right of CIGA to be paid the special bond assessments, all revenues therefrom, the separate account of the Workers' Comp Bond Fund into which special bond assessments are deposited, and the proceeds thereof.

(f) "Special bond assessment" means the premiums collected by CIGA pursuant to Section 1063.74.

(g) "Workers' Comp Bond Fund" means the fund created pursuant to Section 1063.72.

1063.72. The Workers' Comp Bond Fund is hereby created. Proceeds from the sale of bonds shall be deposited in a separate account in the Workers' Comp Bond Fund. Only CIGA, and with respect to payment of the bonds, the trustee for the bonds, shall have the ability to authorize disbursements from the separate account. Special bond assessments shall be deposited in a separate account in the Workers' Comp Bond Fund and shall not be commingled with any other moneys. Only the trustee for the bonds shall have the ability to authorize disbursements from this separate account, and CIGA shall have no right or authority to authorize disbursements from this separate account. The Workers' Comp Bond Fund shall be maintained with the trustee for the bonds. Following payment or provision for payment of the bonds, amounts in the Workers' Comp Bond Fund shall be

transferred to the fund that is designated in the indenture. All money in the Workers' Comp Bond Fund and all special bond assessments shall be used by CIGA for the exclusive purpose of carrying out the purposes of this part, and, notwithstanding any other provisions of law, the Workers' Comp Bond Fund shall not be a state fund, shall not be subject to the rules or procedures of any fund in the State Treasury, and application of the fund shall not be subject to the supervision or budgetary approval of any officer or division of state government. CIGA and the trustee for the bonds may as necessary or convenient to the accomplishment of any other purpose under this article, divide the fund into separate accounts.

1063.73. In the event CIGA determines that the insolvency of one or more member insurers providing workers' compensation insurance will result in covered claim obligations for workers' compensation claims in excess of CIGA's capacity to pay from current funds, the board, in its sole discretion, may by resolution request the Bank to issue bonds pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code to provide funds for the payment of the covered claims and the adjusting and defense expenses relating to those claims. Notwithstanding any other provision of law, CIGA is hereby authorized to borrow proceeds of the bonds to provide for those purposes. CIGA may request the Bank to issue bonds pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code. CIGA shall provide the commissioner with a copy of the request and the commissioner may, within 30 days of receipt of the request, modify, cancel, or require a delay in the requested issuance. The proceeds of bonds issued for workers' compensation benefits may be used by CIGA to reimburse funds advanced or temporarily loaned from other categories to fund workers' compensation claims.

1063.74. (a) Notwithstanding any other limits on assessments, CIGA shall have the authority to levy upon member insurers special bond assessments in the amount necessary to pay the principal of and interest on the bonds, and to meet other requirements established by agreements relating to the bonds. The assessments shall be collected only from the member insurers providing workers' compensation insurance, in the same manner as separate premium payments are used to pay the claims and costs allocated to that category pursuant to

Section 1063.5. Special bond assessments made pursuant to this section shall also be subject to the surcharge provisions in Sections 1063.14 and 1063.145.

(b) In addition to the special bond assessments provided for in this section, the board in its discretion and subject to other obligations of the association, may utilize current funds of CIGA, premium assessments made under Section 1063.5, and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request and shall utilize, to the extent feasible, the recoveries from the liquidators of the estates of insolvent workers' compensation carriers to pay bonds issued at the board's request to fund workers' compensation claims.

1063.75. Any bonds issued to provide funds for covered claim obligations for workers' compensation claims shall be issued prior to January 1, 2007, in an aggregate principal amount outstanding at any one time not to exceed $1.5 billion, and any bonds issued or issued to refund bonds shall not have a final maturity exceeding twenty years from the date of issuance. The bonds shall be issued at the request of CIGA, shall be in the form, shall bear the date or dates, and shall mature at the time or times as the indenture authorized by the request may provide. The bonds may be issued in one or more series, as serial bonds or as term bonds, or as a combination thereof, and, notwithstanding any other provision of law, the amount of principal of, or interest on, bonds maturing at each date of maturity need not be equal. The bonds shall bear interest at the rate or rates, variable or fixed or a combination thereof, be in the denominations, be in the form, either coupon or registered, carry the registration privileges, be executed in the manner, be payable in the medium of payment at the place or places within or without the state, be subject to the terms of redemption, contain the terms and conditions, and be secured by the covenants as the indenture may provide. The indenture may provide for the proceeds of the bonds and funds securing the bonds to be invested in any securities and investments, including investment agreements, as specified therein. CIGA may enter into or authorize any ancillary obligations or derivative agreements as it determines necessary or desirable to manage interest rate risk or security features related to the bonds. The bonds shall be sold at public or private sale by the Treasurer at, above, or below the principal amount thereof, on the terms and conditions and for the consideration in the medium of payment that

the Treasurer shall determine prior to the sale.

1063.76. (a) The collateral shall be used solely for the purpose of paying the principal and redemption price of, and interest on, the bonds and any amounts owing by CIGA under contracts entered into pursuant to Section 1063.77, and shall not be used for any other purpose. Member insurers shall pay the special bond assessments directly to the trustee for the bonds. Any collateral in the possession of CIGA shall be held by CIGA in trust for the benefit of the trustee for the bonds.

(b) Upon the issuance of the first bond, the collateral shall be subject to a first priority statutory lien in favor of the trustee for the bonds, for the benefit of the holders of the bonds and the parties to the contracts entered into pursuant to Section 1063.77, to secure the payment of the principal and redemption price of, and interest on, the bonds and any amounts owing by CIGA under contracts entered into pursuant to Section 1063.77. This lien shall arise by operation of law automatically without any action on the part of CIGA, the bank, or any other person. This lien is a continuous lien on all collateral effective from the time the first bond is issued, whether or not a particular item of collateral exists at the time of the issuance. From the time the first bond is issued, this lien shall be valid, effective, prior, perfected, binding, and enforceable against CIGA, its successors, purchasers of the collateral, creditors, and all others asserting rights in the collateral, irrespective of whether those parties have notice of the lien and without the need for any physical delivery, recordation, filing, or further act. Upon default in the payment of the principal or redemption price of, or interest on, the bonds, or any amounts owing by CIGA under contracts entered into pursuant to Section 1063.77, the trustee for the bonds shall be entitled to foreclose or otherwise enforce this lien on the collateral.

(c) No person acting under any provision of law or principle of equity shall be permitted in any way to impede or in any manner interfere with (1) the full and timely payment of the principal and redemption price of, and interest on, the bonds and any amounts owing by CIGA under contracts entered into pursuant to Section 1063.77, or (2) the statutory lien created by this section and the full and timely application of the collateral to the payment of the principal and redemption price of, and interest on, the bonds and any amounts owing by CIGA under contracts entered into pursuant to Section 1063.77.

(d) None of the collateral shall be subject to garnishment, levy, execution, attachment, or other process, writ (including writ of mandate), or remedy in connection with the assertion or enforcement of any debt, claim, settlement, or judgment against the state, the department, the commissioner, the bank, CIGA, or the board, nor shall any of the collateral be subject to the claims of any creditor of the state, the department, the commissioner, the bank, CIGA, or the board. This paragraph shall not limit the rights or remedies of the trustee for the bonds, the holders of the bonds, or the parties to contracts entered into pursuant to Section 1063.77.

(e) As long as any bond is outstanding, CIGA shall not be subject to Article 14 (commencing with Section 1010) or Article 14.3 (commencing with Section 1064.1) of Chapter 1 of Part 2 of Division 1 of the Insurance Code.

1063.77. CIGA is authorized to enter into those contracts or agreements with those banks, insurers, or other financial institutions or parties that it determines are necessary or desirable to improve the security and marketability of, or to manage interest rates or other risks associated with, the bonds issued pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code. Those contracts or agreements may contain an obligation to reimburse, with interest, any of those banks, insurers, or other financial institutions or parties for advances used to pay the purchase price of, or principal or interest on, the bonds or other obligations.

INSURANCE CODE
SECTION 1064.1-1064.12

1064.1. For the purposes of this act:

(a) "Insurer" means any person subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by the commissioner or the equivalent insurance supervisory official of another state.

(b) "Delinquency proceeding" means any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving that insurer.

(c) "Foreign country" means territory not in any state.

(d) "Domiciliary state" means the state in which an insurer is

incorporated or organized, or, in the case of an insurer incorporated or organized in a foreign country, the state in which the insurer, having become authorized to do business in the state, has, at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States; and any such insurer is deemed to be domiciled in such state.

(e) "Ancillary state" means any state other than a domiciliary state.

(f) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of this act are in force, including the provisions requiring that the commissioner or equivalent insurance supervisory official be the receiver of a delinquent insurer. A "reciprocal state" includes any state also which has, through its commissioner or equivalent supervisory official, entered into a binding and enforceable written agreement with the commissioner of this state which provides that (1) a commissioner or equivalent supervisory official is required to be the receiver of a delinquent insurer; (2) title to assets of the delinquent insurer shall vest in the domiciliary receiver, as of the date of any court order appointing him or her as receiver, and he or she shall have the same rights to recover those assets as provided under subdivision (b) of Section 1064.3; (3) nondomiciliary creditors may file and prove their claims before ancillary receivers; (4) the laws of the domiciliary state of the delinquent insurer shall be applied uniformly to residents and nonresidents in the allowance of preference of claims, except for claims to special deposits created under the laws of the domiciliary state; (5) preferences (including attachments, garnishments, and liens) for creditors with advance information shall be prevented; and (6) the domiciliary receiver may sue in the reciprocal state to recover any assets of a delinquent insurer to which he or she may be entitled under the law.

(g) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or limited class or classes of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States, shall be deemed general assets.

(h) "Preferred claim" means any claim with respect to which the

law of a state accords priority of payment from the general assets of the insurer.

(i) "Special deposit claim" means any claim secured by a deposit made for the security or benefit of a limited class or classes of persons, but not including any general assets.

(j) "Secured claim" means any claim secured by mortgage, trust, deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims, which more than four months prior to the commencement of delinquency proceedings in the state of the insurer's domicile, have become liens upon specific assets by reason of judicial process.

(k) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require.

1064.2. (a) Whenever under the laws of this state a receiver is to be appointed in delinquency proceedings for an insurer domiciled in this state, the court shall appoint the commissioner as receiver. Upon the appointment, the court shall direct the receiver forthwith to take possession of the assets of the insurer and to administer them under the orders of the court.

(b) The domiciliary receiver and his or her successors in office shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer wherever located, as of the date of the order of his or her appointment, and he or she shall have the right to recover the same and reduce them to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are prescribed in this article for ancillary receivers appointed in this state as to assets located in this state. The filing or recording of the order appointing the receiver or certified copy thereof, in the office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded. The domiciliary receiver shall be responsible on his or her official bond for the proper administration of all assets coming into his or her possession or control.

(c) Upon taking possession of the assets of a delinquent insurer the domiciliary receiver shall, subject to the direction of the court, and in accordance with those procedures that the receiver may petition the court to establish, immediately proceed to conduct the

business of the insurer or to take the steps authorized by the laws of this state for the purpose of liquidating, rehabilitating, reorganizing, or conserving the affairs of the insurer. In connection with delinquency proceedings, he or she may appoint one or more special deputy commissioners to act for him or her, and may employ clerks and assistants as he or she deems necessary. The compensation of the special deputies, clerks, or assistants and all expenses of taking possession of the delinquent insurer and of conducting the delinquency proceedings shall be fixed by the receiver, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within the limits of the duties imposed upon them, special deputies shall possess all the powers given to them, and, in the exercise of those powers, shall be subject to all of the duties imposed upon the receiver with respect to delinquency proceedings.

1064.3. (a) Whenever under the laws of this state an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the commissioner as ancillary receiver. The commissioner shall file an application requesting the appointment (1) if he or she finds that there are sufficient assets of that insurer located in this state, or that there are sufficient persons residing in this state having claims against that insurer, to justify the appointment of an ancillary receiver, or (2) if 10 or more persons resident in this state having claims against that insurer file an application with the commissioner requesting the appointment of an ancillary receiver.

(b) The domiciliary receiver of an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer located in this state, and he or she shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this state. He or she shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall, during the ancillary receivership proceedings, have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. All remaining assets shall be promptly transferred to the

domiciliary receiver. Subject to the foregoing provisions, the ancillary receiver and his or her deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets, as a receiver of an insurer domiciled in this state.

(c) Notwithstanding any other provision of this article, in any ancillary receivership proceeding in this state against an insurer domiciled in a reciprocal state, assets located in this state which comprise all or part of any deposit by that insurer under the laws of that reciprocal state for the benefit and security of beneficiaries of awards of workers' compensation against insurers shall be returned promptly to the domiciliary receiver, if he or she so requests, without deduction of any amounts to satisfy claims of policyholders and creditors.

1064.4. (a) In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any in their respective states, or with the domiciliary receiver. All claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(b) Controverted claims belonging to claimants residing in reciprocal states may either (1) be proved in this state as provided by law, or (2), if ancillary proceedings have been commenced in those reciprocal states, be proved in those proceedings. In the event a claimant elects to prove his or her claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in Section 1064.5 with respect to ancillary proceedings in this state, the final allowance of such claim by the courts in the ancillary state shall be accepted in this state as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

1064.5. (a) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary

delinquency proceeding.

(b) Controverted claims belonging to claimants residing in this state may either (1) be proved in the domiciliary state as provided by the laws of that state, or (2), if ancillary proceedings have been commenced in this state, be proved in those proceedings. In the event that any such claimant elects to prove his or her claim in this state, he or she shall file his or her claim with the ancillary receiver in the manner provided by the law of this state for the proving of claims against insurers domiciled in this state, and he or she shall give notice in writing to the receiver in the domiciliary state, either by registered mail or by personal service at least 40 days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based, and the priorities asserted, if any. If the domiciliary receiver, within 30 days after the giving of notice, shall give notice in writing to the ancillary receiver and to the claimant, either by registered mail or by personal service, of his or her intention to contest that claim, he or she shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state.

1064.6. (a) In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this state. All such claims, whether owing to residents or nonresidents, shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

1064.7. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the

claimants may share in the general assets, but, unless applicable law provides otherwise, the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

1064.8. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his or her security and file his or her claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this article, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, that amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

1064.9. During the pendency of delinquency proceedings in this or any reciprocal state, no action or proceeding in the nature of an attachment, garnishment, or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding.

1064.10. The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of that insurer to which he or she may be entitled under the laws of this state.

1064.11. If any provision of this article or the application thereof to any person or circumstances is held invalid, that

invalidity shall not affect other provisions or applications of the article which can be given effect without the invalid provision or application, and to this end the provisions of this article are declared to be severable.

1064.12. (a) This article may be referred to as the "Uniform Insurers Rehabilitation Act."

(b) The Uniform Insurers Rehabilitation Act shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions, when applicable, conflict with Article 14 (commencing with Section 1010), the provisions of this article shall control. The provisions of Article 14 (commencing with Section 1010) not in conflict with this article shall be unaffected by it.

(c) This article does not apply in regard to insurers domiciled in any state that is not a reciprocal state, and to any insurer domiciled in a reciprocal state before that state appoints a domiciliary receiver for the insurer. All those insurers shall be governed by Article 14 (commencing with Section 1010). If a domiciliary receiver is appointed in a reciprocal state while a receivership is proceeding under Article 14 (commencing with Section 1010), the receiver under that article shall thereafter act as ancillary receiver under Section 1064.3.

INSURANCE CODE
SECTION 1065.1-1065.7

1065.1. Whenever the commissioner has reasonable cause to believe, and determines, after a public hearing, that any person specified in Section 1010 is conducting its business and affairs in such a manner as to threaten to render it insolvent, or that it is in a hazardous condition, or is conducting its business and affairs in a manner which is hazardous to its policyholders, creditors or the public, or that it has committed or engaged in, or is committing or engaging in, any act, practice, or transaction which under any provision of this code would constitute ground rendering the person subject to conservation or liquidation proceedings, he may make and serve upon the person such order or orders as shall be reasonably necessary to correct, eliminate or remedy such conduct, condition or ground.

The commissioner shall serve notice of any hearing required by this article upon the person, stating the time and place therefor, and the conduct, condition or ground upon which the commissioner would make his order. The hearing shall occur not less than 20 nor more than 30 days after notice is served upon the person.

1065.2. (a) Whenever it appears to the commissioner that any conduct, condition or ground set forth in Section 1065.1 exists, and that irreparable loss and injury to the property and business of a person specified in Section 1010 has occurred or may occur unless the commissioner acts immediately, the commissioner may, without notice, and before hearing, issue and cause to be served upon such person an order requiring such person to forthwith cease and desist from engaging further in the acts, practices or transactions which are causing such conduct, condition or ground to exist.

(b) At the same time an order is served pursuant to subdivision (a) of this section, the commissioner shall issue and also serve upon the person a notice of hearing to be held at a time and place fixed therein which shall not be less than 20 or more than 30 days after the service thereof. The notice shall contain a statement of the conduct, condition or ground which the commissioner deems violative of the provisions of Section 1065.1.

(c) At any time prior to the commencement of a hearing as provided in Section 1065.1 or subdivision (b) of this section, the person may waive the hearing and have judicial review of the order by means of any remedy afforded by law without first exhausting administrative remedies or procedures.

1065.3. If, after hearing as provided by Section 1065.1 or subdivision (b) of Section 1065.2, any of the statements as to conduct, conditions, or grounds in the notice are found to be true, the commissioner shall make an order or orders as may be reasonably necessary to correct, eliminate, or remedy the conduct, conditions, or grounds. As part of the order or orders, the commissioner may also order the person to whom the order is directed to fully reimburse the commissioner for the commissioner's costs in investigating, examining, and prosecuting the matter. An order of reimbursement shall be enforced as provided in Section 1065.5.

1065.4. Any person subject to an order or proceeding pursuant to this article shall be entitled to judicial review of the order or proceeding by means of any remedy afforded by law. Proceedings for judicial review shall be commenced within 60 days from the making and service of any order issued pursuant to Sections 1065.1 or 1065.3.

1065.5. If any person violates or fails to comply with any order of the commissioner or any part thereof which as to such person has become final and is still in effect, the commissioner may, after a hearing, notice of which shall be given in accordance with the provisions of Section 1065.1, at which it is determined that a violation of such order has been committed, further order that:

(a) Such person shall forfeit and pay to the State of California a sum not to exceed one hundred dollars ($100) per day for each and every day that such violation or failure to comply shall continue, but in no event to exceed a maximum amount of five thousand dollars ($5,000). Such liability shall be enforced in an action brought in any court of competent jurisdiction by the commissioner in the name of the people of the State of California; and that

(b) Proceedings be commenced to revoke or suspend any license or certificate of authority held by such person under this code, in accordance with the procedures provided therefor.

1065.6. The powers vested in the commissioner by this article shall be additional to any and all other powers and remedies vested in the commissioner by law, and nothing herein shall be construed as requiring that the commissioner shall employ the powers conferred herein instead of or as a condition precedent to the exercise of any other power or remedy vested in the commissioner.

1065.7. Any order or notice of the commissioner hereunder may be served on any person, in the same manner and with the same effect as provided for in civil actions in a superior court of this state.

INSURANCE CODE
SECTION 1067-1067.18

1067. This article shall be known and may be cited as the California Life and Health Insurance Guarantee Association Act.

1067.01. (a) The purpose of this article is to protect, subject to certain limitations, the persons specified in Section 1067.02 against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in Section 1067.02, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(b) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purposes of this article.

1067.02. (a) This article shall provide coverage for the policies and contracts specified in subdivision (b) to all of the following:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees of the persons covered under paragraph (2).

(2) To persons who are owners of or certificate holders under those policies or contracts, and who either:

(A) Are residents of this state.

(B) Are not residents, but only under all of the following conditions:

(i) The insurers that issued the policies or contracts are domiciled in this state.

(ii) The insurers never held a license or certificate of authority in the states in which the persons reside.

(iii) The states in which the persons reside have associations similar to the association created by this article.

(iv) The persons are not eligible for coverage by those

associations.

(b) (1) This article shall provide coverage to the persons specified in subdivision (a) for direct, nongroup life, health, annuity, and supplemental policies or contracts and for certificates under direct group life, health, annuity, and supplemental policies and contracts, except as limited by this article. Annuity contracts and certificates under group annuity contracts include, but are not limited to, structured settlement agreements, allocated annuity contracts, and any immediate or deferred annuity contracts, and unallocated annuity contracts except those expressly excluded pursuant to subparagraph (D) of paragraph (2) of this subdivision.

(2) This article shall not provide coverage for any of the following:

(A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policyholder or contractholder.

(B) Any policy or contract of reinsurance, unless assumption certificates have been issued.

(C) Any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds either or both of the following:

(i) The extent to which the rate of interest, averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting six percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated, not to go below a minimum of 0 percent.

(ii) The extent to which the rate of interest, on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting six percentage points from Moody's Corporate Bond Yield Average as most recently available, not to go below a minimum of 3 percent.

(D) Guaranteed investment contracts, guaranteed interest contracts, funding agreements, deposit administration contracts, and all other unallocated annuity contracts; provided however, coverage may be provided for unallocated annuity contracts sold (i) by an insurer as to which an order of liquidation, which contained a finding of insolvency and which later became final, was entered by a court of competent jurisdiction in the state of its domicile, after December 20, 1991, but prior to December 20, 1992, and sold to an employer or a trustee or other plan fiduciary in connection with a

plan or program of an employer prior to December 20, 1992, for purposes of providing the employees of the employer with deferred compensation or pension benefits and (I) the individual employees have an option to participate or not participate, in whole or in part, in the contract, and (II) the individual employee contributes from his or her wages some portion of the funds paid into the plan or program, or (ii) sold by a mutual insurer as to which an order of liquidation that contained a finding of insolvency and that later became final was entered by a court of competent jurisdiction in the state of its domicile after December 1, 1991, but prior to December 31, 1991, and sold to an employer qualifying as an Internal Revenue Code Section 501(c)(3) employer or to a trustee or other plan fiduciary in connection with a plan or program of such an employer for purposes of providing the employees of the employer with deferred compensation or pension benefits and (I) the contract was purchased exclusively with funds of the employer in amounts computed as a uniform percentage of the compensation of each employee entitled to participate under the terms of the plan, (II) the contract has a stated maturity date occurring within 15 days prior to that order of liquidation, and (III) the employer also maintained at the time of the insolvency a tax deferred annuity plan or program described in Section 403(b) of the Internal Revenue Code.

(E) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity under any of the following:

(i) A multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended.

(ii) A minimum premium group insurance plan.

(iii) A stop-loss group insurance plan.

(iv) An administrative services only contract.

(F) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policyholder or contractholder, in connection with the service to or administration of the policy or contract.

(G) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state.

(H) Any annuity issued by a charitable organization that is duly

qualified as such under applicable provisions of the Internal Revenue Code, and that is not engaged in the business of insurance as its primary business.

(c) The benefits for which the association may become liable for life insurance and annuity policies shall in no event exceed the lesser of the following:

(1) Eighty percent of the contractual obligations for each policy or contract as modified pursuant to subparagraph (C) of paragraph (2) of subdivision (b), for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer.

(2) (A) With respect to any one life, regardless of the number of policies or contracts:

(i) Two hundred fifty thousand dollars ($250,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance.

(ii) One hundred thousand dollars ($100,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) However, in no event shall the association be liable to expend more than two hundred fifty thousand dollars ($250,000) in the aggregate with respect to any one individual under subparagraph (A).

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

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

(1) The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer.

(2) With respect to any one individual receiving health care benefits, regardless of the number of policies or contracts, two hundred thousand dollars ($200,000) in health insurance benefits; an amount that shall increase or decrease based upon changes in the health care cost component of the consumer price index from January 1, 1991, to the date on which the insurer becomes an insolvent insurer.

(e) An unallocated annuity contract that is not covered by the association may not be offered to an employer, after January 1, 1994,

unless prior to being offered to the employer, or the participation by the employee, the insurer or agent has disclosed to the employer, and employee in writing in a conspicuous manner that the contract is not covered by the association.

1067.03. This article shall be liberally construed to effect the purpose under Section 1067.01 which shall constitute an aid and guide to interpretation.

1067.04. As used in this article:

(a) "Account" means any of the three accounts created under Section 1067.05.

(b) "Association" means the California Life and Health Insurance Guarantee Association created pursuant to Section 1067.05.

(c) "Commissioner" means the Insurance Commissioner.

(d) "Contractual obligation" means any obligation under a policy or contract, or certificate under a group policy or contract, or portion thereof, for which coverage is provided under Section 1067.02.

(e) "Covered policy" means any policy or contract within the scope of this article under Section 1067.02.

(f) "Impaired insurer" means a member insurer that, after October 1, 1990, is not an insolvent insurer, and (1) is deemed by the commissioner to be potentially unable to fulfill its contractual obligations or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(g) "Health insurance" means the class of insurance described as disability insurance in Section 106.

(h) "Insolvent insurer" means a member insurer that, after October 1, 1990, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(i) "Member insurer" means any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 1067.02 and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include any of the following:

(1) A fraternal benefit society.

(2) A mandatory state pooling plan.

(3) A mutual assessment company or any entity that operates on an assessment basis.

(4) An insurance exchange.

(5) A nonprofit hospital service plan.

(6) A health care service plan.

(7) A grants and annuities society holding a certificate of authority under Section 11520.

(8) Any entity similar to any of the above.

(j) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(k) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(l) "Premiums" means amounts received on covered policies or contracts less premiums, considerations, and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subdivision (b) of Section 1067.02 except that assessable premium shall not be reduced on account of paragraph (2) of subdivision (c) of Section 1067.02 relating to limitations with respect to any one individual, any one participant, and any one contractholder; provided that "premiums" shall not include any premiums in excess of five million dollars ($5,000,000) with respect to multiple policies of individual life insurance issued to any one owner, whether the policyowner is an individual, firm, corporation, or other legal entity, and whether the persons insured are officers, employees, or other persons in whose lives the policyowner has an insurable interest, regardless of the number of policies held by the owner.

(m) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business.

(n) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(o) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under that contract or certificate, and except to the extent allowed in subparagraph (D) of paragraph (2) of subdivision (b) of Section 1067.02.

1067.05. (a) A nonprofit legal entity to be known as the California

Life and Health Insurance Guarantee Association shall exist as a result of the merger of the Seastrand Health Insurance Guaranty Association with and into the California Life Insurance Guaranty Association pursuant to Section 1067.055. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Section 1067.09 and shall exercise its powers through a board of directors established under Section 1067.06. For purposes of administration and assessment, the association shall maintain the following three accounts:

(1) The life insurance account.

(2) The annuity account.

(3) The health insurance account.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

1067.055. In order to provide for the merger of the Seastrand Health Insurance Guaranty Association with and into the California Life Insurance Guaranty Association, the following shall apply:

(a) Notwithstanding the repeal of the California Life Insurance Guaranty Association Act and the Seastrand Health Insurance Guaranty Association Act, the Seastrand Health Insurance Guaranty Association shall, effective immediately prior to that repeal, be merged with and into the California Life Insurance Guaranty Association, which shall then be known as the California Life and Health Insurance Guarantee Association.

(b) Notwithstanding the repeal of the California Life Insurance Guaranty Association Act and the Seastrand Health Insurance Guaranty Association Act, but subject to the last sentence of this subdivision, all of the following shall apply:

(1) The association shall succeed, without other transfer, to all the rights, powers, privileges, assets, and property of each of the California Life Insurance Guaranty Association and the Seastrand Health Insurance Guaranty Association, which for the purposes of this section shall be referred collectively as the merging associations. The association shall be subject to all debts, obligations, and liabilities of each merging association in the same manner as if the association had itself incurred them, in each case under the law in

effect prior to the effective date of this article, as those rights, powers, privileges, obligations, debts, and liabilities may be amended and restated in this article, including, without limitation, the extension of coverage with respect to unallocated contracts as provided in subparagraph (D) of paragraph (2) of subdivision (b) of Section 1067.02, and in each case with respect to member insurers that became impaired insurers or insolvent insurers prior to the effective date of this article and after October 1, 1990. Without limiting the generality of the foregoing, the association shall succeed to (A) all collected, uncollected, or unbilled assessments of the merging associations, (B) all cash, bank accounts, and accrued interest of the merging associations, (C) all rights, powers, privileges, and obligations of the merging associations under any contracts or commitments of the merging association, (D) all subrogations, assignments, and creditor rights and interests of the merging associations, and (E) all rights, powers, privileges, and obligations of each of the trusts established on December 31, 1993, by each of the merging associations as settlor.

(2) All rights of creditors and all liens upon the property of each of the merging associations shall be preserved unimpaired, provided that the liens upon property of a merging association shall be limited to the property affected thereby immediately prior to the effective date of this article.

(3) Any action or proceeding pending by or against a merging association may be prosecuted to judgment, which shall bind the association, or the association may be proceeded against or be substituted in its place.

Notwithstanding the other provisions of this subdivision, all debts, obligations, and liabilities of a merging association that were to be paid out of a specified account of the merging association shall be paid solely out of the assets of that merging association that were available to that merging association to pay those debts and liabilities, including, without limitation, collected, uncollected, or unbilled assessments, and any and all subrogation, assignment, and creditor rights, or out of assets in the same type of account of the association.

(c) Notwithstanding any other provision to the contrary in this article:

(1) It is the intent of this section to preserve rights, powers, privileges, assets, property, debts, obligations, and liabilities of each of the merging associations, and not to provide contractholders and policyholders, or their respective payees, beneficiaries, or assignees, with duplicative rights, powers, privileges, assets, or property.

(2) Accordingly, no contractholder and policyholder, and no contractholder's or policyholder's payee, beneficiary, or assignee, shall be entitled to (A) a recovery from the association that is duplicative of a previous recovery from either of the merging associations, or the trust established by either merging association, or (B) a recovery from the association on account of a claim against either of the merging associations where the association is liable with respect to a claim under the same policy or contract under this article.

1067.06. (a) The board of directors of the association shall consist of not less than nine nor more than 13 member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

1067.07. (a) If a member insurer is an impaired domestic insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer, do any of the following:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer.

(2) Provide moneys, pledges, notes, guarantees, or other means proper to effectuate paragraph (1) and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (1).

(3) Loan money to the impaired insurer.

(b) (1) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in paragraph (2), the association shall, in its discretion, either:

(A) Take any of the actions specified in subdivision (a), subject to the conditions therein.

(B) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

(2) The association shall be subject to the requirements of paragraph (1) only if subparagraphs (A) and (B) apply:

(A) The laws of the state of domicile of the impaired member insurer provide that until all payments of or on account of the impaired insurer's contractual obligations by all guarantee associations, along with all expenses thereof and interest on all of those payments and expenses, shall have been repaid to the guarantee associations or a plan of repayment by the impaired insurer shall have been approved by the guarantee associations, all of the following apply:

(i) The delinquency, rehabilitation, or conservation proceeding shall not be dismissed.

(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.

(iii) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.

(B) Either clause (i) or (ii) applies:

(i) The impaired insurer is a domestic insurer, and it has been placed under an order of conservation or rehabilitation by a court of competent jurisdiction in this state.

(ii) The impaired insurer is a foreign or alien insurer, and all of the following apply:

(I) It has been prohibited from soliciting or accepting new

business in this state.

(II) Its certificate of authority has been suspended or revoked in this state.

(III) A petition for conservation, rehabilitation, or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

(c) If a member insurer is an insolvent insurer, the association shall, in its discretion, either do those things described in paragraph (1) or in paragraph (2):

(1) (A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(C) Provide those moneys, pledges, guarantees, or other means as are reasonably necessary to discharge the duties.

(2) With respect only to life and health insurance policies, provide benefits and coverages in accordance with subdivision (d).

(d) When proceeding under subparagraph (B) of paragraph (1) of subdivision (b), or paragraph (2) of subdivision (c), the association shall, with respect to only life and health insurance policies:

(1) Assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred:

(A) With respect to group life insurance policies, not later than the earlier of the next renewal date under the policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies.

(B) With respect to group health insurance policies, individual health insurance policies and individual life insurance policies, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies.

(2) Make diligent efforts to provide all known insureds or group policyholders, with respect to group policies, 30 days notice of the termination of the benefits provided.

(3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of

paragraph (4), if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(4) (A) In providing the substitute coverage required under paragraph (3), the association may offer either to reissue the terminated coverage or to issue an alternative policy and shall consider obtaining coverage for a medically uninsurable person from the program established under Part 6.5 (commencing with Section 12700) of Division 2.

(B) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(C) The association may reinsure any alternative or reissued policy.

(5) (A) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(C) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(6) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(7) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date that coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(e) When proceeding under subparagraph (B) of paragraph (1) of subdivision (b) or under subdivision (c) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subparagraph (C) of paragraph (2) of subdivision (b) of Section 1067.02.

(f) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this article with respect to that policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(g) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of that order.

(h) The protection provided by this article shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(i) In carrying out its duties under subdivisions (b) and (c), the association may, subject to approval by the court, do either of the following:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association's duties under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens, to be in the public interest.

(2) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

(j) If the association fails to act within a reasonable period of time as provided in subparagraph (B) of paragraph (1) of subdivision (b), and subdivisions (c) and (d), with respect to an impaired or insolvent insurer, the commissioner shall have the powers and duties of the association under this article with respect to the impaired or insolvent insurer.

(k) The association may render assistance and advice to the

commissioner, upon his or her request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(l) The association shall have standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article. That standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

(m) (1) Any person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of those rights and cause of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon that person.

(2) The subrogation rights of the association under this subdivision shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.

(3) In addition to paragraphs (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to the policy or contracts.

(n) The association may do any of the following:

(1) Enter into contracts necessary or proper to carry out the provisions and purposes of this article.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 1067.08 and to settle claims or potential claims against it.

(3) Borrow money to effect the purposes of this article. Any

notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(4) Employ or retain an executive director and other persons necessary to handle the financial transactions of the association, and to perform other functions necessary or proper under this article provided that the executive director shall be subject to the approval of the commissioner.

(5) Take legal action necessary to avoid payment of improper claims.

(6) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this article.

(o) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(p) There shall be no liability on the part of and no cause of action shall arise against the association or against any transferee from the association in connection with the transfer by reinsurance or otherwise of all or any part of an impaired or insolvent insurer's business by reason of any action taken or any failure to take any action by the impaired or insolvent insurer at any time.

(q) With respect to covered policies for which the association becomes obligated after an entry of an order or liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

1067.08. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of director shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not more than 30 days after prior written notice to the member insurers and shall accrue interest

at the rate of 10 percent per annum on and after the due date.

(b) There shall be two assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of subdivision (e) of Section 1067.11. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under Section 1067.07 with regard to an impaired or an insolvent insurer.

(c) (1) The amount of any class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. A non-pro rata assessment shall not exceed two hundred fifty dollars ($250) per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for those calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this article. Classification of assessments under subdivision (b) and computation of assessments under this subdivision shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which that assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e) (1) The total of all assessments upon a member insurer for any account shall not in any one calendar year exceed one percent of the insurer's average premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in that account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(g) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to life or annuity of insurance within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article.

(h) The association shall issue to each insurer paying an assessment under this article, other than class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or date of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in the form and for the amount, if any, and period of time as the commissioner may approve.

(i) (1) Subject to the provisions of paragraph (3), the plan of operation adopted pursuant to Section 1067.09 shall contain provisions whereby each member insurer is required to recoup over a reasonable length of time a sum reasonably calculated to recoup the assessments with respect to the health insurance account paid by the

member insurer under this article by way of a surcharge on premiums charged for health insurance policies to which this article applies. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agent's commission.

(2) Member insurers who collect surcharges in excess of assessments paid pursuant to this section for an insolvent insurer shall remit the excess to the association as an additional assessment within 120 days after the end of the collection period as determined by the association. The excess shall be applied to reduce future health insurance account assessments for that insurer.

(3) The plan of operation may permit a member insurer to omit the collection of the surcharge from its insureds when it determines the amount of the surcharge collectible from each insured would be unreasonably small in relation to the potential confusion of or objection by the insureds even if the aggregate surcharges collectible from all insureds exceeds the expense of collection.

(j) Any statement of the amount of surcharge required to be provided by the association shall include a description of, and purpose for, the California Life and Health Insurance Guarantee Association, as follows:

"Companies writing health insurance business in California are required to participate in the California Life and Health Insurance Guarantee Association. If a company writing health insurance becomes insolvent, the California Life and Health Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share."

"California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" with an amount will be displayed on your premium notice."

1067.09. (a) (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless he or she has not disapproved it within 30 days.

(2) If the association fails to submit a suitable plan of operation within 120 days following the effective date of this article or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice

and hearing, adopt and promulgate those reasonable rules necessary or advisable to effectuate the provisions of this article. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this article, do all of the following:

(1) Establish procedures for handling the assets of the association.

(2) Establish the amount and method of reimbursing members of the board of directors under Section 1067.06.

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(5) Establish the procedure whereby selections for the board of directors will be made and submitted to the commissioner.

(6) Establish any additional procedures for assessments under Section 1067.08.

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all powers and duties of the association, including its administration, except those under paragraph (3) of subdivision (n) of Section 1067.07 and Section 1067.08, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. That corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subdivision shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this article.

1067.10. In addition to the duties and powers enumerated elsewhere in this article:

(a) The commissioner shall do all of the following:

(1) Upon request of the board of directors, provide the

association with a statement of the premiums in this and any other appropriate states for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this article.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture shall not exceed 5 percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if the appeal is taken within 60 days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

(d) The liquidator, rehabilitator, or conservator of any impaired insurer or insolvent insurer may notify all interested persons of the effect of this article.

1067.11. To aid in the detection and prevention of insurer insolvencies or impairments:

(a) It shall be the duty of the commissioner to do the following:

(1) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when he or she takes any of the following actions against a member insurer:

(A) Revocation of license.

(B) Suspension of license.

(C) Makes any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

The notice shall be mailed to all commissioners within 30 days following the action taken or the date on which the action occurs.

(2) To report to the board of directors, the Legislature, and the Governor when he or she has taken any of the actions set forth in paragraph (1) or has received a report from any other commissioner indicating that any action has been taken in another state. The report to the board of directors, the Legislature, and the Governor shall contain all significant details of the action taken on the report received from another commissioner.

(3) To report to the board of directors when he or she has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until that time as it is made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his or her duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Those reports and recommendations shall not be considered public documents.

(d) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(e) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the

board in good faith believes may be an impaired or insolvent insurer. Within 30 days of the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by persons that the commissioner designates. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subdivision (a).

The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing the information that it may have in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by the other associations.

(h) Reports, information, and recommendations from the board to the commissioner and from the commissioner to the board under this Section 1067.11 shall be treated as confidential and shall not be considered public documents except as otherwise specifically provided in this section or by specific action of the board or commissioner.

1067.12. (a) Nothing in this article shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and

duties under Section 1067.07. Records of the negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subdivision shall limit the duty of the association to render a report of its activities under Section 1067.13.

(c) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Section 1067.07. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subdivision, are that proportion of the assets which the reserves that should have been established for those policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) (1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In the determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Section 1067.07 with respect to the insurer have been fully recovered by the association.

(e) (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) to (4), inclusive.

(2) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he or she received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions he or she would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subdivision shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (3) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

1067.13. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, the Governor, and the Legislature each year, not later than 120 days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

1067.14. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

1067.15. There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his or her representatives, for any action or omission by them in the

performance of their powers and duties under this article. The immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to that organization and its agents or employees.

1067.16. All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed not less than 60 days from the date an order of liquidation, rehabilitation, or conservation is final, to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

1067.17. (a) No person, including an insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the California Life and Health Insurance Guarantee Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the California Life and Health Insurance Guarantee Association Act. Provided, however, that this section shall not apply to the California Life and Health Insurance Guarantee Association or any other entity which does not sell or solicit insurance.

(b) The association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subdivision (c). This document shall be submitted to the commissioner for approval. Sixty days after receiving approval, no insurer may deliver a policy or contract described in paragraph (1) of subdivision (b) of Section 1067.02 to a policyholder or contractholder unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except if subdivision (d) applies. The document should also be available upon request by the policyholder. The distribution, delivery, or contents or interpretation of this document shall not

mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the article may require. Failure to receive this document does not give the policyholder, contractholder, certificate holder, or insured any greater rights than those stated in this article.

(c) The document prepared under subdivision (b) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall do all of the following:

(1) State the name and address of the life and health insurance guarantee association and insurance department.

(2) Prominently warn the policyholder or contractholder that the California Life and Health Insurance Guarantee Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state.

(3) State that the insurer and its agents are prohibited by law from using the existence of the California Life and Health Insurance Guarantee Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

(4) Emphasize that the policyholder or contractholder should not rely on coverage under the California Life and Health Insurance Guarantee Association when selecting an insurer.

(5) Provide other information as directed by the commissioner.

(d) No insurer or agent may deliver a policy or contract described in paragraph (1) of subdivision (b) of Section 1067.02, and excluded under subparagraph (A) of paragraph (2) of subdivision (b) of Section 1067.02 from coverage under this article unless the insurer or agent, prior to or at the time of delivery, gives the policyholder or contractholder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the California Life and Health Insurance Guarantee Association. The commissioner shall by rule specify the form and content of the notice.

1067.18. This article shall not apply to any insurer that was declared to be insolvent or impaired, or as to which delinquency proceedings had been commenced, on or before October 1, 1990.

INSURANCE CODE
SECTION 1068-1068.2

1068. (a) As used in this section, the following definitions shall apply:

(1) "Health care service plan" means any plan as defined in Section 1345 of the Health and Safety Code, but this section does not apply to specialized health care service contracts.

(2) "Carrier" means a health care service plan, an insurer issuing group disability coverage which covers hospital, medical, or surgical expenses, a nonprofit hospital service plan, or any other entity responsible for either the payment of benefits for or the provision of hospital, medical, and surgical benefits under a group contract.

(3) "Insolvency" means that the Director of the Department of Managed Health Care has determined that the health care service plan is not financially able to provide health care services to its enrollees and (A) the Director of the Department of Managed Health Care has taken an action pursuant to Section 1386, 1391, or 1399 of the Health and Safety Code, or (B) an order requested by the Director of the Department of Managed Health Care or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1 of the Health and Safety Code.

(b) In the event of the insolvency of a health care service plan, upon order of the commissioner which shall be issued following his or her receipt of a notice issued by the Director of the Department of Managed Health Care pursuant to Section 1394.7 of the Health and Safety Code, any insurer, nonprofit hospital service plan, and any other entity, other than a health care service plan, responsible for either the payment of benefits for or the provision of hospital, medical, and surgical benefits under a group contract, that participated in the enrollment process with the insolvent health care service plan at the last regular open enrollment period of a group, shall offer enrollees of the group in the insolvent health care service plan a 30-day enrollment period commencing upon the date of insolvency. Each such carrier shall offer enrollees of the group in the insolvent health care service plan the same coverages and rates that it offered to enrollees of the group at the last regular open enrollment period of the group.

1068.1. (a) As used in this section:

(1) "Carrier" means a specialized health care service plan, and any of the following entities which offer coverage comparable to the coverages offered by a specialized health care service plan: an insurer issuing group disability coverage; a nonprofit hospital service plan; or other entity responsible for either the payment of benefits for or the provision of services under a group contract.

(2) "Insolvency" means that the Director of the Department of Managed Health Care has determined that the specialized health care service plan is not financially able to provide specialized health care services to its enrollees and (A) the Director of the Department of Managed Health Care has taken an action pursuant to Section 1386, 1391, or 1399 of the Health and Safety Code, or (B) an order requested by the commissioner or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1 of the Health and Safety Code.

(3) "Specialized health care service plan" means any plan authorized to issue only specialized health care service plan contracts as defined in Section 1345 of the Health and Safety Code.

(b) In the event of the insolvency of a specialized health care service plan, upon order of the commissioner which shall be issued following his or her receipt of a notice issued by the Director of the Department of Managed Health Care pursuant to Section 1394.8 of the Health and Safety Code, all carriers that participated in the enrollment process with the insolvent specialized health care service plan at a group's last regular open enrollment period for the same type of specialized health care service benefits shall offer the group's enrollees in the insolvent specialized health care service plan a 30-day enrollment period commencing upon the date of insolvency. Each such carrier shall offer enrollees of the insolvent specialized health care service plan the same specialized coverage and rates that it had offered to the enrollees of the group at its last regular open enrollment period.

1068.2. (a) The commissioner shall have the administrative authority to assess penalties against any person, including a natural person or other entity, for violations of this article.

(b) Upon a showing of a violation of this article in any civil action, a court may also assess the penalties prescribed in this section.

(c) Whenever the commissioner has reasonable cause to believe or determines after a public hearing that any person has violated this

article he or she shall make and serve upon the person an notice of hearing. The notice shall state the commissioner's intent to assess the administrative penalties, the time and place of the hearing, and the conduct, condition or grounds upon which the commissioner is holding the hearing and assessing the penalties. The hearings shall occur within 30 days after the notice is served. Within 30 days after the hearing the commissioner shall issue an order specifying the penalty. The penalties resulting from the hearing shall be paid to the Insurance Fund, but may be spent only when appropriated by the Legislature.

(d) Any person who violates this article is liable for administrative penalties of no less than twenty-five thousand dollars ($25,000).

INSURANCE CODE
SECTION 1070-1076

1070. Any insurer, upon payment of the fees and costs therefor and surrender to the commissioner of its certificate of authority, may apply to withdraw from this State. Such application shall be in writing, duly executed, accompanied by evidence of due authority for such execution, and properly acknowledged.

1070.5. Whenever an admitted insurer fails to take any step necessary to maintain continuance of its certificate of authority, or whenever the certificate of authority admitting an insurer is canceled or revoked, or whenever an admitted insurer as an entity ceases doing an insurance business in this state for any reason, such insurer shall apply to withdraw as an insurer and shall withdraw as such insurer from this state pursuant to this article. Every certificate of authority hereafter granted is so granted subject to this withdrawal requirement. Acceptance of every such certificate of authority is an agreement by the accepting insurer that it will conform to the provisions of this article.

1070.6. The withdrawal procedure and fees prescribed by this

article shall not be required of a nonsurviving admitted constituent to a merger or consolidation into another admitted insurer in accordance with the applicable statutes and the commissioner's prior written consent given pursuant to subdivision (c) of Section 1011, provided the commissioner is satisfied by documents, authenticated so as to be admissible in evidence over objection, filed with him, that:

(a) Such constituent has discharged all of its liabilities to residents of this state in the manner provided by Section 1071.5;

(b) There will be an admitted insurer directly available to such constituent's policyholders: (1) to obtain policy changes and endorsements, (2) to receive payment of premiums and refund unearned premiums, (3) to serve notice of claim, proof of loss, summons, process, and other papers, and (4) for purposes of suit;

(c) Such constituent shall timely file with the commissioner appropriate financial statements reporting its insurance business done in this state during the calendar year of the merger or consolidation and all appropriate tax returns required by law for such period, and shall timely pay all taxes found to be due on account of such business; and

(d) Such constituent has surrendered its current California certificate of authority to the commissioner for cancellation as of the effective date of the merger.

The withdrawal procedure and fees prescribed by this article shall not be required of an insurer which has been liquidated by a final order of a court of record of this or any sister state provided a certified copy of such order reciting the fact of liquidation and discharge of all obligations has been filed with the commissioner.

1071. The commissioner shall publish such application for withdrawal, daily, for one week, in each of two daily newspapers of general circulation, one published in the city of San Francisco, and the other in the city of Sacramento. The expense of such publication shall be paid in advance by the insurer.

1071.5. Every insurer which withdraws as an insurer, or is required to withdraw as an insurer, from this State shall, prior to such withdrawal, discharge its liabilities to residents of this State. In the case of its policies insuring residents of this State it shall

cause the primary liabilities under such policies to be reinsured and assumed by another admitted insurer. In the case of such policies as are subject to cancellation by the insurer, it may cancel such policies pursuant to the terms thereof in lieu of such reinsurance and assumption.

1072. The commissioner shall make, or cause to be made by the insurance authority of the State where the insurer is organized, an examination of the books and records of the insurer. If, upon such examination, he finds that the insurer has no outstanding liabilities to residents of this State and no policies in favor of the residents of this State uncanceled or the primary liabilities under which have not been reinsured and assumed by another admitted insurer, as required by Section 1071.5, he shall cancel the insurer's certificates of authority, if unexpired, and he shall permit the insurer to withdraw. The commissioner may, in his discretion, waive any or all of the above requirements if, after such examination, he finds it to be in a solvent condition. The cost and expense of all such examinations shall be paid as prescribed in Section 736.

1073. Whenever any insurer withdraws from business in this State, and whenever for any reason the commissioner revokes or cancels the certificate of authority admitting any insurer, the commissioner shall thereafter cause a notice of the revocation, cancellation or withdrawal to be published in one daily newspaper published in the city of San Francisco and one daily newspaper published in the city of Los Angeles. The expense of such publication shall be paid by the insurer.

1074. Upon the failure of such insurer to pay the expense of such advertising within thirty days after the presentation of the bill therefor, the commissioner shall collect such fee from the surety in the bond furnished in accordance with the provisions of Article 12 of this chapter or out of securities furnished thereunder.

1076. The withdrawing insurer shall pay to the commissioner a fee

of five hundred ninety dollars ($590) for all services and expenses in connection with the withdrawal.

INSURANCE CODE
SECTION 1077-1077.95

1077. As used in this article:

(a) "Insurer" means and includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of life or disability insurance or of annuities.

(b) "Exceeded its powers" means any of the following conditions:

(1) The insurer has refused to permit examination of its books, papers, accounts, records, or affairs by the commissioner, his or her deputies, employees, or duly commissioned examiners.

(2) A domestic insurer has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer.

(3) The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto.

(4) The insurer has neglected or refused to observe an order of the commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock, or surplus.

(5) The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner.

(6) The insurer, by contract or otherwise, has unlawfully, or has in violation of an order of the commissioner, or has without first having obtained written approval of the commissioner, if approval is required by law, done any of the following:

(A) Totally reinsured its entire outstanding business.

(B) Merged or consolidated substantially its entire property or business with another insurer.

(7) The insurer engaged in any transaction in which it is not authorized to engage under the laws of this state.

(8) The insurer refused to comply with a lawful order of the commissioner.

(c) "Consent" means agreement to administrative supervision by the insurer.

1077.1. The provisions of the article shall apply to all of the following:

(a) All domestic life or disability insurers.

(b) Any other life or disability insurer doing business in this state whose state of domicile has asked the commissioner to apply the provisions of this article as regards that insurer.

1077.2. (a) An insurer may be subject to administrative supervision by the commissioner if, upon examination or at any other time it appears in the commissioner's discretion that any of the following applies:

(1) The insurer's condition renders the continuance of its business hazardous to the public or to its insureds.

(2) The insurer appears to have exceeded its powers granted under its certificate of authority and applicable law.

(3) The insurer has failed to comply with the applicable provisions of the Insurance Code.

(4) The business of the insurer is being conducted fraudulently.

(5) The insurer gives its consent.

(b) If the commissioner determines that the conditions set forth in subdivision (a) exist, the commissioner shall do all of the following:

(1) Notify the insurer of his or her determination.

(2) Furnish to the insurer a written list of the requirements to abate this determination.

(3) Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of the article. The action by the commissioner shall be subject to review pursuant to Section 12940.

(c) If placed under administrative supervision, the insurer shall have 60 days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of this article.

(d) If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the end of the supervision period specified above, the commissioner may extend the period.

(e) If it is determined that none of the conditions giving rise to the supervision exist, the commissioner shall release the insurer from supervision.

1077.3. (a) Notwithstanding any other provision of law, and except as set forth in this section, proceedings, hearings, notices, correspondence, reports, records, and other information in the possession of the commissioner or the department relating to the supervision of any insurer are confidential except as provided by this section.

(b) The personnel of the department shall have access to these proceedings, hearings, notices, correspondence, reports, records, or information as permitted by the commissioner.

(c) The commissioner may open the proceedings or hearings or disclose the notices, correspondence, reports, records, or information to a department, agency, or instrumentality of this or another state of the United States if the commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state of the United States.

(d) The commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records, or other information if the commissioner deems that it is in the best interest of the public or in the best interest of the insurer, its insureds, creditors, or the general public.

(e) This section does not apply to hearings, notices, correspondence, reports, records, or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction.

1077.4. During the period of supervision, the commissioner or his or her designated appointee shall serve as the administrative supervisor. The commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of the commissioner or his or her appointed supervisor:

(a) Dispose of, convey, or encumber any of its assets or its business in force.

(b) Withdraw any of its bank accounts.

(c) Lend any of its funds.

(d) Invest any of its funds.

(e) Transfer any of its property.

(f) Incur any debt, obligation, or liability.

(g) Merge or consolidate with another company.

(h) Approve new premiums or renew any policies.

(i) Enter into any new reinsurance contract or treaty.

(j) Terminate, surrender, forfeit, convert, or lapse any insurance

policy, certificate, or contract, except for nonpayment of premiums due.

(k) Release, pay, or refund premium deposits, accrued cash, or loan values, unearned premiums, or other reserves on any insurance policy, certificate, or contract.

(l) Make any material change in management.

(m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends, or other payments deemed preferential.

1077.5. During the period of supervision the insurer may contest an action taken or proposed to be taken by the supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer by requesting reconsideration by the commissioner. Denial of the insurer's request upon reconsideration entitles the insurer to seek judicial review under Section 12940.

1077.6. Nothing contained in this article shall preclude the commissioner from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation proceedings or other delinquency proceedings, however designated under the laws of this state, regardless of whether the commissioner has previously initiated administrative supervision proceedings under this article against the insurer.

1077.7. The commissioner may adopt reasonable rules necessary for the implementation of this article.

1077.8. Notwithstanding any other provision of law, the commissioner may meet with a supervisor appointed under this article and with the attorney or other representative of the supervisor, without the presence of any other person, at the time of any proceedings or during the pendency of any proceeding held under authority of this article to carry out the commissioner's duties under this article or for the supervisor to carry out his or her

duties under this article.

1077.9. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under this article.

1077.95. The authority granted pursuant to this article is in addition to, and not in lieu of, any other provision of this code.

INSURANCE CODE
SECTION 1080-1091

1080. Any domestic incorporated mutual life insurer or disability insurer or life and disability insurer issuing nonassessable policies on a reserve basis may merge, consolidate or otherwise unite with or become a part of, or may reinsure all of its policies with, and, upon the assumption of all of its liabilities, may transfer its assets to, any incorporated mutual insurer admitted to transact the business of life, disability or life and disability insurance in this State. The plan and agreement by which any such transaction is to be effected shall be submitted to the commissioner who shall examine the same and may require such provisions to be inserted in the agreement and such actions to be taken in connection with the transaction as he may deem necessary in order that the transaction shall be mutually fair and equitable between the respective members and policyholders of the companies parties to the transaction.

When any such plan and agreement shall have been approved by the commissioner the same shall be approved in the case of each domestic insurer party to the merger or consolidation or the reinsuring of its policies and transferring of its assets by two-thirds of the votes cast by the members thereof represented in person or by proxy at a meeting called to consider the same. Notice of said meeting and its purpose shall be given by mail at least 30 days before the day fixed for the meeting to members whose insurance shall have been in force for at least one year prior to such meeting, at their addresses appearing on the books maintained at the home office of the company.

With respect to those members whose addresses do not appear on such books of the company notice shall be deemed to have been given if published at least once in some newspaper of general circulation in the county in which the principal office of the company is located. At such meeting the presence in person or by proxy of 5 percent of such members of such insurer shall constitute a quorum. In the absence of a quorum the members present at the meeting in person or by proxy may adjourn the meeting to a later date. No further notice need be given of the date to which the meeting is adjourned. If the vote is in the affirmative a certified copy of all proceedings relating to the proposed transaction shall be filed with the commissioner. If one of the insurance companies is a foreign company there shall be filed with the commissioner evidence of such approval, consent or other authorization as may be required by the laws of the state of incorporation of said foreign insurance company evidencing the power of the foreign insurance company to assume and carry out the agreement by which such transaction is effected. If the commissioner finds that the proceedings have been in accordance with the law and his requirements he shall approve the agreement which shall thereupon become effective.

1090. An insurer which is insolvent, retiring from business in this state other than by merger or consolidation into an admitted insurer with the commissioner's prior written consent, or the required paid-in capital of which is impaired, shall not reinsure its business until its plan to effect such reinsurance is first submitted to the commissioner and approved by him.

1091. The retiring insurer shall pay to the commissioner a fee of seven hundred fifty dollars ($750) for filing the documents initiating approval proceedings under this article. If the plan be approved and consummated the retiring insurer shall apply for withdrawal under Article 15 of this chapter and such fee shall also cover the services and expenses of the commissioner in connection with the withdrawal.

1100. In this state, all investments and deposits of the assets of an insurer, all purchases on behalf of an insurer, and all sales made of the property and effects of an insurer shall be made in its own name, or in that of a corporation authorized to act as a trustee under the laws of this state, or in the name of a nominee of such a corporation in accordance with any law of this state permitting such a trustee to make use of nominees, or in the name of a qualified custodian, qualified subcustodian, or qualified depository (as defined in Section 1104.9) or in the name of a nominee of a qualified custodian, qualified subcustodian, or qualified depository, provided that the nominee is not a corporation and, as to any nominee which is a partnership, the partnership shall consist solely of the employees, officers, or directors of the qualified custodian, qualified subcustodian, or qualified depository or a corporation which is a member of the same holding company system as the nominee, or any combination thereof, or in the name of a nominee approved by the commissioner.

1100.1. Every admitted incorporated insurer may under a certificate of authority issued pursuant to the provisions of Article 3 (commencing with Section 699), engage in this state in the type of loan transactions otherwise permitted by law without obtaining any other license or certificate.

Pursuant to the authority contained in Section 1 of Article XV of the State Constitution, the restrictions upon rates of interest contained in Section 1 of Article XV of the California Constitution shall not apply to any obligation of, loans made by, or forbearances of, any incorporated admitted insurer.

This section creates and authorizes incorporated admitted insurers as an exempt class of persons pursuant to Section 1 of Article XV of the Constitution.

1101. (a) An admitted insurer's officers, directors, trustees and any persons who have authority in the management of the insurer's funds, shall not, unless otherwise provided in this code:

(1) Receive any money or valuable thing for negotiating, procuring, recommending or aiding in, any purchase by or sale to such

insurer of any property, or any loan from such insurer.

(2) Be pecuniarily interested as principal, coprincipal, agent, attorney or beneficiary, in any such purchase, sale or loan.

(3) Directly or indirectly purchase, or be interested in the purchase of, any of the assets of the insurer.

(b) This section shall not apply to:

(1) The purchase or exchange of stock of an admitted insurer by an admitted insurer or between admitted insurers nor to any merger, consolidation or corporate reorganization of such insurers, and shall not apply as to such purchase, merger, exchange, consolidation or reorganization, nor to the officers, directors, trustees or any persons having authority in the management of such insurers funds in respect to any such transaction and no such transaction shall be either void or voidable, if:

(i) The transaction is just and reasonable as to the insurers involved at the time it is authorized or approved and if no such officer, director, trustee or other person having authority in the management of such insurers funds receives any money or other valuable thing, other than his usual compensation for his regular duties, for negotiating, procuring, recommending or aiding in such transaction, and, either

(ii) Any interest in such transaction on the part of any officers, directors, trustees, or persons who have authority in the management of any such insurer's funds is disclosed or known to its board of directors or committee, authorizing, approving or ratifying the transaction, and noted in the minutes thereof, and the board or committee authorizes, approves or ratifies the transaction in good faith by a vote sufficient for the purpose without counting the vote or votes of any interested officers, directors, trustees, or persons who have authority in the management of the funds of any such insurer, or

(iii) The fact of such interest is disclosed or known to the shareholders in the case of a stock insurance company, or in the case of a mutual insurer to the policyholders, and they approve or ratify the transaction in good faith by a vote or written consent of a majority of the shares or policyholders, as the case may be, entitled to vote, unless the consent or vote of more than a majority is otherwise required, in which event the vote or written consent shall be that so otherwise required.

Any such officer, director, trustee, or other person who has such interest may be counted in determining the presence of a quorum at any meeting which authorizes, approves or ratifies such transaction.

(2) Any transaction relating to an insurer if the transaction

meets the other requirements of subdivision (b) and such officers, directors, and trustees of the insurer do not in the aggregate own more than 5 percent of the stock of any corporation with which the insurer is entering into a transaction.

(3) Any transaction if prior to its consummation the insurer has applied for and obtained from the commissioner a certificate of exemption in respect to the specific transaction therein described and such transaction is consummated in conformity with such certificate and the representations and disclosures made in or in connection with the application therefor.

(i) To obtain the certificate of exemption the insurer shall file with the commissioner a written application, accompanied by a filing fee of two hundred ninety-five dollars ($295). Such application shall be verified as provided in Section 834, be in such form as the commissioner shall require and shall contain all of the following:

(A) A specific description of the particular transaction for which the certificate is sought.

(B) Copies of all contracts and other legal documents involved or to be involved in the transaction.

(C) A description of all assets involved in the transaction.

(D) The names, titles, capacities and business relationships of all persons in any way involved in the transaction who are connected with the insurer or any of its affiliates, officers, directors, managers, or controlling persons or entities in any of the capacities described in this section.

(E) A description of any and all considerations on either or any side of the transaction.

(F) Evidence that its governing board has specifically authorized the filing of the application.

(G) Such other information, opinions, or matters as the commissioner may require.

The commissioner may issue such certificate of exemption if he finds, with or without a hearing, that the transaction is fair, just and equitable and not hazardous to policyholders, stockholders or creditors. The commissioner may impose such conditions, including but not limited to disclosure of the circumstances and terms of the transaction either before or after its consummation either publicly or to such persons and entities as he may designate and the approval of the transaction by such persons or entities as he may designate. He may also require that a report of the transaction be filed with him subsequent to its consummation in such form and containing such information as he may prescribe.

The certificate of exemption issued pursuant to paragraph (3) of subdivision (b) shall only exempt the transaction from the

prohibitions of this section and shall not affect the rights or remedies of any persons under any other law.

The amendment made to this section at the 1955 General Session shall not apply to contracts, sales, transfers or other transactions entered into prior to the effective date hereof.

The commissioner shall not issue a certificate of exemption under paragraph (3) of subdivision (b) in respect to any transaction consummated prior to the effective date of the amendment made to this section at the 1967 Regular Session.

(c) Whenever it appears to the commissioner that any insurer, or any director, officer, employee, or agent thereof, has committed or is about to commit a violation of this section, the commissioner may apply to the superior court for the county in which the principal office of the insurer is located, or if such insurer has no such office in this state, then to the Superior Court for the County of Los Angeles, or for the City and County of San Francisco, for an order enjoining such insurer, or such director, officer, employee, or agent thereof, from violating or continuing to violate this section, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

1101.1. An officer, excluding a director who holds no other office, or employee of an admitted insurer shall not receive any money or valuable thing directly or indirectly as a brokerage commission on reinsurance ceded by such insurer and an insurer shall not pay such commissions. This provision shall not apply to brokerage or commissions authorized by the board of directors of the ceding insurer as compensation for services actually rendered nor to dividends received by any such officer or employee upon the stock of a corporation in which such officer or employee or his immediate family does not own a controlling interest or in fact exercises control.

1102. The financial obligation of any officer, director, trustee, or other person having authority in the management of an insurer's funds shall not be guaranteed by such insurer in any capacity, and any such guarantee shall be void.

1103. Whenever an insurer is injured or made to suffer loss by reason of any violation of the provisions of sections 1101, 1102 or 1104, such insurer may recover from the guilty officer, director, trustee or other person, or any one or more of them jointly or severally damages sufficient to compensate such insurer for such loss.

1104. An admitted insurer shall not make any loan, other than a policy loan, to any officer, director, trustee or other person having authority in the management of its funds, nor shall such officer, director, trustee or other person accept any such loan.

This section does not prohibit a loan to, or for the benefit of, an employee for the purpose of paying the premiums on a life insurance policy on the life of such employee.

1104.1. The commissioner may from time to time require any domestic admitted insurer to report to him, in such detail as he may prescribe, the moneys and securities owned by it, the place where such moneys and securities are deposited and, in the case of moneys and securities deposited outside the State, the reason for maintaining each such deposit outside the State.

Whenever the commissioner after hearing following notice, finds that such moneys or securities are maintained on deposit outside the State in excess of legal requirements and of the reasonable needs of the business of such insurer, he may order such insurer to transfer to, and maintain in, this State money and securities to the extent of such excess and to cease, pending such transfer, from unnecessary transfers of moneys and securities from this State to any place outside this State.

1104.2. Every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of stock of a domestic insurer or who is a director or officer of such insurer shall file in the office of the Insurance Commissioner on or before the 31st day of October, 1965, or within 10 days after he becomes such a beneficial owner, director or officer, a statement, in such form as the commissioner may prescribe, of the amount of all stock of such insurer of which he is the beneficial owner, and within 10 days after the close of each calendar month thereafter, if there has been a

change in such ownership during such month, shall file in the office of the commissioner a statement, in such form as the commissioner shall prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

1104.3. For the purpose of preventing the unfair use of information which may have been obtained by any beneficial owner of an insurer, or director or officer thereof, described in Section 1104.2, by reason of his relationship to such insurer, any profit realized by him from any purchase and sale, or any sale and purchase, of any stock of such insurer within any period of less than six months, unless such stock was acquired in good faith in connection with a debt previously contracted, shall inure to, and be recoverable by, the insurer, irrespective of the intent of the beneficial owner, director or officer who entered into the transaction of holding the stock purchased or not repurchasing the stock sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer or by the owner of any stock of the insurer in the name of and on behalf of the insurer if the insurer shall fail or refuse to bring such suit within 60 days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. This section shall not be construed to cover any transaction where a beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the stock involved, or any transaction or transactions which the commissioner may by rules and regulations exempt as not within the scope of this section or Section 1104.2.

1104.4. It shall be unlawful for any beneficial owner of an insurer, or director or officer thereof, described in Section 1104.2, to, directly or indirectly, sell any stock of such insurer if he or his principal does not own the stock sold, or, if he or his principal owns the stock, he does not deliver it against such sale within 20 days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make

such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

1104.5. The provisions of Section 1104.3 shall not apply to any purchase and sale, or sale and purchase, and the provisions of Section 1104.4 shall not apply to any sale of stock of a domestic insurer (not then or theretofore held in an investment account), by a dealer in the ordinary course of his business and incidental to the establishment or maintenance by him of a primary or secondary market (other than on an exchange as defined in the Securities Exchange Act of 1934) for such stock. The commissioner may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to stock held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

1104.6. The provisions of Sections 1104.2, 1104.3, and 1104.4 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner may adopt in order to carry out the purposes of this article.

1104.7. The term "stock" as it is used in Sections 1104.2, 1104.3, 1104.4, 1104.5 and 1104.8 means any stock or similar security, or any security, convertible, with or without consideration, into such stock or carrying any warrant or right to subscribe to or purchase such stock, or any such warrant or right, or any other security which the commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as stock.

1104.8. The provisions of Sections 1104.2, 1104.3, and 1104.4 shall not apply to a domestic insurer if:

(a) Its stock shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended; or if

(b) Such domestic insurer shall not have any class of its stock

held of record by 100 or more persons on the last business day of the year next preceding the year in which stock of the insurer would be subject to the provisions of Sections 1104.2, 1104.3, and 1104.4 except for the provisions of this subdivision.

1104.9. (a) (1) As used in this section, "qualified custodian" means: (A) commercial banks (as defined in Section 105 of the Financial Code), savings and loan associations (as defined in Section 5102 of the Financial Code), and trust companies (other than trust departments of title insurance companies), or any entity approved by the commissioner as a qualified custodian; (B) that is domiciled and has a principal place of business in this state; and (C) that either has a net worth of at least one hundred million dollars ($100,000,000) or is able to demonstrate to the satisfaction of the commissioner that it is financially secure. The commissioner may consider, among other factors, evidence of the following in order to determine whether a custodian is financially secure for the purpose of this subdivision: (i) its obligations under an agreement approved by the commissioner pursuant to subdivision (c) are guaranteed by its parent holding company, (ii) its parent holding company has a net worth of at least one hundred million dollars ($100,000,000), or (iii) it is a member of a holding company system with a net worth of at least one hundred million dollars ($100,000,000).

(2) As used in this section, "qualified depository" means an entity that is located in this state or a reciprocal state and is (A) a depository that provides for the long-term immobilization of securities or a clearing corporation that is also a depository, and that in either case has been approved by or registered with the Securities and Exchange Commission, (B) a Federal Reserve bank, or (C) an entity approved by the commissioner as a qualified depository.

A "qualified depository" may also include an entity that is located outside the United States, if it is a securities depository and clearing agency, incorporated or organized under the laws of a country other than the United States, (i) that operates a transnational system for securities or equivalent book entries (specifically Euroclear and Cedel, or successors to all or substantially all of their operations), or (ii) that operates a central system for securities or equivalent book entries, but solely for securities issued by, or by entities within, the country in which the securities depository and clearing agency is incorporated or organized. The depository shall meet all qualifying requirements

imposed by this section upon Euroclear or Cedel.

(3) As used in this section, "qualified subcustodian" means an entity located in this state or a reciprocal state (A) that holds securities of the domestic insurer, and maintains an account through which the securities are held, in this state or a reciprocal state and (B) that has shareholder equity of at least one hundred million dollars ($100,000,000) or is able to demonstrate to the satisfaction of the commissioner that it is financially secure. The qualified subcustodian shall be: (A) a commercial bank, a savings and loan association, or a trust company (other than trust departments of title insurance companies); (B) a subsidiary of a qualified custodian; or (C) any entity approved by the commissioner as a qualified subcustodian. The commissioner may consider, among other factors, evidence of the following in order to determine whether a subcustodian is financially secure for the purpose of this subdivision: (i) its obligations are guaranteed by its parent company, (ii) its parent holding company has shareholder equity of at least one hundred million dollars ($100,000,000), or (iii) it is a member of a holding company system with shareholder equity of at least one hundred million dollars ($100,000,000). A "qualified subcustodian" may also include an entity that is located outside the United States, that is used by the domestic insurer for the purpose of obtaining access to a qualified depository located outside the United States. The qualified foreign subcustodian shall be a banking institution or trust company, incorporated or organized under the laws of a country other than the United States, that is regulated by that country's government or an agency thereof, and that has shareholders' equity in excess of two hundred million dollars ($200,000,000), whether in United States dollars or the equivalent of United States dollars, as of the close of its most recently completed fiscal year; or a majority-owned direct or indirect subsidiary of a qualified United States bank or bank holding company, if the subsidiary is incorporated or organized under the laws of a country other than the United States and has shareholders' equity in excess of one hundred million dollars ($100,000,000), whether in United States dollars or the equivalent of United States dollars, as of the close of its most recently completed fiscal year; or is able to demonstrate to the satisfaction of the commissioner that it is financially secure. The commissioner may consider, among other factors, evidence of the following in order to determine whether a qualified foreign subcustodian is financially secure for purposes of this subdivision: (i) its obligations are guaranteed by its parent company, (ii) its parent holding company has shareholder equity of at least two hundred million dollars ($200,000,000), or (iii) it is a

member of a holding company system with shareholder equity of at least two hundred million dollars ($200,000,000).

(4) As used in this section, "subsidiary" means: (A) an entity all of whose voting securities (other than director qualifying shares, if any) are owned, directly or indirectly, by a qualified custodian; or (B) any affiliated entity approved by the commissioner as a subsidiary of a qualified custodian. For the purpose of this section, an affiliated entity means an entity that (A) controls or is controlled, either directly or indirectly or through one or more intermediaries by a qualified custodian or (B) is under the common control, directly or indirectly, as or with a qualified custodian.

(5) As used in this section, "entity approved by the commissioner as a qualified custodian," "entity approved by the commissioner as a qualified depository," "entity approved by the commissioner as a qualified subcustodian," and "entity approved by the commissioner as a subsidiary of a qualified custodian" mean those entities that meet the conditions or standards established by the commissioner. The commissioner shall charge and collect in advance a one-time fee of one thousand five hundred dollars ($1,500) to review an application for approval of any entity pursuant to this section.

(6) As used in this section, "reciprocal state" has the same meaning as in subdivision (f) of Section 1064.1.

(7) As used in this section, "moneys" means cash held incidental to securities transactions occurring in the ordinary course of business with respect to securities held pursuant to the custodial agreements under this section.

(8) (A) Except as provided in subparagraph (B), as used in this section, "insurer," "domestic insurer," and "domestic admitted insurer" mean any insurer, other than a domestic life insurer that is incorporated or which has its principal place of business in this state. Except as provided in subparagraph (B), no portion of this section applies to domestic life insurers nor shall this section affect the interpretation of any other portion of this code with respect to domestic life insurers nor is it intended to create a precedent for the application of its provisions to those insurers. However, the exclusion of domestic life insurers from this section shall not be construed to diminish the commissioner's existing authority over those insurers under any other provision of this code.

(B) Domestic life insurers that are wholly owned by any insurer other than a domestic life insurer or are part of an insurance holding company system whose other insurer affiliates are not domestic life insurers may elect to be subject to this section by affirmatively stating that election in the statement otherwise

required to be filed by that system pursuant to Section 1215.4.

(b) Notwithstanding Section 1104.1, a domestic admitted insurer may maintain its securities and moneys in a reciprocal state, subject to the requirements of this section, through a custodian account located in California in or with a qualified custodian, and that qualified custodian may maintain those securities or moneys in a qualified depository or qualified subcustodian, either or both of which may be located in a reciprocal state. In addition, a domestic insurer that has foreign investments or any other investments that require delivery outside of the United States upon sale or maturity that qualify under Section 1240, 1241, or 10506, or any other provision of this code may maintain those securities or moneys in or with a qualified depository located in a jurisdiction outside the United States. However, the aggregate amount of general account investments so deposited shall not exceed the lesser of 5 percent of the total admitted assets of the insurer or 25 percent of the excess of admitted assets over the sum of paid up capital, liabilities, and surplus required by Section 700.02. However, unless exempted by the commissioner, not more that 50 percent of that amount of assets that an insurer is authorized to invest pursuant to Section 1241 or 1241.1 may be maintained in any single country in a qualified depository as defined in clause (ii) of paragraph (2) of subdivision (a) and as to life companies not more than 12.5 percent of that amount of assets that an insurer is authorized to invest pursuant to Section 1241 or 1241.1 may be maintained in any single country in a qualified depository as defined in clause (ii) of paragraph (2) of subdivision (a). The percentage or dollar value of admitted assets and paid up capital and liabilities shall be determined by the insurer's last preceding annual statement of conditions and affairs made as of the preceding December 31 that has been filed with the commissioner pursuant to law. No broker or agent, as defined in the Federal Securities Exchange Act of 1934 (15 U.S.C.A. Sec. 78c et seq.), may serve as a qualified custodian, qualified subcustodian, or qualified depository under this section. However, no otherwise qualified custodian or subcustodian shall be disqualified on account of its activities as a broker or dealer, as so defined, when the activities are incidental to its custodial or other business.

(c) No securities shall be deposited in or with a qualified custodian, qualified depository, or qualified subcustodian except as authorized by an agreement between the insurer and the qualified custodian, if the agreement is satisfactory to and has been approved by the commissioner. The agreement shall require that the securities be held by the qualified custodian for the benefit of the insurer and that the books and records of the qualified custodian shall so

designate. The agreement shall further require that beneficial title to the securities remain in the insurer and shall require that the qualified subcustodian and qualified depository be the agents of the qualified custodian. The agreement shall also specifically require that the qualified custodian shall exercise the standard of care of a professional custodian engaged in the banking or trust company industry and having professional expertise in financial and securities processing transactions and custody would observe in these affairs. This section does not affect the burden of proof under applicable law with respect to the assertion of liability in any claim, action, or dispute alleging any breach of, or failure to observe, that standard of care.

(d) No agreement between the qualified custodian and the insurer shall be approved by the commissioner unless the qualified custodian agrees therein to comply with this section. Except when the agreement is submitted in conjunction with an application for an original certificate of authority or variable contract qualification, a fee of five hundred dollars ($500) shall be paid to the commissioner at the time of filing the agreement for approval. However, no fee shall be required if the form of the agreement has been previously submitted for approval and approved by the commissioner as certified by the insurer and qualified custodian submitting the agreement to the commissioner. The agreement shall be deemed approved unless, within 60 days after receipt by the commissioner of that agreement and any required filing fee, the commissioner has disapproved the agreement in writing citing specific reasons for disapproval.

(e) Notwithstanding the maintenance of securities with an out-of-state qualified depository or qualified subcustodian pursuant to agreement, if the commissioner has reasonable cause to believe that the domestic insurer (1) is conducting its business and affairs in such a manner as to threaten to render it insolvent, or (2) is in a hazardous condition or is conducting its business and affairs in a manner that is hazardous to its policyholders, creditors, or the public, or (3) has committed or is committing or has engaged or is engaging in any act that would constitute grounds for rendering it subject to conservation or liquidation proceedings, or if the commissioner determines that irreparable loss and injury to the property and business of the domestic insurer has occurred or may occur unless the commissioner acts immediately, then the commissioner may, without hearing, order the insurer and the qualified custodian promptly to effect the transfer of the securities back to a qualified custodian, qualified subcustodian, or qualified depository located in this state from any qualified depository or qualified subcustodian

located outside of this state (the transfer order). Upon receipt of the transfer order, the qualified custodian shall promptly effect the return of the securities. Notwithstanding the pendency of any hearing or action provided for in subdivision (f), the transfer order shall be complied with by those persons subject to that order. Any challenge to the validity of the transfer order shall be made in accordance with subdivision (f). It is the responsibility of both the insurer and the qualified custodian to oversee that compliance with the transfer order is completed as expeditiously as possible. Upon receipt of a transfer order, there shall be no trading of the securities without specific instructions from the commissioner until the securities are received in this state, except to the extent trading transactions are in process on the day the transfer order is received by the insurer and the failure to complete the trade may result in loss to the insurer's account. Issuance of a transfer order does not affect the qualified custodian's liabilities with regard to the securities that are the subject of the order.

(f) At the same time the transfer order is served, the commissioner shall issue and also serve upon the insurer a notice of hearing to be held at a time and place fixed therein which shall not be less than 20 nor more than 45 days after the service thereof. Upon request of the insurer and agreement of the department, the hearing may be held within a shorter time but in no event less than 10 days after the service of the notice of hearing. The transfer order and notice of hearing may be served by certified mail, express mail, messenger, telegram, or any other means calculated to give prompt actual notice to (1) the California office of the insurer designated in the agreement, its home office as shown on its most recently filed annual or quarterly statement, or its California agent for service of process; and (2) the California office of the qualified custodian designated in the agreement. If, as a result of the hearing, any of the statements as to conduct, conditions, or grounds for the transfer order are found to be true, or if other conditions or grounds are discovered or become known at the hearing and are found to be true, the commissioner shall affirm the transfer order and may make additional order or orders, pertaining to the transfer order, as may be reasonably necessary.

The insurer subject to the transfer order is entitled to judicial review in the state of the commissioner's order issued as a result of the hearing.

Alternatively, at any time prior to the commencement of the hearing on the transfer order, the insurer may waive the hearing and have judicial review in this state of the transfer order by petition for writ of mandate and declaratory relief without first exhausting

administrative remedies or procedures. In that event the insurer is not entitled to any extraordinary remedies prior to trial.

No person other than the insurer has standing at the hearing by the commissioner or for any judicial review of the transfer order.

1105. This article shall not prevent:

(a) The purchase by any person of any asset which the commissioner requires to be sold, at a price approved by the commissioner.

(b) The borrowing in accordance with its terms by any person upon a policy of life insurance upon his own life.

(c) The payment of a fee to any attorney for legal services rendered to any such insurer.

(d) The receipt of advances under agency contracts by agents of life insurers.

(e) Any admitted insurer's officers, directors, trustees or other persons who have authority in the management of the funds of such insurer from entering into any transaction with such insurer if:

(1) Such transaction is pursuant to a permit issued by the Insurance Commissioner under authority granted to him by other provisions of this code or is such as requires his approval prior to its consummation under other provisions of this code;

(2) The application for any such permit or the request for any such approval sets forth under oath the complete details concerning all such transactions with any such officers, directors, trustees or other persons; and

(3) Where the commissioner in his permit or approval specifically finds that the consummation of such transaction will not be unfair, unjust or inequitable to such insurer or to any of its stockholders or policyholders.

(f) Any transaction between an insurer and a person having authority in the management of the insurer's funds (except officers, directors, and trustees), if such insurer is subject to registration and reporting under the Insurance Holding Company System Regulatory Act (Article 4.7 (commencing with Section 1215) of Chapter 2 of this part), or subject to substantially similar registration and reporting requirements under the laws of its domicile.

(g) An admitted insurer making a loan for the purchase of a principal residence by, and acquiring, at a price not to exceed the fair market value thereof, the principal residence from, an officer or person having authority in management of the insurer's funds, nor shall such officer or person be prohibited from accepting such loan

or acquisition, in connection with the relocation of the place of employment at the request of the insurer, either during the course of employment or upon initial employment of such officer or person having authority in management of the insurer's funds.

Any loan permitted under this subdivision shall be secured by a first trust deed or first mortgage, shall not exceed 90 percent of the fair market value of the property, shall carry an interest rate no more favorable than that rate given to other employees of such insurer not subject to the limitations of this article and shall be subject to the approval of the insurer's board of directors or delegated committee thereof.

This subdivision shall not apply to directors and trustees of insurers.

1106. Any person violating, or wilfully aiding another in the violation of, Sections 1101, 1101.1, 1102, 1103, 1104 or the commissioner's order issued pursuant to Section 1104.1 is guilty of a misdemeanor. The commissioner shall, after a hearing upon due notice, revoke, or deny the renewal of, the certificate of authority of a domestic admitted insurer persisting for more than 60 days from and after the commissioner's order issued pursuant to Section 1104.1 in failure to comply with such order. The proceedings shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code and the commissioner shall have the powers granted therein.

1107. In accordance with either subdivision (e) of Section 1001 or Section 1101.1 of the Corporations Code, an insurer may apply for the insurance commissioner's approval of the terms and conditions of the covered transactions and the fairness of such terms and conditions to deliver consideration other than securities which shall be in such form, contain such information and be accompanied by such documents as the commissioner deems appropriate or requires.

1107.1. The commissioner shall require the payment of two hundred fifty dollars ($250) in lawful money of the United States as fee for the determination referred to in Section 1107.

INSURANCE CODE
SECTION 1110-1113

1110. This article does not apply to combination automobile insurance policies in which one insurer issues a policy covering certain classes of insurance on a risk, and another insurer covers certain other classes of insurance on the same risk. This article applies to:

(a) The issuance of a policy in which more than one insurer indemnifies the insured severally, jointly, or jointly and severally with other insurers for all or a specified portion of a risk.

(b) The issuance of a policy which is subject to an automatic reinsurance agreement under which several insurers participate with the insurer or insurers issuing the policy to the same extent as though they were primary insurers, and the contract is negotiated upon the basis of such reinsurance and the policy makes reference to the fact of such reinsurance.

(c) Policies issued pursuant to a plan providing for the allocation among various insurers of risks who have been unable to procure such insurance without resort to the plan.

1111. Insurers desiring to issue policies to which this article is applicable, and to pay commissions to persons who are licensed as insurance agents, but not as agents for all insurers participating in the risk, and who are not licensed as insurance brokers, may file with the commissioner in such form as he may require, a statement of the plan under which they intend to operate, and a list of the insurers that will operate under the plan. If the commissioner finds that the nature of the plan is not such that the interests of the insuring public will be jeopardized by permitting an agent of one or more of the insurers to act in a transaction with or for all the insurers, or for the particular insurer paying the commission without being licensed as agent for such insurer or as an insurance broker, he may issue a permit authorizing the operation of the plan by or on behalf of the insurers listed in the application, and the payment of commissions pursuant to the plan as approved by the commissioner shall be lawful.

1112. Within 10 days after the withdrawal of an insurer from the plan or from the time additional insurers participate in the plan, notice of the change shall be given the commissioner in writing, and unless such notice is so given, the permit theretofore issued by the commissioner shall expire on the tenth day after such change. Unless the permit expires as provided in the preceding sentence, it shall remain in force continuously unless the commissioner after hearing finds that the insurers have deviated materially from the plan, and that it is against public interest to continue its operation.

1113. For filing application for a permit issued pursuant to this article, the commissioner shall charge and collect the sum of forty-four dollars ($44).

INSURANCE CODE
SECTION 1140-1142

1140. Except as otherwise provided in this code, incorporated insurers are subject to the provisions of the general corporation law in like manner with other corporations.

1140.5. (a) Notwithstanding any other provision of law, a copy of every form of proxy or written consent or authorization for use at any meeting or proceeding of shareholders or stockholders of any domestic insurer to evidence authority to cast the vote of any shareholder or stockholder, or to record the consent or the authorization of any shareholder or stockholder to any action of the insurer, and a copy of every solicitation, announcement, or advertisement used to obtain, or to influence any shareholder or stockholder to sign, any proxy, or written consent or authorization shall be filed with the commissioner, accompanied by a filing fee of fifty-eight dollars ($58), by the person intending to use, issue, publish, or circulate such document. No such document shall be used, issued, published, or circulated before a period of 10 days following the date of its filing, or any shorter period as may be designated by the commissioner, has elapsed. Within such 10-day or shorter period the commissioner may disapprove of any document filed

with him pursuant to this section, stating his reasons therefor in writing, in which case such document shall not be used, issued, published, or circulated.

(b) Any person who fails to make the filing required by this section and who thereafter uses any document required to be filed, or who uses any such document before it has been filed with the commissioner for the period required, or who uses any such document after receiving written notice that the document has been disapproved by the commissioner is guilty of a misdemeanor. It shall be unlawful to use any proxy or consent obtained in violation of this section; and the superior court of the State of California in and for the county in which is located the principal place of business of such insurer shall have jurisdiction to enforce the provisions of this section and the regulations promulgated pursuant thereto, and to grant appropriate relief upon the verified petition of the commissioner, such domestic insurer or and any of its shareholders or stockholders.

(c) The purposes of this section are: to ensure that the shareholders, stockholders or other persons entitled to vote or give written consents or authorizations are provided with adequate and accurate information regarding the affairs of the insurers in which they have interests, the interests of those soliciting proxies or written consents or authorizations and of those upon whose behalf such solicitations are made, and the matters as to which proxies or written consents or authorizations are solicited; and to prevent fraud or deception in connection with proxies, proxy statements or other proxy solicitations. In furtherance of the purposes of this section the commissioner may make rules and regulations therefor. Such rules and regulations may differ as to different classes and types of insurers.

(d) The provisions of this section shall not apply to any domestic insurer having less than 100 shareholders or stockholders and shall not apply to any domestic insurer if 95 percent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares of stock are owned by less than 500 shareholders or stockholders. Any domestic insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934 and the amendments thereto and the applicable regulations thereunder, is exempt from the provisions of this section.

1141. No director, trustee, officer or agent of any insurer shall

be subject to personal liability by reason of any payment or any determination not to contest or seek recovery of any payment made subsequent to June 4, 1944, or hereafter made, by or on behalf of such insurer on account of any tax, license, fee, deposit or other charge paid pursuant to the terms of any statute, law or ordinance of this or any other State, county, city or taxing authority, unless prior to such payment or determination such statute, law or ordinance shall have been judicially rendered invalid by action of the State court having final appellate jurisdiction in the premises or by action of the Supreme Court of the United States. This section is applicable not only to directors, trustees, officers and agents of insurers generally but also to reciprocal or interinsurance exchanges, members of their subscribers' boards, their attorneys in fact and any director, trustee, officer and agent thereof.

1142. In situations of hardship, financial embarrassment or where other good cause is shown the commissioner may, in his discretion, by written order, permit an insurer to acquire by gift, devise, bequest or other transfer an asset, or a part thereof, not otherwise permissible, or retain an asset, however obtained. Such order, or any amendments thereto, shall specify the asset and the mode of acquisition or retention which is to be permitted and shall specify such reasonable time as the commissioner may determine in his discretion for the retention, or further retention of such asset. At the end of such time or earlier if he determines circumstances warrant such action the commissioner may invoke the procedure of Section 1202 for the purpose of requiring the insurer to dispose of the asset, or a part thereof, so acquired or held.

This section shall not apply to any asset of an insurer which:

(1) Has been held for 25 years or more, and

(2) Consists entirely of corporate securities, and

(3) The value does not exceed more than one-tenth of 1 percent of the total assets of the insurer.

The insurer may retain such an asset.

1152. (a) Domestic incorporated stock insurers, except those governed by Sections 10530, 12373, and 12640.06, shall be governed by the provisions of this section and, if the insurer is subject to registration pursuant to Sections 1215.4 and 1215.5, as to payment or distribution of dividends to stockholders. Such insurers may make dividends only from earned surplus.

(b) No dividends shall be declared out of earned surplus derived from the mere net appreciation in the value of assets not yet realized, nor shall any dividends be declared from any part of such earned surplus derived from an exchange of assets, unless and until such earned surplus have been realized or unless the assets received are currently realizable in cash.

(c) An insurer may declare and distribute a dividend otherwise prohibited by this section if (1) following payment of the dividend the insurer's surplus as regards policyholders is (A) reasonable in relation to its outstanding liabilities and (B) adequate to its financial needs as prescribed in Section 1215.5, and (2) the commissioner has given approval for the dividend prior to payment.

(d) For purposes of this section, "earned surplus" means unassigned funds, as required to be reported on the insurer's annual statement.

1153. An insurer shall not be admitted within three years from and after the time when it commences business as an insurer, nor within three years from and after the time when it is first incorporated, unless assets equal to the sum of its liabilities and the minimum capital and surplus required for admission are maintained in cash or one or more of the following:

(a) Securities specified in Sections 1170 to 1175, inclusive.

(b) Premiums that are in the course of collection, or agents' balances representing premiums, on policies effected not more than 90 days prior to the date on which these premiums or balances are valued for the purpose of this section, and earned service fees receivable, not over 90 days due, and evidences of debt representing those assets.

(c) In the case of a life insurer, the amount of current deferred premiums receivable, after deducting therefrom the amount of the loading.

(d) Interest accrued and dividends declared, receivable on any of the assets specified in subdivisions (a) to (c), inclusive, no part of which interest or dividends has been due in excess of one year.

(e) Amount of reinsurance recoverable from admitted insurers.

(f) With the prior approval of the commissioner, any investments

authorized by this code if the following conditions are met:

(1) The insurer has previously been authorized to write life or health insurance, or is seeking authority to write life or health insurance.

(2) The solvency of the insurer is guaranteed by another insurer (the "guaranteeing insurer") that meets the following criteria:

(A) The guaranteeing insurer has an ownership interest of at least 50 percent in the insurer.

(B) The guaranteeing insurer, which may be a reciprocal or interinsurance exchange, has been admitted to do business in this state for not less than 10 years.

(C) The guaranteeing insurer has maintained a surplus of admitted assets over all liabilities of at least five hundred million dollars ($500,000,000) for not less than three years.

(3) The commissioner, in his or her discretion, determines that the proposed investment is sound in relation to the insurer's business plan and operations.

1153.5. An admitted insurer which has been in business as an insurer less than three years from and after the time when it commenced business as an insurer shall maintain its assets during the balance of such three-year period in the types of assets specified in Section 1153, excepting such of its assets as are in excess of the sum of its liabilities and the surplus and capital requirements for admission. On its failure so to do, the commissioner may revoke its certificate of authority. The proceedings shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

1154. After the period specified in Sections 1153 and 1153.5, the requirements of those sections shall no longer be applicable to any insurer specified therein and shall no longer affect or modify the application or nonapplication of any section of this code.

The provisions of Sections 1153 and 1153.5 shall not govern or limit the investments of any insurer formed by merger, consolidation, or reinsurance of the entire business of any one or more admitted insurers if any one or more of the merged, consolidated, reinsuring or reinsured insurers was, prior to such consolidation, merger, or reinsurance, admitted, or authorized to do business as an insurer in any state, for a period of three or more years.

1155. An insurer, within such limits as may be set by the board of directors, may contribute to community funds or to charitable, philanthropic, or benevolent instrumentalities conducive to public welfare or civic betterment.

INSURANCE CODE
SECTION 1170-1182

1170. Domestic incorporated insurers may invest their assets in the purchase of any of the securities specified in this article, or in loans upon such securities, if such purchase or loan conforms to all the following conditions:

(a) Such securities are not in default as to principal or interest at the date of investment.

(b) In the case of a purchase, the purchase price does not exceed the market value of the securities at the date of investment.

(c) In the case of a loan not governed by the provisions of section 1176, the amount loaned does not exceed eighty-five per cent of such market value at the date of investment.

1171. Such insurers may invest in obligations of the United States or obligations for which the faith and credit of the United States are pledged for payment of principal and interest.

1171.5. Such insurers may invest in obligations of the United States Postal Service.

1172. Such insurers may invest in obligations of the Dominion of Canada, or the Commonwealth of Puerto Rico, or of any province of the Dominion of Canada, or of any political subdivision of the Commonwealth of Puerto Rico, or obligations for which are pledged the

faith and credit either of the dominion, or the commonwealth, or of any province of the dominion, or of any political subdivision of the commonwealth, for the payment of principal and interest, if within 10 years immediately preceding the investment such province or such political subdivision was not in default for more than 90 days in the payment of principal or interest upon any legally authorized obligation issued by it.

1173. Such insurers may invest in obligations issued under authority of law by any county, municipality, or school district in this State or in any other state, or in any province of the Dominion of Canada or in any political subdivision of the Commonwealth of Puerto Rico, if the obligor has not within two years next preceding the investment defaulted for more than 90 days in the payment of any part of either principal or interest upon any legally authorized obligation issued by it, and the obligations of the state or province or political subdivision in which it is located are legal for investment under the provisions of Sections 1172 or 1174.

1174. Such insurers may invest in obligations of this State or those for which the faith and credit of this State are pledged for the payment of principal and interest, and in obligations of any other State in the United States, if within ten years immediately preceding the investment such State was not in default for more than ninety days in the payment of any part of principal or interest of any debt duly authorized by the Legislature of such State to be contracted by such State since the first day of January, 1878.

1175. Such insurers may invest in bonds of any permanent road division in this state, or any district organized under the laws of this state, when such bonds are legal investments for savings banks of this state, or have been certified as legal investments for savings banks pursuant to Division 10 (commencing with Section 20000) of the Water Code, or when the statutes or laws providing for the issuance of such bonds provide that such bonds shall be entitled to the same force or value or use as bonds issued by any municipality, or such law specifically states that such bonds shall be legal

investments for either savings banks, insurance companies, all trust funds, state school funds or any funds which may be invested in bonds of cities, counties, cities and counties, school districts, or municipalities in the state, or when such bonds have been investigated and approved by a commission or board now or hereafter authorized by law to conduct such investigation and give such approval when such law specifies that upon that approval the bonds are legal investments for insurers, or which the commissioner approves in writing as legal for investment of the funds of insurers.

The commissioner in determining whether to approve any bonds as legal investments which do not otherwise qualify as such pursuant to any part of this code, shall, at the expense of any insurer requesting approval, make an adequate independent investigation of such bonds and the security therefor. A copy of the data secured in such investigation and the resulting opinion of the commissioner shall be furnished to the insurer.

1175.5. Such insurers may invest in bonds of any county water district operating under Division 12 of the Water Code.

1176.5. Such insurers may make, invest in or purchase loans which are guaranteed by the United States or any agency thereof pursuant to the provisions of the "Servicemen's Readjustment Act of 1944" or any act of Congress supplementary or amendatory thereof.

1176.6. None of the provisions of the Insurance Code limiting or restricting loans by insurers or prescribing the security therefor shall apply to any loans which are fully guaranteed by the United States or any agency thereof pursuant to the provisions of the "Servicemen's Readjustment Act of 1944" or any act of Congress supplementary or amendatory thereof; and in any case in which payment of a portion of any loan is guaranteed by the United States or any agency thereof pursuant to the provisions of the "Servicemen's Readjustment Act of 1944" or any act of Congress supplementary or amendatory thereof, the guaranteed portion of such loan shall not be deemed a part of said loan for the purposes of any provision of the Insurance Code limiting the amount which may be loaned by an insurer upon the security of real property or improvements thereon shall be

applicable to such loan.

1177. Such insurers may invest in notes or bonds secured by mortgage guaranteed as to payment by a policy of mortgage insurance, and mortgage participation certificates issued by a mortgage insurer in accordance with the provisions of this code.

1178. Such insurers may invest in collateral trust bonds or notes, secured by any of the following:

(a) A deposit of obligations authorized for investment by this article or Articles 4, 5, or 6 of this chapter having a market value at least fifteen per cent in excess of the par value of the collateral trust bonds or notes issued.

(b) A deposit of obligations authorized for investment by this article or Articles 4, 5, or 6 of this chapter, together with other securities, the combined market value of the deposit being at least twenty per cent in excess of the par value of the collateral trust bonds or notes issued, with the par value of the collateral trust bonds or notes not exceeding the market value of the deposited obligations which are authorized for investment by this article or Articles 4, 5, or 6 of this chapter.

(c) A deposit of obligations authorized for investment by this article, or Articles 4, 5, or 6 of this chapter, together with other securities, and conforming to the following requirements:

(1) The combined market value of the deposit is at least thirty per cent in excess of the par value of the collateral trust bonds or notes issued.

(2) The par value of such collateral trust bonds or notes issued does not exceed the market value of deposited obligations authorized for investment by this article.

(3) The deposited collateral consists of obligations authorized for investment by this article, or Articles 4, 5, or 6 of this chapter, having a market value of at least seventy-five per cent of the par value of such collateral trust bonds or notes issued.

1179. Such insurers may invest in farm loan bonds, consolidated

farm loan bonds, collateral trust debentures, consolidated debentures, or other obligations issued under the Federal Farm Loan Act, approved July 17, 1916, as amended (Title 12 U.S.C. Sections 636 to 1012 inclusive, and Sections 1021 to 1129 inclusive), and the Farm Credit Act of 1933, as amended (Title 12 U.S.C. Sections 1131 to 1138f inclusive), and the Farm Credit Act of 1971 (Title 12 U.S.C. Sections 2001 to 2259 inclusive). Under this section such insurers may invest in farm loan bonds and consolidated farm loan bonds issued by federal land banks, consolidated collateral trust debentures and all other debentures issued by federal intermediate credit banks, debentures issued by the Central Bank for Cooperatives and consolidated debentures issued by banks for cooperatives.

1180. Such insurers may invest in bonds issued under the "Home Owners' Loan Act of 1933"; bonds, debentures and notes issued by any federal home loan bank, or consolidated federal home loan bank notes, bonds and debentures issued by the Federal Home Loan Bank Board in accordance with the provisions of the Federal Home Loan Bank Act, and mortgage, mortgage participation, pass-through or trust certificates, or obligations or other securities issued or guaranteed by the Federal Home Loan Mortgage Corporation, pursuant to Section 305 or Section 306 of the Federal Home Loan Mortgage Corporation Act (12 U.S.C. Secs. 1454, 1455), by the Government National Mortgage Association, pursuant to Section 306 or Section 313 or Title III of the National Housing Act (12 U.S.C. Secs. 1721, 1723(e)), or by the Federal National Mortgage Association pursuant to 12 U.S.C. Sections 1717-1719.

1181. Such insurers may also invest in registered warrants of this State, issued pursuant to law.

1182. Domestic incorporated insurers may invest in an account or accounts in one or more banks or savings and loan associations to the extent the account or accounts are insured by an agency or instrumentality of the federal government. As used in this section, an account may include a certificate of deposit.

1185. (a) Every domestic incorporated insurer shall file a report with the commissioner 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 commissioner for review, approval, or information purposes pursuant to other provisions of this code, laws, regulations, or other requirements.

(b) The report shall be filed within 15 days after the end of the calendar month in which any of the foregoing transactions occur.

(c) One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall be filed with the department and the National Association of Insurance Commissioners.

(d) All reports obtained by, or disclosed to the commissioner pursuant to this article, shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the commissioner, the National Association of Insurance Commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer who would be affected thereby, notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof in such manner as he or she may deem appropriate.

1186. (a) No acquisitions or dispositions of assets shall be reported pursuant to Section 1185 if the acquisitions or dispositions are not material. For purposes of this article, 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 nonrecurring and not in the ordinary course of business and involves more than 5 percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of

domicile.

(b) Asset acquisitions subject to this article 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 that purpose. Asset dispositions also include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction, or other disposition.

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

(1) Date of the transaction.

(2) Manner of acquisition or disposition.

(3) Description of the assets involved.

(4) Nature and amount of the consideration given or received.

(5) Purpose of, or reason for, the transaction.

(6) Manner by which the amount of consideration was determined.

(7) Gain or loss recognized or realized as a result of the transaction.

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

(d) Insurers shall report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and that 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 one million dollars ($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 5 percent of the insurer's capital and surplus.

1187. (a) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements shall be reported pursuant to Section 1185 if the nonrenewals, cancellations, or revisions are not material. For purposes of this article, a material nonrenewal, cancellation, or revision is one that affects for property and casualty business, including accident and health business when written as such, more than 50 percent of an insurer's ceded written premium, or for life,

annuity, and accident and health business, more than 50 percent of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer's most recently filed statutory statement; provided, however, that no filing is required if the insurer's ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less than 10 percent of direct plus assumed written premium or 10 percent of the statutory reserve requirement prior to any cession, respectively.

(b) Subject to the criteria specified in subdivision (a), a report is to be filed without regard to which party has initiated the nonrenewal, cancellation, or revision of ceded reinsurance whenever one or more of the following conditions exist:

(1) The entire cession has been canceled, nonrenewed, or revised and ceded indemnity and loss adjustment expense reserves after any nonrenewal, cancellation, or revision represent less than 50 percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred.

(2) An authorized or accredited reinsurer has been replaced on an existing cession by an unauthorized reinsurer.

(3) Collateral requirements previously established for unauthorized reinsurers have been reduced; for example, the requirement to collateralize incurred but not reported (IBNR) claim reserves has been waived with respect to one or more unauthorized reinsurers newly participating in an existing cession.

(4) Subject to the materiality criteria, for purposes of paragraphs (2) and (3), a report shall be filed if the result of the revision affects more than 10 percent of the cession.

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

(1) Effective date of the nonrenewal, cancellation, or revision.

(2) The description of the transaction with an identification of the initiator thereof.

(3) Purpose of, or reason for, the transaction.

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

(d) Insurers shall report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which 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 one million dollars ($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 5 percent of the insurer's capital and surplus.

INSURANCE CODE
SECTION 1190-1202

1190. Any domestic incorporated insurer, which maintains in cash on hand or on deposit in a national or state bank, or in securities specified in Article 3 (commencing with Section 1170), an amount equal to its required minimum paid-in capital, may invest the remainder of its assets in the purchase of, or loans upon the securities set forth in this article. The investments are known as excess funds investments and are subject to the restrictions set forth in this article.

1191. Excess funds investments may be made in the stock of any corporation organized and carrying on business under the laws of this or any other state, or of the United States, or of the District of Columbia, or of the Dominion of Canada or of any province of the Dominion of Canada.

1191.1. Excess fund investments may be made in the purchase and sale of exchange traded call options on common stock pursuant to this section.

An insurer may sell exchange traded call options only through an exchange and only with respect to stock which it owns. Common stock that is obligated under an unexpired written call option shall not be sold unless the insurer first enters into a closing purchase transaction. An insurer shall not sell any other options pursuant to this section.

An insurer may purchase exchange traded call options only through an exchange and only for the purpose of a closing purchase transaction. An insurer shall not purchase any other options pursuant to this section.

1191.5. (a) Excess fund investments may be made by a domestic life insurer having admitted assets aggregating in value not less than one hundred million dollars ($100,000,000) in the purchase and sale of call options on interest-bearing obligations pursuant to subdivision (b) or (c). These investments may be made only in options on interest-bearing obligations issued by the United States of America, or any of its agencies or instrumentalities specified in Section 1180.

(b) An insurer may purchase call options pursuant to this section for the sole purpose of executing a closing purchase transaction for the interest-bearing obligation subject to the option. An insurer shall not purchase any other options pursuant to this section.

(c) An insurer may sell call options pursuant to this section only on interest-bearing obligations that it owns. An insurer shall not sell an interest-bearing obligation subject to an unexpired written call option sold by it except pursuant to a closing purchase transaction under the call option.

1192. Excess funds investments may be made in:

(a) Interest-bearing obligations issued by a nonaffiliate institution, as defined in paragraph (5) of subdivision (f) of Section 1196.1, organized under the laws of any state, or of the United States, or of the District of Columbia, or of the Dominion of Canada or of any province of the Dominion of Canada, or interest-bearing obligations registered with the Securities Exchange Commission and publicly traded issued by an affiliate corporation organized under the laws of any state, or of the United States, or of the District of Columbia, or of the Dominion of Canada or of any province of the Dominion of Canada, or interest-bearing obligations issued by an authority established pursuant to the California Industrial Development Financing Act provided for in Title 10 (commencing with Section 91500) of the Government Code, to which the corporation is obligated with respect to payment, or

(b) Equipment trust obligations or certificates, or other adequately secured instruments, evidencing an interest in or lien upon transportation equipment used or to be used by a common carrier or common carriers and a right to receive determined portions of fixed obligatory payments for the use or purchase of this equipment, when the obligations, certificates or instruments are issued by a corporation specified in paragraph (a) or are unconditionally guaranteed or assumed by the corporation as to principal and as to

interest or dividends and as to the payment of the fixed obligatory payments or the payment of the determined portions thereof.

1192.1. Excess funds investments may be made in bonds, notes or other obligations issued, assumed or guaranteed by the International Bank for Reconstruction and Development, or the Inter-American Development Bank, or the Government Development Bank for Puerto Rico, or the Asian Development Bank, the International Finance Corporation, or the African Development Bank. Investments held under the authority of this section at any one time shall not be in excess of 21/2 percent of the insurer's admitted assets or an amount equal to 25 percent of the total of the capital and surplus of such insurer, whichever is the lesser. Percentage or dollar value of assets and surplus as provided herein shall be determined by the insurer's last preceding annual statement of conditions and affairs filed with the commissioner pursuant to law.

1192.2. An insurer may lend on the security of a first lien on an unencumbered leasehold on real property if:

(a) The real property subject to the leasehold is primarily improved by a single family residence, the term of the loan does not exceed 30 years, and the amount of the loan plus the amount of the liens of any public bond, assessment or tax assessed upon the property loaned upon does not exceed 75 percent of the sound market value of the leasehold for loan purposes as determined by appraisal; or

(b) The real property subject to the leasehold is not primarily improved by a single family residence, the term of the loan does not exceed 30 years, and the amount of the loan plus the amount of the liens of any public bond, assessment or tax assessed upon the property loaned upon does not exceed 66 2/3 percent of the sound market value of the leasehold for loan purposes as determined by appraisal; or

(c) Where the loan is a building loan, the principal so loaned plus the amount of the liens of any public bond, assessment or tax assessed upon the property subject to said leasehold at no time exceeds 75 percent if made upon the kind of property and improvements referred to in (a) above or if other than referred to in (a) above, at no time exceeds 662/3 percent of the sound market value of the

leasehold for loan purposes as determined by appraisal, including the actual cost of the improvements thereon taken as security; or

(d) The loan is fully guaranteed or fully insured or covered by a commitment to fully guarantee or fully insure by the United States, the Federal Housing Administrator, or by any other agency of the United States which the commissioner shall have approved for the purposes of this subdivision as an issuer of insurance or guarantees of loans on real property, whether the proceeds of the guarantee or insurance is payable in cash or in obligations of the United States; or

(e) The loan is fully guaranteed by the United States or any agency thereof pursuant to the "Servicemen's Readjustment Act of 1944" or any act of Congress supplementary or amendatory thereof, or, if a portion of the loan is so guaranteed, then if the unguaranteed portion of the loan does not exceed 75 percent of the sound market value of the leasehold for loan purposes as determined by appraisal.

(f) In all cases mentioned in subsections (a), (b), (c) and (e), the loan must be repayable in equal installments not less often than annually in amounts sufficient to completely amortize the loan within three-fourths of the remaining term of the leasehold including options to renew exercisable by the lender.

A leasehold on real property is not encumbered within the meaning of this section if subject only to one or more of the following: (a) the lien of taxes and assessments not delinquent at the time of investment, (b) the lien for delinquent taxes or assessments delinquent at the time of investment, which are being contested by any legal proceedings, provided that indemnity has been given pursuant to the indenture under which the bonds and notes are issued, or otherwise, for the payment of any amount which may be found to be due upon the final adjudication of such contest, (c) the lien of taxes and assessment becoming delinquent subsequent to the time of investment, (d) outstanding mineral, oil or timber rights, (e) easements or rights-of-way, (f) sewer rights, (g) rights in walls, (h) building restrictions or other restrictive covenants, or conditions or regulations of use, or subleases under which rents or profits are reserved to the owner.

For the purposes of this section, delinquent taxes funded on any deferred payment plan shall be deemed delinquent.

1192.3. Excess fund investments may be made by a life insurer having admitted assets aggregating in value not less than two hundred

million dollars ($200,000,000) in the following:

(a) Equipment obligations, securities, or certificates of any equipment trust evidencing rights to receive partial payments agreed to be made upon any contract of leasing or conditional sale.

(b) The purchase and ownership of machinery or equipment, which is or will within 30 days after acquisition become subject to contracts for sale or use under which contractual payments may reasonably be expected to return the principal of and provide earnings on the investment within the anticipated useful life of the property which shall be not less than five years.

Except upon the prior approval, in writing, of the commissioner, an investment may not be made under the authority of this section if at the time of the making of such investment it would result in such insurer then owning such obligations, securities, certificates, machinery and equipment in an amount exceeding five percent of such insurer's admitted assets as determined by the insurer's last preceding annual statement filed with the commissioner.

Any investment in a single piece of machinery or equipment shall not be made in excess of one percent of the insurer's admitted assets or 10 percent of the aggregate of the insurer's capital paid-up and unassigned surplus, whichever is larger.

1192.4. No domestic insurer shall have more than 10 percent of its capital and surplus invested in stock of corporations organized under the laws of the Dominion of Canada or of any province of the Dominion of Canada, but this limitation shall not affect the authority conferred by Sections 1172, 1199 and 1240.

1192.5. Excess funds investments may be made in all deposits and debt obligations of banks or savings and loan associations whose accounts are insured by an agency or instrumentality of the federal government including accounts or certificates of deposit not subject to Section 1182, bankers' acceptances, and commercial paper.

1192.6. (a) An insurer, except an insurer authorized to transact mortgage guaranty insurance as defined in Section 119, may invest in a mortgage, mortgage-backed bond, or a mortgage participation,

pass-through, conventional pass-through, trust or participation certificate, which is secured by or represents an undivided interest in any loan secured by real property if the loan is a permitted investment for the insurer or in a pool of those loans if each is a permitted investment for an insurer; and for which there exists, at the time of making the investment, a resale market.

(b) If the loan or pools of loans have been transferred or contributed by an insurer to a corporation, all the voting securities of which are owned by the insurer, then the mortgage, mortgage-backed bond, or mortgage participation, pass-through, conventional pass-through, trust or participation certificate secured by or representing an undivided interest in the loan or pool of loans shall not be revalued solely due to that transfer. Any subsequent transfer to an affiliate from the wholly owned subsidiary shall be valued at the lower of book value or market value.

1192.7. (a) A domestic insurer having admitted assets aggregating in value not less than one hundred million dollars ($100,000,000) may make excess funds investments in participation certificates (1) which represent an undivided interest in an interest-bearing obligation issued by a corporation and (2) for which a resale market exists at the time the investment is made.

(b) No investment in a participation certificate may be made pursuant to this section unless the entire obligation is a form of investment which the insurer would be authorized to acquire pursuant to subdivision (a) of Section 1192.

(c) An investment may not be made under the authority of this section if at the time of making the investment it would result in the insurer then owning participation certificates described in this section in an amount exceeding 4 percent of the insurer's admitted assets as determined by the insurer's last preceding annual statement filed with the commissioner.

1192.8. (a) A domestic life insurer having admitted assets aggregating in value not less than one hundred million dollars ($100,000,000) may make excess fund investments pursuant to this section in interest-bearing notes, bonds, or obligations issued by (1) any operating business trust or limited partnership organized under the laws of any state of the United States, the District of Columbia, the Dominion of Canada, any province of the Dominion of

Canada or (2) an authority established pursuant to the California Industrial Development Financing Act, Title 10 (commencing with Section 91500) of the Government Code. The issuer of the notes, bonds, or obligations through itself or its paying agent shall be obligated thereunder to make payments, with respect to the notes, bonds, or other obligations, directly to the insurer or the insurer's nominee.

(b) Except upon the prior written approval of the commissioner, an investment may not be made under the authority of this section unless the note, bond, or obligation is exchange-traded. "Exchange-traded," as used in this subdivision, means listed and traded on the National Market System of the NASDAQ Stock Market or on a securities exchange subject to regulation, supervision, or control under a statute of the United States and acceptable to the commissioner.

(c) Without the prior written consent of the commissioner investment made pursuant to this section shall not exceed in the aggregate 10 percent of the life insurer's policyholder surplus.

(d) A request to the commissioner for (1) approval pursuant to subdivision (b) to invest in notes, bonds, or obligations that are not exchange-traded or (2) consent to exceed the 10 percent limitation set forth in subdivision (c), shall be in writing and shall be accompanied by any supporting data and documentation that the commissioner may require. The commissioner shall require the payment of a five thousand dollar ($5,000) fee in advance for the determination of whether to approve or disapprove each request. Each request shall be in writing and shall be deemed approved unless the commissioner disapproves it within 60 days with respect to requests under subdivision (c) or 20 days with respect to requests under subdivision (b), after the request has been filed in the commissioner's office.

(e) This section shall not be construed to increase or reduce the authority to invest in any operating business trust or limited partnership specifically permitted in other sections of this code.

1192.9. Notwithstanding Section 1100, an insurer may make excess funds investments in shares of an open-end diversified management investment company, as defined in the Federal Investment Company Act of 1940, that meets all of the following standards:

(a) It is registered with and reporting to the United States Securities and Exchange Commission.

(b) It is domiciled in the United States with all assets held in

the United States by a bank, trust company, or other authorized custodian chartered by the United States, its territories, possessions, or states.

(c) It has assets in excess of one hundred million dollars ($100,000,000).

(d) Its annual management investment fee shall not exceed six-tenths of 1 percent of the average daily asset value, and no other fees or commissions shall be charged to the insurer by any person.

(e) All of its assets are composed of (1) debt obligations issued by or on behalf of the United States, its territories and possessions, the District of Columbia, and states or their political subdivisions, agencies, and instrumentalities, including industrial development obligations; (2) corporate debt obligations other than debt obligations of the insurer or any company affiliated with the insurer; or, (3) accounts, deposits, or obligations of banks or savings and loan associations. The assets shall be required to meet the requirements of and be authorized for investment by the insurer under Articles 3 (commencing with Section 1170) and 4 (commencing with Section 1190) of Chapter 2.

(f) Shares of the management investment company shall be issued to the insurer or be retained by a bank, trust company, or other entity other than the management investment company which is authorized by the United States to act as a transfer and dividend paying agent for the management investment company.

(g) All shares of the management investment company shall be of the same class with equal rights and privileges. Each share shall be entitled to one vote and to participate equally in dividends and distributions declared by the management investment company and in the net distributable assets of the management investment company on liquidation. When issued, the share shall be fully paid and nonassessable and shall have no preemptive, conversion, or exchange rights.

(h) Shareholders shall be entitled to require the management investment company to redeem all shares.

1192.95. (a) Notwithstanding Section 1100, an insurer may make excess funds investments in investment pools and cash management pools established pursuant to this section. The pools shall meet all of the following standards:

(1) All participants in a pool shall each be affiliated with one another within the meaning of subdivision (a) of Section 1215 and

shall all be insurers, or a pension plan or profit-sharing plan of a participant or affiliate.

(2) The pools shall be a corporation, partnership, trust, limited liability company, or business trust domiciled in the United States with all assets held in accordance with Section 1104.9 and shall be maintained in one or more accounts in the name of or on behalf of the investment pool. Pool assets shall be held under a bank custody agreement that states and recognizes the claims and rights of each participant, acknowledges that the pool assets are held solely for the benefit of each participant in proportion to the aggregate amount of its pool investments, and states that the investments shall not be commingled with the general assets of the custodian or any other person. The pool manager shall be an insurer as defined by Section 826 or a business entity registered as an investment adviser under the federal Investment Act of 1940. The fiduciary duties a manager owes to the limited liability company and its members are those of a partner to a partnership. This duty may not be restricted by agreement.

(3) Any management fee shall be subject to disapproval by the commissioner. Costs directly incurred in acquiring or selling assets, such as commissions, transaction fees, or custodial fees, are not management fees and may be charged by the pool to the participants as long as these fees are on a direct cost reimbursement basis. All costs shall be apportioned to each participant in proportion to its interest in the pool.

(4) All shares of the pool shall be of the same class with equal rights, preferences, and privileges. Each share shall participate equally in dividends and distributions declared by the pool on liquidation in proportion to each participant's interest. When issued, the shares shall be fully paid and nonassessable and shall have no preemptive, conversion, or exchange rights.

(5) Each participant shall be entitled to require the pool to redeem all or any portion of the shares held by the participant on demand without penalty or assessment on any business day.

(6) All assets of a cash management pool shall be assets that participant insurers may lawfully acquire individually and shall be: (A) debt obligations issued by or on behalf of the United States, its territories and possessions, the District of Columbia, and states or their political subdivisions, agencies, and instrumentalities, including industrial development obligations, having a maturity not exceeding one year; (B) corporate debt obligations, other than debt obligations issued, assumed, guaranteed, or insured by a participant or by any affiliate of a participant, having a maturity not exceeding one year and that are rated One or Two by the Securities Valuation

Office of the National Association of Insurance Commissioners; or (C) accounts, deposits, or obligations of banks or savings and loan associations insured by an agency or instrumentality of the federal government.

(7) All assets of an investment pool shall be: (A) investments that are authorized under Section 1191, other than stock issued, assumed, guaranteed, or insured by a participant or any affiliate of a participant; (B) accounts, deposits, or obligations of banks or savings and loan associations insured by an agency or instrumentality of the federal government; or (C) investments that are authorized under Section 1192, other than securities or notes issued, assumed, guaranteed, or insured by a participant or any affiliate of a participant, or under Section 1194.5 or 1241.

(8) The assets of pools shall be required to meet the requirements of and be authorized for investment by a domestic incorporated insurer under Article 3 (commencing with Section 1170) or this article.

(9) No pool shall make investments in purchases of, or loans upon, more than 30 percent of the total in par value or more than 30 percent of the total number of outstanding shares of the capital stock of any one corporation.

(10) Transactions between the pool and its participants shall not be deemed to be material for purposes of subdivision (d) of Section 1215.4 or subdivision (b) of Section 1215.5. Investment activity of pools and transactions between pools and participants shall be reported in the annual registration statement required by Section 1215.4 and pursuant to Section 1215.5.

(11) Participation in an investment pool shall be subject to a written pooling agreement that shall be approved by the participant's board of directors and shall provide that (A) the underlying assets of the pool shall not be commingled with the general assets of the pool manager or any other person; (B) each participant must own an undivided interest in the underlying assets of the pool; (C) the underlying assets of the investment pool are held solely for the benefit of each participant; and (D) the pool manager shall make the records of the investment pool available for inspection by the commissioner. Pool agreements shall also specify what type of share participants hold to evidence their beneficial interest in the pool's assets. Prior to the execution of a pool agreement, a participating insurer's board of directors must approve the agreement only after having received a written opinion from an independent outside counsel explaining the ramifications and possible effects that a declaration of insolvency by a participant will have on the insurer's share of the investment pool.

(12) No participant insurer may invest more than 10 percent of admitted assets in a single pool or more than 25 percent of admitted assets in all pools combined.

(13) Each participant's proportionate share of the assets of a pool shall be deemed to be the direct holdings of that participant for purposes of determining compliance with the investment requirements of this code and shall be reported as such on required quarterly and annual reports. Pools operated as limited liability companies pursuant to Title 2.5 (commencing with Section 17000) of the Corporations Code shall conform their investments to this paragraph and the requirements of Sections 1200 and 1201.

(14) The pool manager shall compile and maintain detailed accounting records setting forth (A) the cash received and disbursements reflecting each participant's proportional investment in the investment pool; (B) a complete description of all underlying assets of the investment pool including amount, interest rate, and maturity date, if any, and other appropriate designations; and (C) other records that, on a daily basis, will allow the commissioner and the participants to verify each participant's investments in the pool.

(15) Pools shall not borrow or loan assets, except for securities-lending arrangements that are otherwise lawful for insurer participants of the pool.

(b) As used in this section, "share" means stock, participation unit, certificate of interest, or other evidence of beneficial ownership in the pool, whether evidenced by an instrument or by a book entry maintained by the pool.

(c) The commissioner shall have the authority to review any pool agreement and to disapprove any agreement that does not comply with this section. The commissioner shall have the authority to review the operation of any pool and to order compliance with this section. The commissioner shall have the authority to disallow, as an admitted asset, any pool investment not in compliance with this section. The commissioner may impose a fee upon any pool to recoup the actual cost of review under this section.

1192.10. (a) Excess funds investments may be made in securities evidencing an undivided interest in, the right to receive payments from, or payable primarily from distributions on a pool of financial assets held by an unaffiliated business entity, other than those authorized by Section 1192.6, if all of the following conditions are

met:

(1) The business entity is not a sole proprietorship and is established solely for the purpose of acquiring specific types of financial assets, issuing securities representing an undivided interest in, or right to receive cash flows from, those assets, and engaging in related activities.

(2) The pool of assets consists solely of interest-bearing obligations or other contractual obligations representing the right to receive payment from the assets.

(3) The investment is rated in one of the three highest rating categories by at least one nationally recognized statistical rating organization approved by the Securities and Exchange Commission and within one of the two highest categories established by the securities valuation office of the National Association of Insurance Commissioners.

(b) No investment under this section may be made if, as a result of giving effect to that investment, the aggregate amount of investments then held by the insurer under this section would exceed 10 percent of its admitted assets.

(c) Investments authorized by this section shall not be subject to subdivision (c) of Section 1196.

1193. Excess funds investments may be made in bonds of any permanent road division, or any district of any state when such bonds are legal investments for savings banks of this State, or have been certified as legal investments for savings banks pursuant to Division 10 of the Water Code, or when the statutes or laws providing for the issuance of such bonds, provide that such bonds shall be entitled to the same force or value or use as bonds issued by any municipality, or such law specifically states that such bonds shall be legal investments for either savings banks, insurance companies, all trust funds, state school funds or any funds which may be invested in bonds of cities, counties, cities and counties, school districts, or municipalities in the State, or when such bonds have been investigated and approved by a commission or board now or hereafter authorized by law to conduct such investigation and give such approval when such law specifies that upon such approval said bonds are legal investments for insurers, or which the commissioner approves in writing as legal for investment of the funds of insurers.

The commissioner in determining whether to approve any bonds as legal investments which do not otherwise qualify as such, shall make, upon the request of any insurer, at such insurer's expense, an

investigation and finding as provided for in Section 1175.

1194. Excess funds investments may be made in bonds issued by any county, municipality, or school district in this State to represent assessments for local improvements authorized by law. At the date of such investment the purchase price or principal loaned shall not exceed fifty per cent of the market value of the real property or of the real property together with the improvements thereon, upon which the bond is the first lien.

1194.1. Excess funds investments may be made in bonds issued pursuant to the Improvement Bond Act of 1915.

1194.5. Excess funds investments may be made in any debt obligation issued by the United States, a federal agency or entity authorized to issue debt obligations by federal statute; the Commonwealth of Puerto Rico, its agencies and political subdivisions; any state, its agencies or political subdivisions, or by any city, county, or city and county, or by any department or board of such city, county, or city and county, whether issued in bearer, registered or book entry form.

1194.6. (a) Excess funds investments may be made by an insurer in bonds, notes, or other evidences of indebtedness payable in United States dollars, and issued by a corporation incorporated under the laws of an alien government provided all of the following conditions are met:

(1) All the stock of the corporation is owned and ultimately controlled by a domestic corporation.

(2) Payment in full of any bond, note, or other evidence of indebtedness is guaranteed by the domestic corporation.

(3) Any bond, note, or other evidence of indebtedness is evaluated by the National Association of Insurance Commissioners as a bond which may be carried at amortized cost.

(b) Excess fund investments may be made by a life insurer in bonds, notes, or other evidence of indebtedness payable in a currency

other than United States dollars and issued by a corporation incorporated under the laws of an alien government provided all the following conditions are met:

(1) All of the stock of the corporation is owned and ultimately controlled by a domestic corporation.

(2) Payment in full of any bond, note, or other evidence of indebtedness is guaranteed by the domestic corporation.

(3) Any bond, note, or other evidence of indebtedness is evaluated by the National Association of Insurance Commissioners as a bond which may be carried at amortized cost.

(4) The life insurer shall, prior to or within five business days after purchase, enter into a contract with a qualified bank pursuant to which the bank agrees to exchange the payments made on the nondollar denominated investment for the full term to maturity of the investment for United States currency at a rate approximating the prevailing exchange rate at the time of the purchase. For purposes of this subdivision, a qualified bank means a bank the accounts of which are insured by an agency or instrumentality of the federal government or which is a member of the Federal Reserve System and a bank that has a net worth equal to or in excess of two hundred fifty million dollars ($250,000,000) as shown on its most recently published financial statements.

(c) "Domestic," as used in this section, means organized under the laws of any state, or of the United States or of the District of Columbia.

1194.7. Excess funds investments may be made in the stock of a Federal home loan bank. Any domestic incorporated insurer investing in the stock of a Federal home loan bank and thereby becoming a member thereof shall have power (a) to obtain advances from, and (b) to pledge collateral as security for such advances from such Federal home loan bank.

1194.8. (a) Excess fund investments may be made by a domestic insurer in real estate and leases thereof and in making improvements thereon for business or residential purposes as an investment for the production of income. The phrase "business or residential purposes" shall not include real estate or leases primarily intended for use or valued as agricultural, horticultural, farm, ranch or mineral property. Any such investment may be made by admitted insurers having admitted assets aggregating in value not less than twenty-five

million dollars ($25,000,000).

Domestic insurers, other than life, title, mortgage and mortgage guaranty insurers, having admitted assets aggregating in value less than twenty-five million dollars ($25,000,000) but not less than tenmillion dollars ($10,000,000) may also qualify to make suchinvestments for a period of 12 months with the prior approval of thecommissioner. Real estate and leases acquired and improvements madethereon under this section shall not exceed in the aggregate anamount equal to 10 percent of the insurer's admitted assets. Realestate and leases acquired under this section shall be in addition tothat which is authorized to be acquired under the provisions ofparagraphs (a) to (h), inclusive, of Section 1194.86. Except uponthe prior approval in writing of the commissioner, an investment maynot be made under the authority of this section if at the time of themaking of the investment it would result in the insurer then owningreal estate and leases thereof, other than of the kind and for thepurposes described in paragraphs (a), (b), and (f) of Section 1194.86, in an amount exceeding 10 percent of the insurer's admittedassets. Any investment in a single parcel of real estate or in asingle leasehold including improvements thereonmade under theauthority of this section shall not be made in an amount in excess of1 percent of the insurer's admitted assets or 10 percent of theaggregate of the insurer's capital paid-up and unassigned surplus,whichever amount is larger. A lease eligible for purchase hereundershall be for a term which at the date of purchase shall not expirefor at least 24 years. Percentage or dollar value of assets andcapital paid-up and unassigned surplus as provided herein shall bedetermined by the insurer's last preceding annual statement ofconditions and affairs made as of the December 31st last precedingand which has been filed with the commissioner pursuant to law.

(b) In computing the value of real estate held by a domesticinsurer for the purpose of complying with the asset standards orpercentage of asset standards, the insurer shall add the net equityof the real estate owned by the insured to the amount of encumbrancesand liens against the property for which the insurer could be heldliable for any deficiency in the event of foreclosure or other actionto realize the value of the liens. "Net equity" as used in thissection means book value less the value of liens and encumbrances.

(c) Notwithstanding subdivision (a) or Section 1100, excess fundinvestments may be made by a domestic life insurer as an investmentfor the production of income in interests in publicly traded limitedpartnerships, limited partnerships in which the life insurer is thegeneral partner, general partnerships, or in shares of beneficialinterests in trusts substantially all the assets of which are realestate or leases thereof or improvements thereon for business orresidential purposes. "Business or residential purposes" does

notinclude real estate or leases primarily intended for use or valued asagricultural, horticultural, farm, ranch, or mineral property. Anyinvestment authorized by this subdivision may be made by domesticlife insurers having admitted assets aggregating in value not lessthan one hundred million dollars ($100,000,000).

Investments acquired pursuant to this subdivision shall be inaddition to investments authorized to be acquired under subdivisions (a) to (h), inclusive, of Section 1194.86. Except upon the priorapproval in writing of the commissioner, an investment may not bemade under the authority of this subdivision in a general partnershipor a nonpublicly traded trust if at the time of the making of theinvestment it would result in the life insurer owning aggregateinterests in those investments in an amount exceeding 3 percent ofthe life insurer's admitted assets. Except uponthe prior approvalin writing of the commissioner, an investment may not be made if atthe time it would result in the life insurer owning interests ingeneral or limited partnerships or in shares of beneficial interestsin trusts in an amount exceeding 10 percent of the life insurer'sadmitted assets.

An investment in a single partnership or shares of beneficialinterest in a single trust made pursuant to this subdivision shallnot be made in an amount in excess of 1 percent of the life insurer'sadmitted assets or 10 percent of the aggregate of the life insurer'scapital paid-up and unassigned surplus, whichever is larger.Percentage or dollar value of assets and capital paid-up andunassigned surplus as provided herein shall be determined by the lifeinsurer's last preceding annual statement of conditions and affairsmade as of the December 31st last preceding and which has been filedwith the commissioner pursuant to applicable provisions of law.

For purposes of this subdivision, "publicly traded" meanssecurities of a limited partnership or trust listed and traded on asecurities exchange subject to regulation, supervision, or controlunder a statute of the United States or listed on the NASDAQ system.

(d) Investments made pursuant to subdivisions (a) and (c) shallnot exceed in the aggregate an amount equal to 10 percent of theinsurer's admitted assets and shall produce sufficient cash-flow toamortize any mortgage, except with the prior written consent of thecommissioner.

1194.81. Domestic incorporated insurers may invest in notes orbonds secured by a mortgage or other first lien upon unencumberedreal property meeting the criteria of subdivision (e), if the securedobligation meets the conditions of subdivisions (a) and (b), asfollows:

(a) There exists no condition or right of reentry or of forfeitureunder which the lien can be cut off, subordinated, or otherwisedisturbed.

(b) The secured obligation satisfies the conditions of paragraph(1), (2), (3), or (4), as follows:

(1) The principal so loaned or the entire note or bond issue sosecured, plus the amount of the liens of any public bond, assessment,or tax assessed upon the property loaned upon, does not exceed 80percent of the market value of that real property, together withimprovements which are taken as security at the date of investment.

(2) Where the loan is insured by an admitted mortgage guarantyinsurer conforming to the provisions of Chapter 2A (commencing withSection 12640.01) of Part 6 of Division 2, the unguaranteed portionof the loan, plus the amount of the liens of any public bond,assessment, or tax assessed upon the property loaned upon, does notexceed 80 percent of the market value of that real property, togetherwith improvements which are taken as security at the date ofinvestment.

(3) Where the loan is made or the notes or bonds are issued for abuilding loan on real property, the principal so loaned, or theentire outstanding notes or bonds so issued, plus the amount of thelien of any public bond, assessment, or tax assessed upon theproperty loaned upon, at no time exceeds 80 percentof the marketvalue of the real property together with the actual cost of theimprovements thereon taken as security.

(4) Where the loan is secured by a first mortgage or other firstlien upon real property primarily improved with a residentialbuilding, or buildings, which for the purposes of this paragraphincludes a condominium unit, designed for occupancy by not more thanfour families, the terms of the loan provide for monthly payments ofprincipal and interest sufficient to effect full repayment of theloan within the remaining useful life of the building as estimated inthe appraisal for the loan, or 40 years, whichever is less, and theprincipal so loaned or the entire note or bond issue so secured, plusthe amount of the liens of any public bond, assessment, or taxassessed upon the property loaned, does not exceed 90 percent of themarket value of that real property, or of that real property togetherwith improvements which are taken as security on the date ofinvestment.

(c) Real property is not encumbered within the meaning of thissection if subject only to one or more of the following:

(1) The lien of taxes and assessments not delinquent at the timeof investment.

(2) The lien for delinquent taxes or assessments delinquent at thetime of investment, which are being contested by any legalproceedings, if indemnity has been given pursuant to the indentureunder which the bonds and notes are issued, or otherwise, for thepayment of any amount which may be found to be due upon the finaladjudication of that contest.

(3) The lien of taxes and assessments becoming delinquentsubsequent to the time of investment.

(4) Outstanding mineral, oil or timber rights.

(5) Easements or rights-of-way.

(6) Sewer rights.

(7) Rights in walls.

(8) Building restrictions or other restrictive covenants, orconditions or regulations of use, or leases under which rents orprofits are reserved to the owner.

(d) For the purposes of this section, delinquent taxes funded onany deferred payment plan shall be deemed delinquent.

(e) Only real property meeting the following criteria of paragraph(1), (2), or (3) may secure notes or bonds eligible for investmentunder this section:

(1) There is an improvement on the real property with a value thatis substantial in relation to the total value of the property.

(2) There is no improvement on the real property, but the fundsloaned on account of the secured obligation, which meets the criteriaof paragraph (3) of subdivision (b), are used to construct animprovement on real property and the value of the improvementconstructed on the real property is at all times substantial inrelation to the amount of the construction loan funds advanced by theinsurer and drawn down by or on account of the borrower.

(3) There is no improvement on the real property, but the propertyis revenue producing and is used primarily as agricultural,horticultural, farm, or ranch property.

(4) There is no improvement on the real property, but the note orbond secured by that real property is held in conjunction withanother note or bond held by the insurer that is secured by otherreal property on which there exists a substantial improvement.However, the value of the unimproved real property may not exceed 20percent of the total value of all real property taken as security forall those notes or bonds.

1194.82. (a) An insurer may invest in notes or bonds secured bysecond mortgages or other second liens, including all inclusive orwraparound mortgages or liens, upon real property encumbered only bya first mortgage or lien which meets the requirements set forth inSection 1194.81, subject to either of the following conditions:

(1) The insurer also owns the note or bond secured by the priorfirst mortgage or lien and the aggregate value of both loans does notexceed the loan to market value ratio requirements of Section

1194.81.

(2) The note or bond is secured by an "all-inclusive" or"wraparound" lien or mortgage which conforms to the requirementsspecified in subdivision (b), provided that the aggregate value ofthe resulting loan

does not exceed the loan to market value ratiorequirements of Section 1194.81.

(b) The terms "wraparound" and "all-inclusive" lien or mortgagerefer to a loan made by an insurer to a borrower on the security of amortgage or lien on real property other than property containing aresidence of one to four units or upon which a residence of one tofour units is to be constructed, where the real property isencumbered by a first mortgage or lien and which loan is subject toall of the following:

(1) There is no more than one preexisting mortgage or lien on thereal property.

(2) The total amount of the obligation of the borrower to theinsurer under the loan is not less than the sum of the amountdisbursed by the insurer on account of the loan and the outstandingbalance of the obligation secured by the preexisting lien ormortgage.

(3) The instrument evidencing the lien or mortgage by which theobligation of the borrower to the insurer under the loan is secured,is recorded, and the lien is insured under a policy of titleinsurance in an amount not less than the total amount of theobligation of the borrower to the insurer under the loan.

(4) The insurer either (A) pursuant to subdivision (b) of Section2924 of the Civil Code, files for record in the office of therecorder of the county in which the real property is located a dulyacknowledged request for a copy of any notice of default or of saleunder the preexisting lien, (B) otherwise arranges with the recorderof any county in which the real property is located to be advised incase of the filing for record of any notice of default or of salewith respect to any obligation secured by the preexisting lien, or
(C) is entitled under applicable law to receive notice of default,sale, and foreclosure of the preexisting lien.

(5) The amount disbursed by an insurer under any single wraparoundor all-inclusive loan made pursuant to this section shall not exceedthe greater of 1 percent of the insurer's admitted assets or 10percent of the aggregate of the insurer's capital paid-up andunassigned surplus.

1194.85. In any case in which a domestic insurer has requested theapproval of the commissioner to make the investments specified insubdivision (a) or (c) of Section 1194.8, that insurer shallreimburse the department for all actual expenses, not to exceed fivehundred dollars ($500), incurred by it in making a determination ofwhether to approve or disapprove that request.

1194.86. Every admitted incorporated insurer may purchase, hold, orconvey real estate only for the following purposes and in thefollowing manner:

(a) The building in which it has its principal office and the landupon which that building stands.

(b) Real estate requisite for its accommodation in the convenienttransaction of its business.

(c) Real estate acquired by it, or by any person for it, to securethe payment of loans previously contracted or for moneys due.

(d) Real estate purchased at sales upon deeds of trust or uponjudgments or decrees obtained for those loans or debts.

(e) Real estate conveyed to it in satisfaction of debts previouslycontracted in the course of its dealings.

(f) Real estate acquired by gift or devise.

(g) Real estate acquired in part payment of the consideration ofthe sale of real property owned by it, if each such transaction shallnot effect an increase in its investment in such real property.

(h) Upon the written approval of the Insurance Commissioner, realestate requisite or desirable for the protection or enhancement ofthe value of other real or personal property owned by the insurers.

(i) Real estate and improvements thereon which domestic insurersare permitted to invest pursuant to the provisions and subject to theconditions and limitations of Section 1194.8 or Section 1210.

1194.87. If, after a hearing, the commissioner is satisfied that aninsurer is carrying upon its books any parcel or parcels of realestate at values exceeding the sound market value thereof, he or shemay order the insurer to:

(a) Create an adequate contingency reserve against the book valueof the parcel or parcels, or

(b) Reduce the book value of the parcel or parcels by acorresponding amount.

In the case of real estate, not of a character described insubdivision (a), (b), (h), or (i) of Section 1194.86, which has beenheld by the insurer for more than five years, the commissioner mayorder the insurer to dispose of the real estate within six months if,after a hearing, the commissioner is satisfied that:

(1) The insurer has refused reasonable offers for the sale of thereal estate, or

(2) The real estate may be disposed of without undue hardship tothe insurer.

For the purpose of enabling him or her to determine whether to issue an order pursuant to this section, the commissioner, if he orshe is not satisfied with the appraisal furnished at his or herrequest by the insurer, may appraise the real estate at the expenseof the insurer.

The commissioner may suspend or revoke the certificate ofauthority of an insurer failing to comply with any order issued under

this section.

1194.88. Every admitted incorporated insurer may, for theprotection or enhancement of the value of real property acquiredunder the provisions of Section 1194.86, use its funds in the manneras it shall deem proper to repair, alter, remodel, rehabilitate,demolish, purchase furnishings or other personal property for use inor otherwise to improve the real estate.

1194.9. If the commissioner shall decide, after due notice andhearing that the interest of any company having real estate acquiredpursuant to the provisions of Section 1194.8 requires that anyspecific parcel or parcels of such real estate be disposed of, thensuch insurance company shall dispose of such real estate within suchreasonable time as the commissioner shall direct.

1194.95. Excess funds investments may be made in an electroniccomputer or data processing machine or system to be used inconnection with the business of the insurer; provided, however, thatthis machine or system shall have an original cost of at least twohundred fifty thousand dollars ($250,000) and shall be amortized infull over a period not to exceed four full calendar years.

1195. This article does not authorize investments in any obligationunless the obligation is interest or income-bearing ordividend-paying.

An obligation is interest or income-bearing within the meaning ofthis section if it is not in default in payment of interest or incomeon the date of acquisition by the insurer and if no such default wasimminent on such date.

Nothing in this section contained, however, shall limit or affectthe authority conferred by section 1191 of this code.

1196. Excess funds investments shall not be made in any stock orobligation unless:

(a) The stock or obligation qualifies as a sound investment.

(b) In case of a purchase, the price paid for the security is notin excess of the current market value at the date of purchase.

(c) In case of a loan, the amount loaned does not exceedeighty-five per cent of the market value, at the date of the loan, ofthe collateral taken as security.

1196.1. (a) No domestic insurer shall acquire, directly orindirectly, any medium grade or lower grade obligation of anyinstitution if, after giving effect to any such acquisition, theaggregate amount of all medium

grade and lower grade obligations thenheld by the domestic insurer would exceed 20 percent of its admittedassets, provided that, (1) no more than 10 percent of its admittedassets consists of obligations rated four, five, or six by theSecurities Valuation Office; (2) no more than 3percent of itsadmitted assets consist of obligations rated five or six by theSecurities Valuation Office; and (3) no more than 1 percent of itsadmitted assets consists of obligations rated six by the SecuritiesValuation Office. Attaining or exceeding the limit of any onecategory shall not preclude an insurer from acquiring obligations inother categories subject to the specific and multicategory limits.

(b) No domestic insurer may invest more than an aggregate of 1percent of its admitted assets in medium grade obligations issued,guaranteed, or insured by any one institution nor may it invest morethan one-half of 1 percent of its admitted assets in lower gradeobligations issued, guaranteed, or insured by any one institution.In no event, however, may a domestic insurer invest more than 1percent of its admitted assets in any medium or lower gradeobligations issued, guaranteed, or insured by any one institution.

(c) Notwithstanding subdivision (a) or (b), a domestic insurer mayacquire an obligation of an institution in which the insurer alreadyhas one or more obligations if the obligation is acquired in orderto protect an investment previously made in the obligations of theinstitution; provided that all of those acquired obligations shallnot exceed one-half of 1 percent of the insurer's admitted assets.

(d) Nothing contained in this section; (1) shall prohibit adomestic insurer from acquiring an obligation as a result of arestructuring of a medium or lower grade obligation already held; or(2) shall require a domestic insurer to sell or otherwise dispose ofany obligation legally acquired prior to the effective date of thissection.

(e) The board of directors of any domestic insurer that acquiresor invests, directly or indirectly, more than 2 percent of itsadmitted assets in medium grade and lower grade obligations, shalladopt a written plan for the making of that investment. The plan, inaddition to guidelines with respect to the quality of the issuesinvested in, shall contain diversification standards including, butnot limited to, standards for issuers, industry duration, liquidity,and geographic location.

(f) As used in this section:

(1) "Medium grade obligations" means obligations which are ratedthree by the Securities Valuation Office of the National Associationof Insurance Commissioners.

(2) "Lower grade obligations" means obligations which are ratedfour, five, or six by the Securities Valuation Office of the NationalAssociation of Insurance Commissioners.

(3) "Admitted assets" means the amount shown as of the last day ofthe

most recently concluded annual statement year, computed in themanner prescribed by the commissioner.

(4) "Aggregate amount of medium grade and lower grade obligations"means the aggregate statutory statement value of the obligation.

(5) "Institution" means (A) any corporation, business trust, orlimited partnership organized under the laws of any state of theUnited States, District of Columbia, the Dominion of Canada, anyprovince of the Dominion of Canada or (B) an authority establishedpursuant to the California Industrial Development Financing Act,Title 10 (commencing with Section 91500) of the Government Code.

1197. Excess funds investments shall not be made in a loan to anyone borrower, including all affiliates which shall be treated as oneborrower, in an amount exceeding 10 percent of the capital stock andsurplus or 1 percent of the admitted assets of the lending insurer,whichever amount is greater.

1198. Excess funds investments shall not be made in purchases of orloans upon shares of the capital stock of any one corporation in anamount exceeding 10 percent of the excess of the admitted assets ofthe investing insurer over the liabilities and required reserves ofsuch insurer.

Nor shall the excess amount of any such investment over and above25 percent of the excess of the admitted assets of the owner thereofover the liabilities and required reserves of such owner be retained.

The commissioner may determine the retention of such excess amountover said 25 percent to be a violation of the provisions of thisarticle within the meaning of and subject to all the provisions of Section 1202.

No investment which is permitted under Section 1199 shall beprohibited or its retention limited by this section.

1199. No domestic incorporated fire, life or marine insurer shallmake excess funds investments in purchases of, or loans upon, morethan 30 percent of the total in par value or number of outstandingshares of the capital stock of any one corporation, except:

(a) In the purchase of the stock of another admitted domesticinsurer; or

(b) With the prior authorization of the commissioner, in thepurchase of stock of any other insurance corporation organized underthe laws of any other state, or of the Dominion of Canada or of anyprovince of the Dominion of Canada, which is supervised by the stateor dominions or provincial insurancecommissioner or similarofficial, and the investments of which comply in substance with theinvestment requirements and

limitations imposed by this code uponlike domestic insurers; provided, that no such domestic insurer shallhave in the aggregate more than 50 percent of its capital andsurplus invested in the stocks of insurance corporations organizedunder the laws of this state or other states or of the Dominion ofCanada or of any province of the Dominion of Canada.

(c) In the purchase of stock of any corporation organized underthe laws of this state for the exclusive purpose of engaging in thebusiness of financing insurance premiums and any and all mattersincidental thereto and engaging exclusively in such business and suchmatters.

(d) Such insurer may purchase or otherwise acquire all or anypercent of the issued and outstanding stock of any corporation whichis any of the following:

(1) A corporation providing investment advisory, management, or sales services to an investment company or separate account.

(2) A real property holding, developing, managing, or leasingcorporation.

(3) A data processing or computer service corporation.

(4) An investment company or companies as defined by theInvestment Company Act of 1940, (Title 15, U.S.C., Sec. 80 a-1, etseq.).

(5) A corporation acting as administrative agent for agovernmental instrumentality performing insurance-related functions,or for private health and welfare plans.

1200. An excess funds investment shall not be made unlessauthorized or approved by the directors of the investor or by acommittee thereof charged with the duty of supervising or making suchinvestment. Such authorization or approval shall be entered uponthe records or minutes of the investor and, if made upon authority ofsuch a committee a report shall be submitted to the directors attheir next meeting.

1201. The entry of approval shall show:

(a) The fact of making such investment.

(b) The amount thereof.

(c) The name of each director voting to approve the investment.

(d) The amount, character and value of the security purchased or taken as collateral.

(e) If the investment is a loan, the name of the borrower, the rate of interest thereon and the due date thereof.

1202. The commissioner may, in his discretion and after hearing, bywritten order require the disposal of any investments made inviolation of the provisions of this article, pending which disposalpursuant to such order no value shall be allowed for such investmentin any statement, required by any provision of this code, purportingto show the financial condition of the ownerthereof, or in measuringthe financial condition of

the owner thereof for the purpose ofdetermining whether such owner is solvent or insolvent. Thecommissioner may also, for good cause, require the disposal of anyexcess funds investments.

INSURANCE CODE SECTION 1210

1210. (a) Any domestic incorporated insurer, after investing anamount equal to its required minimum paid-in capital in securitiesspecified in Article 3 (commencing with Section1170), may make suchinvestments as it may see fit in the purchase of, or loans upon,properties and securities other than or in addition to or in excessof those set forth in Articles 2 (commencing with Section 1150), 3(commencing with Section 1170) and 4 (commencing with Section 1190)of this chapter. Investments under this section shall not exceed, inthe aggregate, the lesser of any of the following:

(1) Five percent of the insurer's admitted assets.

(2) Fifty percent of the excess of admitted assets over the sum ofcapital paid up, liabilities and the surplus required by Section700.02. The percentage or dollar value of admitted assets andcapital paid up and liabilities shall be determined by the insurer'slast preceding annual statement of conditions and affairs made as ofthe preceding December 31st and which has been filed with thecommissioner pursuant to law. The investments shall be subject tothe provisions of Sections 1153.5, 1154, 1200, 1201, and 1202 as ifthey were excess funds investments. This section shall apply to aninsurer other than life only if the insurer has aggregate capital andsurplus of at least ten million dollars ($10,000,000).

(b) An investment originally made by an insurer pursuant to thissection which subsequently meets therequirements of an investmentcontained in Article 2 (commencing with Section 1150), 3 (commencingwith Section 1170) or 4 (commencing with Section 1190) may, at theelection of the insurer, be considered to be held pursuant to anyprovision contained in those articles.

(c) Pursuant to the authority conferred by subdivision (a),notwithstanding Section 1100, an insurer may make discretionaryinvestments in shares of an open-end diversified managementinvestment company, as defined in the federal Investment Company Actof 1940, as amended. Nothing in this subdivision is intended toprohibit any other discretionary investment, now or in the future,that might otherwise be made by an insurer, whether expresslyidentified in this section or not.