

CHAPTER 2

INSURANCE GROUP

Authority

N.J.S.A. 17:1C-6(e), 17:1-8.1, 17:17-1 et seq., 17B:17-1 et seq., 34:15-77, and 54:18A-1 et seq.

Source and Effective Date

R.1996 d.3, effective November 30, 1995.
See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

Executive Order No. 66(1978) Expiration Date

Chapter 2, Insurance Group, expires on November 30, 2000.

Chapter Historical Note

Chapter 2, Insurance Group, was originally filed and became effective prior to September 1, 1969.

1970 Revisions: Subchapter 10, Casualty Insurers, Personal Lines Insurance was adopted as new rules by R.1970 d.71, effective June 26, 1970.

1972 Revisions: Subchapter 11, Rules Governing Advertisement of Health Insurance, was adopted as new rules by R.1972 d.95, effective May 16, 1972. See: 4 N.J.R. 69(b), 4 N.J.R. 128(d).

1974 Revisions: Subchapter 12, Mass Marketing of Property and Liability Insurance, was adopted as new rules by R.1974 d.271, effective September 25, 1974. See: 6 N.J.R. 313(d), 6 N.J.R. 408(a). Subchapter 13, Group Coverage Discontinuance and Replacement, was adopted as new rules by R.1974 d.272, effective February 1, 1975. See: 5 N.J.R. 342(c), 6 N.J.R. 409(a).

1981 Revisions: Subchapter 17, Unfair Claims Settlement Practices, was adopted as new rules by R.1981 d.407, effective November 2, 1981 (operative January 15, 1982). See: 12 N.J.R. 600(f), 13 N.J.R. 774(c), 13 N.J.R. 894(a).

1982 Revisions: Subchapter 18, Readable Policies, was adopted as new rules by R.1982 d.410, effective November 15, 1982. See: 14 N.J.R. 967(a), 14 N.J.R. 1307(c).

1985 Revisions: Subchapter 10, Casualty Insurers, Personal Lines Insurance, was repealed by R.1985 d.71, effective February 19, 1985. See: 16 N.J.R. 2920(a), 17 N.J.R. 458(b). Subchapter 23, Advertisement of Life Insurance and Annuities, was adopted as new rules by R.1985 d.600, effective November 18, 1985. See: 16 N.J.R. 2626(a), 17 N.J.R. 2776(a). Subchapter 19 was adopted as new rules by R.1985 d.608, effective December 2, 1985. See: 16 N.J.R. 2920(b), 17 N.J.R. 2901(b).

1989 Revisions: Subchapter 1, Educational Requirements for Licensing, and Subchapter 19 were repealed by R.1989 d.192, effective April 3, 1989. See: 20 N.J.R. 1152(a), 21 N.J.R. 899(b). Subchapter 26, Annual Audited Financial Reports, was adopted as new rules by R.1989 d.612, effective December 18, 1989. See: 21 N.J.R. 3054(a), 21 N.J.R. 3919(b).

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 2 was readopted as R.1991 d.4, effective November 30, 1990, with amendments effective January 7, 1991. As part of R.1991 d.4, Subchapter 8 was repealed effective January 7, 1991. See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a). Subchapter 32, Custodial Deposits, was adopted as new rules by R.1991 d.14, effective January 7, 1991. See: 22 N.J.R. 2640(a), 23 N.J.R. 105(a). Subchapter 31, Manner of Determining Premium for Perpetual Homeowners Insurance, was adopted as new rules by R.1991 d.139, effective March 18, 1991. See: 22 N.J.R. 601(a), 23 N.J.R. 860(b). Subchapter 29, Orderly Withdrawal of Insurance Business, was adopted as new rules by R.1991 d.262,

effective May 20, 1991. See: 23 N.J.R. 15(b), 23 N.J.R. 1673(a). Subchapter 35, Relief from Insurer Obligations Under the Fair Automobile Insurance Reform Act of 1990, was adopted as new rules by R.1991 d.519, effective October 21, 1991. See: 23 N.J.R. 660(a), 23 N.J.R. 3166(a).

1992 Revisions: Subchapter 27, Determination of Insurers in a Hazardous Financial Condition, was adopted as new rules by R.1992 d.292, effective July 6, 1992. See: 23 N.J.R. 3197(a), 24 N.J.R. 2456(a).

1993 Revisions: Subchapter 33, Workers' Compensation Self-Insurance, was adopted as new rules by R.1993 d.157, effective April 5, 1993. See: 24 N.J.R. 1944(a), 24 N.J.R. 2708(b), 25 N.J.R. 1526(a). Subchapter 28, Credit for Reinsurance, was adopted as emergency new rules by R.1993 d.448, effective August 16, 1993 (expires October 15, 1993). See: 25 N.J.R. 4289(a). The provisions of R.1993 d.448 were readopted as R.1993 d.557, effective October 15, 1993. See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a). Subchapter 36, Risk Retention Groups and Purchasing Groups, was adopted as emergency new rules by R.1993 d.449, effective August 16, 1993 (expires October 15, 1993). See: 25 N.J.R. 4298(a). The provisions of R.1993 d.449 were readopted as R.1993 d.558, effective October 15, 1993. See: 25 N.J.R. 4298(a), 25 N.J.R. 5197(a). Subchapter 37, Producer-Controlled Insurers, was adopted as emergency new rules by R.1993 d.450, effective August 16, 1993 (expires October 15, 1993). See: 25 N.J.R. 4304(a). The provisions of R.1993 d.450 were readopted as R.1993 d.559, effective October 15, 1993. See: 25 N.J.R. 4304(a), 25 N.J.R. 5202(a). Subchapter 38, Increase in Property and Casualty Capital and Surplus Requirements, was adopted as emergency new rules by R.1993 d.451, effective August 16, 1993 (expires October 15, 1993). See: 25 N.J.R. 4306(a). The provisions of R.1993 d.451 were readopted as R.1993 d.560, effective October 15, 1993. See: 25 N.J.R. 4306(a), 25 N.J.R. 5204(a). Subchapter 39, Increase in Capital and Surplus Requirements for Life and Health Insurers, was adopted as emergency new rules by R.1993 d.452, effective August 16, 1993 (expires October 15, 1993). See: 25 N.J.R. 4309(a). The provisions of R.1993 d.452 were readopted as R.1993 d.561, effective October 15, 1993. See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a). Subchapter 40, Life, Health and Annuity Reinsurance Agreements, was adopted as emergency new rules by R.1993 d.453, effective August 16, 1993 (expires October 15, 1993). See: 25 N.J.R. 4314(a). The provisions of R.1993 d.453 were readopted as R.1993 d.562, effective October 15, 1993. See: 25 N.J.R. 4314(a), 25 N.J.R. 5212(a). Subchapter 34, Surplus Lines Insurance: Allocation of Premium Tax and Surcharge, was adopted as new rules by R.1993 d.582, effective November 15, 1993. See: 25 N.J.R. 1826(a), 25 N.J.R. 5194(a).

1994 Revisions: Subchapter 17, Unfair Claims Settlement Practices, Petition for Rulemaking. See: 26 N.J.R. 2487(b).

1995 Revisions: Subchapter 41, Windstorm Market Assistance Program, was adopted as new rules by R.1995 d.53, effective January 17, 1995. See: 26 N.J.R. 4304(a), 27 N.J.R. 364(a). Subchapter 1, Admission Requirements for Foreign and Alien Life and Health Insurers, was adopted as new rules by R.1995 d.80, effective February 6, 1995. See: 26 N.J.R. 4586(a), 27 N.J.R. 559(a).

1996 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 2 was readopted as R.1996 d.3, effective November 30, 1995, with amendments effective January 2, 1996. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. ADMISSION REQUIREMENTS FOR FOREIGN AND ALIEN LIFE AND HEALTH INSURERS

- 11:2-1.1 Purpose
- 11:2-1.2 Scope
- 11:2-1.3 Definitions
- 11:2-1.4 General eligibility requirements

- 11:2-1.5 Letter of intent
- 11:2-1.6 Final application
- 11:2-1.7 Review procedures; appeals
- 11:2-1.8 Compliance
- 11:2-1.9 Severability

SUBCHAPTER 2. INSURANCE ON FINANCED AUTOMOBILES

- 11:2-2.1 Return of unearned premiums

SUBCHAPTER 3. CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND HEALTH INSURANCE

- 11:2-3.1 Scope
- 11:2-3.2 Definitions
- 11:2-3.3 Forms
- 11:2-3.4 Amount
- 11:2-3.5 Term
- 11:2-3.6 Policy provisions, disclosure to debtors
- 11:2-3.7 Credit life insurance in connection with leases of personal property
- 11:2-3.8 Credit accident and health insurance in connection with leases of personal property
- 11:2-3.9 Open-end credit coverage
- 11:2-3.10 Balloon coverage
- 11:2-3.11 Prohibited provisions of credit insurance policies
- 11:2-3.12 Delivery of policy; procedures
- 11:2-3.13 Application or notice of proposed insurance
- 11:2-3.14 Filing
- 11:2-3.15 Group policy; delivery
- 11:2-3.16 Disapproval by Commissioner
- 11:2-3.17 Standards for premium rates
- 11:2-3.18 Joint credit accident and health insurance
- 11:2-3.19 Maximum payments by debtors
- 11:2-3.20 Refunds
- 11:2-3.21 Maintenance of statistics
- 11:2-3.22 Issuance of policies
- 11:2-3.23 Payment of claims
- 11:2-3.24 Existing insurance; choice of insurer
- 11:2-3.25 Separability
- 11:2-3.26 Effect on previously filed forms and rates

APPENDIX. CREDIT ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER 4. ELECTRONIC DATA PROCESSING EQUIPMENT

- 11:2-4.1 Cost of equipment as admitted asset

SUBCHAPTER 5. PROXIES, CONSENTS AND AUTHORIZATIONS

- 11:2-5.1 Applicability
- 11:2-5.2 Solicitation; prohibition
- 11:2-5.3 Disclosure of equivalent information
- 11:2-5.4 Definitions
- 11:2-5.5 Information to be furnished to stockholders
- 11:2-5.6 Proxy requirements
- 11:2-5.7 Material required to be filed
- 11:2-5.8 False or misleading statements
- 11:2-5.9 Undated or postdated proxy; prohibition
- 11:2-5.10 Election contests; special provisions

SUBCHAPTER 6. INFORMATION REQUIRED IN PROXY STATEMENT, GENERALLY

- 11:2-6.1 Revocability of proxy
- 11:2-6.2 Dissenters' rights of appraisal
- 11:2-6.3 Solicitation by management
- 11:2-6.4 Solicitation by nonmanagement
- 11:2-6.5 Solicitation by specially engaged employees or paid solicitors
- 11:2-6.6 Disclosure of interests of solicitors
- 11:2-6.7 Stocks and principal stockholders

- 11:2-6.8 Nominees and directors
- 11:2-6.9 Remuneration and other transactions with management and others
- 11:2-6.10 Bonus, profit sharing and other remuneration plans
- 11:2-6.11 Pension and retirement plan
- 11:2-6.12 Options, warrants or rights
- 11:2-6.13 Authorization or issuance of stock
- 11:2-6.14 Mergers, consolidations, acquisitions and similar matters
- 11:2-6.15 Restatement of accounts
- 11:2-6.16 Matters not required to be submitted
- 11:2-6.17 Amendment of charter, bylaws or other documents

SUBCHAPTER 7. INFORMATION REQUIRED BY PARTICIPANTS IN PROXY SOLICITATION IN ELECTION CONTESTS

- 11:2-7.1 Required information

SUBCHAPTER 8. (RESERVED)

SUBCHAPTER 9. INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

- 11:2-9.1 Definitions
- 11:2-9.2 Transactions exempted from the operation of N.J.S.A. 17:17B-2
- 11:2-9.3 Filing of statements under N.J.S.A. 17:17B-1
- 11:2-9.4 Ownership of more than 10 percent of an equity security under N.J.S.A. 17:17B-1
- 11:2-9.5 Disclaimer of beneficial ownership under N.J.S.A. 17:17B-1
- 11:2-9.6 Exemptions from N.J.S.A. 17:17B-1 and 2
- 11:2-9.7 Exemption from Act of securities purchased or sold by odd-lot dealers
- 11:2-9.8 Transferable options, puts, calls, spreads and straddles
- 11:2-9.9 Ownership of securities held in trust
- 11:2-9.10 Exemption from N.J.S.A. 17:17B-1; small transactions
- 11:2-9.11 Exemption from N.J.S.A. 17:17B-2 of transactions which need not be reported under N.J.S.A. 17:17B-1
- 11:2-9.12 Exemption from N.J.S.A. 17:17B-2—certain transactions effected in connection with a distribution
- 11:2-9.13 Exemption from N.J.S.A. 17:17B-2—acquisitions of shares of stock and stock options under certain stock bonus, stock option or similar plans
- 11:2-9.14 Exemption from N.J.S.A. 17:17B-2—certain transactions in which securities are received by redeeming other securities
- 11:2-9.15 Exemption of long-term profits incident to sales within six months of exercise of an option
- 11:2-9.16 Exemption from N.J.S.A. 17:17B-2—certain acquisitions and dispositions of securities pursuant to merger or consolidations
- 11:2-9.17 Exemption from N.J.S.A. 17:17B-2—certain securities received upon surrender of similar equity securities
- 11:2-9.18 Exemption from N.J.S.A. 17:17B-2—certain transactions involving exchange of similar securities
- 11:2-9.19 Exemption from N.J.S.A. 17:17B-3—certain securities
- 11:2-9.20 Exemption from N.J.S.A. 17:17B-3—certain transactions effected in connection with a distribution
- 11:2-9.21 Exemption from N.J.S.A. 17:17B-3—sales of securities to be acquired
- 11:2-9.22 Arbitrage transactions under N.J.S.A. 17:17B-5
- 11:2-9.23 Instructions for Form A
- 11:2-9.24 Form A
- 11:2-9.25 Instructions for Form B
- 11:2-9.26 Form B

SUBCHAPTER 10. (RESERVED)

SUBCHAPTER 11. RULES GOVERNING ADVERTISEMENT OF HEALTH INSURANCE

- 11:2-11.1 Purpose, general provisions and definitions
- 11:2-11.2 Advertisements in general
- 11:2-11.3 Advertisements of benefits payable, losses covered or premiums payable

INSURANCE GROUP

- 11:2-11.4 Necessity for disclosing policy provisions relating to renewability, cancellability and termination
- 11:2-11.5 Method of disclosure of required information
- 11:2-11.6 Endorsements by third parties
- 11:2-11.7 Use of statistics
- 11:2-11.8 Inspection of policy
- 11:2-11.9 Identification of plan or number of policies
- 11:2-11.10 Disparaging comparisons and statements
- 11:2-11.11 Jurisdictional licensing
- 11:2-11.12 Identity of insurer
- 11:2-11.13 Group or quasi-group implications
- 11:2-11.14 Introductory, initial or special offers
- 11:2-11.15 (Reserved)
- 11:2-11.16 Service facilities
- 11:2-11.17 Statements about an insurer
- 11:2-11.18 Insurers' responsibility and control; advertising file; certificate of compliance
- 11:2-11.19 Penalties
- 11:2-11.20 Prior regulation superseded
- 11:2-11.21 Effective date
- 11:2-11.22 Severability

SUBCHAPTER 12. MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE

- 11:2-12.1 Introduction
- 11:2-12.2 Definitions
- 11:2-12.3 Applicability
- 11:2-12.4 Fictitious arrangement prohibited
- 11:2-12.5 Premiums and policy forms
- 11:2-12.6 Statistics
- 11:2-12.7 Producers
- 11:2-12.8 Compulsory participation prohibited
- 11:2-12.9 Tie-in sales prohibited
- 11:2-12.10 Disclosure required
- 11:2-12.11 Underwriting standards
- 11:2-12.12 Cancellation and nonrenewal
- 11:2-12.13 Compulsory facilities
- 11:2-12.14 Eligibility
- 11:2-12.15 Severability

SUBCHAPTER 13. GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT

- 11:2-13.1 Scope
- 11:2-13.2 Definition of group type basis and member
- 11:2-13.3 Effective date of discontinuance for nonpayment of premium or subscription charges
- 11:2-13.4 Requirements for notice of discontinuance
- 11:2-13.5 Extension of benefits
- 11:2-13.6 Continuance of coverage in situations involving replacement of one carrier by another
- 11:2-13.7 Provisions as favorable
- 11:2-13.8 Separability of provisions
- 11:2-13.9 Effective date

SUBCHAPTER 14. (RESERVED)

SUBCHAPTER 15. INSOLVENT INSURERS

- 11:2-15.1 Cancellation of property and liability policies

SUBCHAPTER 16. GUARANTEED ARREST BOND CERTIFICATES OF AUTOMOBILE CLUB UNDERTAKING

- 11:2-16.1 General provisions

SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES

- 11:2-17.1 Purpose
- 11:2-17.2 Scope
- 11:2-17.3 Definitions
- 11:2-17.4 Miscellaneous rules
- 11:2-17.5 Misrepresentation of policy provisions

- 11:2-17.6 Rules for replying to pertinent communications
- 11:2-17.7 Rules for prompt investigation and settlement of claims
- 11:2-17.8 Rules for fair and equitable settlements and reasonable explanations applicable to all insurance
- 11:2-17.9 Rules for fair and equitable settlements applicable to life and health
- 11:2-17.10 Rules for fair and equitable settlements applicable to property and liability insurance
- 11:2-17.11 Written notice by insurer of payment of third-party claims
- 11:2-17.12 Examinations
- 11:2-17.13 Special claims reports
- 11:2-17.14 Separability
- 11:2-17.15 Penalties

SUBCHAPTER 18. READABLE POLICIES

- 11:2-18.1 Purpose
- 11:2-18.2 Scope
- 11:2-18.3 Definitions
- 11:2-18.4 Minimum readability standards
- 11:2-18.5 Procedures for requesting an opinion of compliance with the Plain Language Law
- 11:2-18.6 Enforcement
- 11:2-18.7 Separability

EXHIBIT A REQUEST FOR OPINION AS TO COMPLIANCE WITH PLAIN LANGUAGE LAW

EXHIBIT B AFFIDAVIT OF COMPLIANCE

SUBCHAPTERS 19 THROUGH 22. (RESERVED)

SUBCHAPTER 23. ADVERTISEMENT OF LIFE INSURANCE AND ANNUITIES

- 11:2-23.1 Purpose
- 11:2-23.2 Applicability
- 11:2-23.3 Definitions
- 11:2-23.4 Form and content of advertisements in general
- 11:2-23.5 Disclosure requirements
- 11:2-23.6 Identification of insurer, plan and number of policies
- 11:2-23.7 Jurisdictional licensing and status of insurer; statements about the insurer
- 11:2-23.8 Insurers' responsibility and control; advertising file; certificate of compliance
- 11:2-23.9 Failure to comply
- 11:2-23.10 Severability

SUBCHAPTERS 24 THROUGH 25. (RESERVED)

SUBCHAPTER 26. ANNUAL AUDITED FINANCIAL REPORTS

- 11:2-26.1 Purpose
- 11:2-26.2 Scope
- 11:2-26.3 Definitions
- 11:2-26.4 Filing of annual audited financial reports; extensions
- 11:2-26.5 Contents of annual audited financial report
- 11:2-26.6 Qualifications of independent certified public accountants
- 11:2-26.7 Certification by independent certified public accountant
- 11:2-26.8 Consolidated or combined audits
- 11:2-26.9 Scope of examination and report
- 11:2-26.10 Notification of adverse financial condition
- 11:2-26.11 Report on significant deficiencies in internal controls
- 11:2-26.12 Accountant's letter of qualifications
- 11:2-26.13 Availability and maintenance of workpapers
- 11:2-26.14 Exemptions
- 11:2-26.15 Alien insurers
- 11:2-26.16 Confidentiality of documents
- 11:2-26.17 Penalties
- 11:2-26.18 Severability

SUBCHAPTER 27. DETERMINATION OF INSURERS IN A HAZARDOUS FINANCIAL CONDITION

- 11:2-27.1 Purpose and scope
- 11:2-27.2 Definitions

- 11:2-27.3 Determination of hazardous financial condition; factors
- 11:2-27.4 Determination of hazardous financial condition; corrective action

SUBCHAPTER 28. CREDIT FOR REINSURANCE

- 11:2-28.1 Purpose and scope
- 11:2-28.2 Definitions
- 11:2-28.3 Reinsurer licensed in New Jersey
- 11:2-28.4 Reinsurer accredited in New Jersey
- 11:2-28.5 Reinsurer domiciled and licensed in another state or jurisdiction which employs substantially similar standards to this subchapter
- 11:2-28.6 Reinsurer maintaining trust funds
- 11:2-28.7 Credit for reinsurance required by law
- 11:2-28.8 Reduction from liability for reinsurance ceded to an unauthorized assuming insurer
- 11:2-28.9 Trust agreements qualified pursuant to N.J.A.C. 11:2-28.8
- 11:2-28.10 Letters of credit qualified pursuant to N.J.A.C. 11:2-28.8
- 11:2-28.11 Other security
- 11:2-28.12 Reinsurance contract
- 11:2-28.13 Contracts affected

APPENDIX

SUBCHAPTER 29. ORDERLY WITHDRAWAL OF INSURANCE BUSINESS

- 11:2-29.1 Purpose and scope
- 11:2-29.2 Definitions
- 11:2-29.3 General provisions
- 11:2-29.4 Elements of proposed plan of orderly withdrawal
- 11:2-29.5 Replacement; non-renewal
- 11:2-29.6 Confidentiality of plan of orderly withdrawal
- 11:2-29.7 Fines and penalties
- 11:2-29.8 Severability

SUBCHAPTER 30. (RESERVED)

SUBCHAPTER 31. MANNER OF DETERMINING PREMIUM FOR PERPETUAL HOMEOWNERS INSURANCE

- 11:2-31.1 Purpose
- 11:2-31.2 Scope
- 11:2-31.3 Definitions
- 11:2-31.4 Determination of premium
- 11:2-31.5 Data filed; examination
- 11:2-31.6 Penalties

SUBCHAPTER 32. CUSTODIAL DEPOSITS

- 11:2-32.1 Purpose and scope
- 11:2-32.2 Definitions
- 11:2-32.3 Deposits with custodian; establishment of fees
- 11:2-32.4 Compliance dates
- 11:2-32.5 Penalties

SUBCHAPTER 33. WORKERS' COMPENSATION SELF-INSURANCE

- 11:2-33.1 Purpose and scope
- 11:2-33.2 Definitions
- 11:2-33.3 Exemption from insuring compensation liability; filing requirements
- 11:2-33.4 Renewals
- 11:2-33.5 Confidentiality
- 11:2-33.6 Cancellation of exemption
- 11:2-33.7 Failure to comply with subchapter; denial of exemption
- 11:2-33.8 Severability

APPENDIX. EXHIBIT A THROUGH EXHIBIT E

SUBCHAPTER 34. SURPLUS LINES INSURANCE: ALLOCATION OF PREMIUM TAX AND SURCHARGE

- 11:2-34.1 Purpose and scope
- 11:2-34.2 Definitions
- 11:2-34.3 Allocation of premium tax and surcharge
- 11:2-34.4 Duty to file allocation form
- 11:2-34.5 Duty to keep records
- 11:2-34.6 Penalties

APPENDIX. SURPLUS LINES PREMIUM TAX AND ALLOCATION SCHEDULE

SUBCHAPTER 35. RELIEF FROM INSURER OBLIGATIONS UNDER THE FAIR AUTOMOBILE INSURANCE REFORM ACT OF 1990

- 11:2-35.1 Purpose and scope
- 11:2-35.2 Definitions
- 11:2-35.3 Application procedures and filing format
- 11:2-35.4 Informational filing requirements
- 11:2-35.5 Relief
- 11:2-35.6 Hearings

SUBCHAPTER 36. RISK RETENTION GROUPS AND PURCHASING GROUPS

- 11:2-36.1 Purpose and scope
- 11:2-36.2 Definitions
- 11:2-36.3 Risk retention group registration requirements
- 11:2-36.4 Additional risk retention groups requirements
- 11:2-36.5 Notice and registration requirements of purchasing groups
- 11:2-36.6 Fines and penalties

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

SUBCHAPTER 37. PRODUCER-CONTROLLED INSURERS

- 11:2-37.1 Purpose
- 11:2-37.2 Scope
- 11:2-37.3 Definitions
- 11:2-37.4 Filing of Producer-Controlled Insurer Information Report
- 11:2-37.5 Contents of the Producer-Controlled Insurer Information Report
- 11:2-37.6 Confidentiality of documents
- 11:2-37.7 Penalties

APPENDIX A

SUBCHAPTER 38. TEMPORARY WAIVER FROM INCREASE IN PROPERTY AND CASUALTY CAPITAL AND SURPLUS REQUIREMENTS

- 11:2-38.1 Purpose and scope
- 11:2-38.2 Definitions
- 11:2-38.3 Requests for temporary waiver of capital and surplus requirements
- 11:2-38.4 Fines and penalties
- 11:2-38.5 (Reserved)
- 11:2-38.6 (Reserved)

SUBCHAPTER 39. INCREASE IN CAPITAL AND SURPLUS REQUIREMENTS FOR INSURERS

- 11:2-39.1 Purpose and scope
- 11:2-39.2 Definitions
- 11:2-39.3 RBC reports
- 11:2-39.4 Company action level event

11:2-39.5	Regulatory action level event
11:2-39.6	Authorized control level event
11:2-39.7	Mandatory control level event
11:2-39.8	Filings of RBC Plans
11:2-39.9	Hearings
11:2-39.10	Confidentiality and prohibition on announcements
11:2-39.11	Supplemental provisions
11:2-39.12	Foreign insurers
11:2-39.13	Severability clause
11:2-39.14	Notices
11:2-39.15	Phase-in provision

SUBCHAPTER 40. LIFE, HEALTH AND ANNUITY REINSURANCE AGREEMENTS

11:2-40.1	Purpose and scope
11:2-40.2	Definitions
11:2-40.3	Reinsurance agreements
11:2-40.4	Agreements or conditions precluding reduction of liability or inclusion as an asset
11:2-40.5	Exceptions to agreements or conditions precluding reduction of liability or inclusion as an asset
11:2-40.6	Additional standards
11:2-40.7	Penalties
11:2-40.8	Severability

APPENDIX

SUBCHAPTER 41. WINDSTORM MARKET ASSISTANCE PROGRAM

11:2-41.1	Purpose and scope
11:2-41.2	Definitions
11:2-41.3	Creation of the Windstorm MAP
11:2-41.4	Governing committee
11:2-41.5	Plan of operation
11:2-41.6	Informal Referral Program ("IRP")
11:2-41.7	Formal Assistance Program ("FAP") application process
11:2-41.8	Right to petition for appeal to the Commissioner
11:2-41.9	Reports
11:2-41.10	Windstorm deductibles

APPENDIX A

SUBCHAPTER 1. ADMISSION REQUIREMENTS FOR FOREIGN AND ALIEN LIFE AND HEALTH INSURERS

11:2-1.1 Purpose

This subchapter establishes the procedures, requirements and standards which govern the application of foreign and alien insurers engaged in the business of life and health insurance for a certificate of authority to transact the business of insurance in this State.

11:2-1.2 Scope

This subchapter applies to all foreign and alien insurers that apply for a certificate of authority to transact the business of life and health insurance in this State. The filing requirements contained in this subchapter shall not apply to the continuation, renewal or timely reinstatement of existing certificates of authority except where the Commissioner, pursuant to law, shall otherwise require.

11:2-1.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

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

"Committee on Admissions" means the advisory committee within the Department appointed by the Commissioner to aid in the review of applications for admission to transact the business of insurance in this State and to render to the Commissioner recommendations as to the disposition of such applications.

"Department" means the Department of Insurance of this State.

"IRIS" means the NAIC Insurance Regulatory Information System.

"NAIC" means National Association of Insurance Commissioners.

11:2-1.4 General eligibility requirements

(a) In order for a foreign or alien insurer to be admitted as a life and health insurer in this State, the requirements in this section shall be satisfied in addition to any other requirements in this subchapter or any other provision of law.

1. The applicant shall satisfy the Commissioner that its condition or methods of operation are not such as would render its operation hazardous to the public or its policyholders in this State. In determining whether a hazardous financial condition exists, the factors identified in N.J.A.C. 11:2-27.3 shall be considered. A hazardous financial condition shall exist when those factors indicate, either singly or in combination of two or more, that the financial condition of any applicant which has applied to transact, or is already transacting the business of insurance in any jurisdiction, is considered by the Commissioner to be hazardous to the policyholders, stockholders, claimants, creditors, or the general public. The Commissioner shall further consider any other fact or circumstance that indicates that an insurer's operations may be hazardous.

2. The applicant shall satisfy at least the minimum capital and surplus requirements of a similar domestic insurer of this State for all lines of insurance that it is authorized to write pursuant to the certificate of authority issued by its place of domicile, whether or not the applicant desires to transact any of those lines of insurance in this State, subject to the following:

i. In determining whether an applicant meets the minimum capital and surplus requirements, the following shall be deducted from unassigned funds:

(1) The statement value of any and all special deposits not held for the protection of all policyholders;

(2) Reserves and losses reinsured with companies not authorized in New Jersey, accredited as reinsurers in New Jersey, or otherwise in compliance with N.J.S.A. 17:51B-1 et seq., net of any offsets;

(3) The statement value for the portion of assets held in excess of investment limitations for life and health insurers pursuant to N.J.S.A. 17B:20-1 et seq.;

(4) Reserve shortfalls caused by the company holding reserves weaker than those mandated by N.J.S.A. 17B:19, or such other standards provided by administrative rule, actuarial guidelines, or determined necessary by actuarial analysis;

(5) The excess of the statement value over the market value of bonds held by the applicant; and

(6) Off balance sheet guarantees and contingent liabilities for which the company has not previously established a liability in an appropriate amount.

ii. Capital and surplus requirements may be reduced to the level required for the kinds of insurance actually being marketed if the applicant:

(1) Does not transact one or more of the kinds of insurance contained in the certificate of authority issued by its state or country of domicile; and

(2) Submits a resolution by its board of directors stating that it will refrain from transacting the kind(s) of insurance permitted by the certificate of authority issued by its state or country of domicile.

3. The applicant shall be deemed ineligible if any one of the following conditions exist:

i. An applicant which has received from the NAIC a "first priority" designation for the calendar year next preceding its application date shall not be considered for admission until such designation has been removed by the NAIC;

ii. An applicant which is a member of an insurance holding company system, where its parent or subsidiary has received from the NAIC a "first priority" designation, shall not be considered for admission until such designation has been removed by the NAIC; or

iii. An applicant which has total adjusted capital of less than its company action level risk-based capital or which has otherwise triggered a company action level event, as these terms are defined in N.J.A.C. 11:2-39, as of December 31 of the preceding calendar year, shall not be considered for admission until the applicant's status has improved.

4. The applicant shall be deemed to have its application deferred if any one of the following conditions exist:

i. An applicant which has been identified as "second or third priority" and/or has failed four or more IRIS tests shall have its application deferred until it has demonstrated to the Commissioner and its place of domicile that the IRIS test results are not indicative of a financial condition that may be hazardous to the policyholders, stockholders, claimants, creditors or the general public; or

ii. An applicant which has failed to file with the NAIC an annual statement for the prior year shall have its application deferred until it has filed with the NAIC such annual statement.

5. The applicant shall satisfy the following seasoning requirements:

i. Subject to the provisions of this subchapter, no applicant shall be considered for a certificate of authority to transact the business of insurance in this State unless the Commissioner has been furnished with evidence that the applicant has been authorized by its state or country of domicile to engage in the kind(s) of insurance business for which the applicant seeks a certificate of authority, and has in fact been actively, continuously and successfully engaged in such business, without a change in control, for a period of at least five years prior to the date of the application for the New Jersey certificate of authority.

ii. An applicant qualified under (a)5i above shall demonstrate that:

(1) During any three of the last five years, including therein the two most recent years of business operations, it generated a net gain from operations, after Federal taxes, as reported in the annual statement;

(2) Surplus has not decreased over the five-year period in question except for dividends to policyholders, reserve strengthening and increases in the asset valuation reserve; and

(3) It has received either an evaluation acceptable to the Department from Dun and Bradstreet or one of the top three ratings from one of the following: Standard and Poor's, Duff and Phelps, Moody's, A.M. Best or other nationally recognized rating agency.

iii. The Commissioner may, upon request of an applicant, on a case by case basis, waive in the case of (a)5iii(1), (2) and (3) below, or reduce in the case of (a)5iii(1) below, the five-year seasoning requirements of (a)5i and ii above. In determining whether a reduction or waiver is appropriate in a particular case, the Commissioner shall consider whether the requirements of this section have been satisfied, and, in addition, whether the requirements described in (a)5iii(1) through (4) below, if applicable, have been satisfied. These requirements relate, respectively, to the following circumstances:

3. Some rate, coverage, underwriting or substantial service advantage is provided which is not available from the same insurer on a nonplan basis.

“Personal property-liability insurance” shall mean all forms of personal lines, fire, allied lines, casualty, marine and inland marine insurance and insurance to which Sections 17:17-1 et seq. and 39:6A et seq. of the insurance law applies.

11:2-12.3 Applicability

This regulation shall be applicable only to insurance policies issued or renewed in this State and is in addition to, and not in substitution for, other applicable requirements of the insurance law and Department regulations. The requirements of this regulation are not applicable to methods of marketing other than mass marketing plans.

Case Notes

Mass marketing of property and liability insurance rules discussed in holding that plaintiff failed to present sufficient evidence to infer that defendants conspired to give defendant medical malpractice insurer a monopoly in the New Jersey medical malpractice field, that defendants engaged in an unlawful boycott or that defendants conspired to drive plaintiff out of business. *Owens v. Aetna Life & Casualty Co.*, 654 F.2d 218 (3rd Cir.1981), certiorari denied 102 S.Ct. 657, 454 U.S. 1092, 70 L.Ed.2d 631 (1981).

11:2-12.4 Fictitious arrangement prohibited

No insurer shall sell insurance pursuant to a mass marketing plan to members of any association or organization formed principally for the purpose of obtaining such insurance.

11:2-12.5 Premiums and policy forms

(a) Premiums under a mass market plan shall comply with the filing requirements and with the standards in the insurance law, including the standards that rates not be excessive, inadequate, or unfairly discriminatory. Rates shall not be deemed to be unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expenses factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy.

(b) Prior to the sale or use of any mass marketing plan in New Jersey, the individual or master policy forms and certificates of insurance of such plan shall first be filed with and approved by the Commissioner.

11:2-12.6 Statistics

An insurer selling insurance pursuant to mass marketing plans shall maintain separate statistics as to loss and expense experience pertinent to each individual plan only if such individual plan provides some rate or coverage advantage not available from the same insurer on a nonplan basis.

11:2-12.7 Producers

No person shall act as an insurance agent or an insurance broker in connection with a mass marketing plan for any kind of insurance unless such person is duly licensed, under N.J.S.A. 17:22A-1 et seq. as an insurance agent or broker for such kind of insurance in such insurance plan.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Editorial changes only.

11:2-12.8 Compulsory participation prohibited

No insurer shall sell insurance pursuant to a mass marketing plan if it is a condition of employment or of membership in an association, organization or other group that any employee or member purchase insurance pursuant to such plan, or if any employee or member shall be subject to any penalty by reason of his nonparticipation. The fact that a nonparticipant does not voluntarily enjoy the benefits of any employer contribution shall not be deemed a penalty.

11:2-12.9 Tie-in sales prohibited

(a) No insurer shall sell insurance pursuant to a mass marketing plan if:

1. The purchase of insurance available under such plan is contingent upon the purchase of any other insurance, product or service; or
2. The purchase or price of any other insurance, product, or service is contingent upon the purchase of insurance available under such plan.

(b) This provision shall not be deemed to prohibit the reasonable requirement of safety devices, such as, heat detectors, lightning rods, theft prevention equipment and the like or other kinds of insurance prescribed by law.

11:2-12.10 Disclosure required

Every insurer, agent or broker selling insurance pursuant to a mass marketing plan shall, prior to sale, make full and fair disclosure to prospective employee and member insureds of all features of such plan, whether favorable or unfavorable, including, but not limited to, premium rates, contributions, benefits, exclusions, duration of coverage, policyholder services, conversion privileges available, and the financial interests in the plan, if any, of the sponsoring employer, association, organization or the group. Said disclosure shall be provided in writing and a copy filed with the Department.

Amended by R.1996 d.3, effective January 2, 1996.
See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

11:2-12.11 Underwriting standards

(a) No insurer shall use underwriting standards for individual risk selection in a mass marketing plan which are, on the whole, either less restrictive, unless written with an appropriate charge as contemplated by the insurer's filed

rates, or more restrictive than the standards used by such insurer for individual risk selection in the sale of the same kind of insurance in this State other than pursuant to mass marketing plans.

(b) Underwriting standards used for any mass marketing plan shall be filed with the Commissioner together with individual or master policy forms and certificates used in conjunction with such plan.

11:2-12.12 Cancellation and nonrenewal

(a) The failure of an employer, association, organization or other group to remit premiums when due for any reason (including but not limited to interruption or termination of employment or membership) shall not be regarded as "non-payment of premium" by any employee or member insured under any such plan providing for remittance of premium by such employer, association, organization or other group, unless such insured shall have been given written notice of such failure to remit and shall not himself have paid such premium by the later of ten days after such notice or the due date of such premium remittance under the mass marketing plan.

(b) Any insurer which delivers in this State to any employer, association or organization a contract of insurance pursuant to the application or request of such employer, association or organization, acting for an insured other than itself, shall be deemed to have authorized such employer, association or organization to receive on its behalf payment of any premium which is due on such contract at the time of its issuance or delivery. Moneys collected for premiums for a mass marketing plan shall be kept in a separate account for the benefit of insured employees or members.

(c) Unless otherwise covered by statute, regulation or policy, all mass marketing plans shall provide those insured under such plan with an opportunity to purchase individual equivalent coverage in the same insurer upon termination of employment or membership or upon the discontinuance of the mass marketing plan. The insured employee or member may maintain his policy in force upon payment of the premium applicable to the class of risk to which he belongs on an individual basis. The option to maintain the insurance in force shall be exercised within 30 days following the date of termination.

(d) Any notice of cancellation or nonrenewal of any policy of an employee or member insured under a mass marketing plan shall be accompanied by a notice to the employee or member that, at his request, the insurer will afford the employee or member, and the employer, association, organization or other group a reasonable opportunity to consult with the insurer and to present facts in opposition to cancellation or nonrenewal.

11:2-12.13 Compulsory facilities

An insurer, agent or broker selling insurance pursuant to a mass marketing plan shall, with respect to any employees or members who apply for but are denied insurance under such plan and are not otherwise insured, assist such persons in their efforts to obtain insurance through any other appropriate voluntary or mandatory insurance plan, such as, the New Jersey Automobile Insurance Plan or the plans of the New Jersey Insurance Underwriting Association.

11:2-12.14 Eligibility

(a) Any employer, association, or organization domiciled or principally located in New Jersey may be eligible for a mass marketed insurance plan if 25 or more employees or members are enrolled to participate upon inception of the plan.

(b) Size of group and number of participant requirements are not applicable where the employer, association or organization having some employees or members in New Jersey is domiciled or principally located outside of New Jersey, provided such employer, association or organization has its mass marketing plan approved by such other state.

11:2-12.15 Severability

If any provision of this regulation or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this regulation, and to this end each Section of this regulation is declared to be severable.

SUBCHAPTER 13. GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT

11:2-13.1 Scope

This regulation shall be applicable to all life and accident and health insurance policies and subscriber contracts issued, amended or provided by an insurance company or a nonprofit service corporation on a group or group type basis. However, this regulation shall not apply to contracts issued in connection with temporary disability benefits or workmen's compensation laws.

As amended, R.1975 d.129, eff. April 24, 1975.
See: 7 N.J.R. 114(b), 7 N.J.R. 276(c).

11:2-13.2 Definition of group type basis and member

(a) The term "group type basis" means a benefit plan, other than "salary savings" or "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

1. Coverage is provided through insurance policies or subscriber contracts to classes of employees, members or debtors defined in terms of conditions pertaining to employment, membership or indebtedness.

2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group.

3. There are arrangements for bulk payment of premiums or subscription charges to the insurer or nonprofit service corporation.

4. There is sponsorship of the plan by the employer, union, association or creditor.

(b) The term "member" will hereinafter be construed to include employee, debtor or any other individuals who are a part of a particular organization or group.

11:2-13.3 Effective date of discontinuance for nonpayment of premium or subscription charges

(a) If a policy or contract subject to these rules and regulations provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(b) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making premium payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

11:2-13.4 Requirements for notice of discontinuance

(a) Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved to notify members covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise, in any instance in which the plan involves member contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

(b) The carrier will prepare and furnish to the policyholder or other entity at the same time a supply of a notice form to be distributed to the members concerned, indicating such discontinuance and the effective date thereof and urging the members to refer to their certificates or contracts in order to determine what rights, including but not limited to, privileges of conversion if any are available to them upon such discontinuance.

(c) Discontinuance of the group policy will not serve to reduce the specified time limit which must be satisfied for the furnishing of notice of claim or proof of loss.

11:2-13.5 Extension of benefits

(a) Every group policy or other contract subject to these rules and regulations hereafter issued, or under which the level of benefits is hereafter altered, modified or amended, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract, as required by the following paragraphs of this Section.

(b) In case of a group life plan which contains a disability benefit extension of any type (for example, premium waiver extension, extended death benefit in event of total disability or payment of income for a specified period during total disability), the discontinuance of the group policy shall not operate to terminate such extension.

(c) In the case of a group plan providing benefits for loss of time from work or specified indemnity during hospital confinement, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement.

(d) In the case of hospital, medical or dental expense coverages, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered reasonable if it provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverages, and under other types of hospital, medical or dental expense coverages, other than for maternity, provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force (such as, an accident). For hospital or medical expense coverages related to maternity, any extension of benefits or accrued liability shall be considered reasonable if benefits are provided for expenses incurred in connection with maternity resulting from conception prior to the date of discontinuance of the group policy.

(e) Any applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the policy's or contract's regular benefit limits (for

example, benefits ceasing at exhaustion of a benefit period or of maximum benefits).

As amended, R.1975 d.109, effective April 24, 1975.
See: 7 N.J.R. 114(b), 7 N.J.R. 276(a).

11:2-13.6 Continuance of coverage in situations involving replacement of one carrier by another

(a) This Section shall indicate the carrier responsible for liability in those instances in which one carrier's contract replaces a plan of similar benefits of another.

(b) The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

(c) Liability of succeeding carriers is governed by the following:

1. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier's plan of benefits.

2. Each person not covered under the succeeding carrier's plan of benefits in accordance with paragraph 1 of this subsection must nevertheless be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective:

i. The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan;

ii. Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:

(1) The date the individual becomes eligible under the succeeding carrier's plan as described in paragraph 1 above;

(2) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage (for example, at termination of employment or ceasing to be an eligible dependent, as the case may be);

(3) In the case of an individual who was totally disabled, and in the case of a type of coverage for which Section 5 of this Subchapter requires an extension or accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by Section 5 of this Subchapter, or if the prior carrier's policy or contract is not subject to that Section, would have been required of that carrier had its policy or contract been subject to Section 5 of this Subchapter at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

3. In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lesser of:

i. The benefits of the new plan determined without application of the preexisting conditions limitation; and

ii. The benefits of the prior plan.

4. The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. The definition of waiting period includes, but is not limited to, the period of time required to be satisfied before maternity benefits become available. The aggregate period of time to be applied may be the greater of that required by either the prior plan or the succeeding plan. But in any event, the aggregate period of time will be satisfied by taking into consideration the full portion of the waiting period satisfied under the prior plan. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan, but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

5. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available of pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purpose of this Section, benefits of the prior plan will be determined in accordance with all the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

As amended, R.1975 d.109, eff. April 24, 1975.
See: 7 N.J.R. 114(b), 7 N.J.R. 276(a).

11:2-13.7 Provisions as favorable

No policy of group insurance and no certificate thereunder shall be delivered or issued for delivery in this State if such policy or certificate contains any provision inconsistent with any of the provisions of this rule, except that such policy may contain provisions which in the opinion of the Commissioner are as favorable as the provisions herein required.

As amended, R.1975 d.109, effective April 24, 1975.
See: 7 N.J.R. 114(b), 7 N.J.R. 276(a).

11:2-13.8 Separability of provisions

If any provision of this regulation or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect the provisions or applications of this regulation which can be given effect without the invalid provision or application, and for this purpose the provisions of this regulation are separable.

11:2-13.9 Effective date

This regulation shall become effective on February 1, 1975.

SUBCHAPTER 14. (RESERVED)

SUBCHAPTER 15. INSOLVENT INSURERS**11:2-15.1 Cancellation of property and liability policies**

Whenever an insurer is declared insolvent by a court of competent jurisdiction, or its business is suspended under the laws of its state of incorporation, or its certificate of authority is revoked by this State, the company's insurance policies shall be deemed cancelled by said insurer if the policy is terminated at the request of the policyholder. The insurer thereupon shall be obligated to return the unearned premiums including the unearned commissions to the policyholder.

R.1974 d.190, effective July 16, 1974.
See: 6 N.J.R. 323(a).

**SUBCHAPTER 16. GUARANTEED ARREST
BOND CERTIFICATES OF AUTOMOBILE
CLUB UNDERTAKING**
11:2-16.1 General provisions

(a) Whenever a domestic or foreign surety company which has qualified to transact surety business in this State,

in any year, becomes surety in an amount not to exceed \$500.00 with respect to any guaranteed arrest bond certificates issued in such year by an automobile club or association by filing with the Commissioner of Insurance an undertaking thus to become surety, such undertaking shall state:

1. The name and address of the automobile club or clubs or automobile association or associations with respect to guaranteed arrest bond certificates of which the surety company undertakes to be surety;

2. The unqualified obligation of the surety company to pay the fine or forfeiture in an amount not to exceed \$500.00 of any person who, after posting a guaranteed arrest bond certificate with respect to which the surety company has undertaken to be surety, failed to make the appearance for which the guaranteed arrest bond certificate was posted.

(b) Such finding shall be filed with the Commissioner 10 days prior to its effective date. If such undertaking is terminated, the Commissioner of Insurance shall be notified as promptly as possible but not later than the effective date of such termination.

(c) Any undertakings to become surety that are in effect at this time shall be filed with the Commissioner of Insurance in accordance with the above within 30 days of the effective date of this regulation.

R.1974 d.282, effective October 11, 1974.
See: 6 N.J.R. 322(a), 6 N.J.R. 437(a).
Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Increased maximums in (a) from \$200.00 to \$500.00.

**SUBCHAPTER 17. UNFAIR CLAIMS
SETTLEMENT PRACTICES**
11:2-17.1 Purpose

N.J.S.A. 17:29B-4(9) and 17B:30-13.1 prohibit insurers from engaging in unfair claims settlement practices. The purpose of this subchapter is to promote the fair and equitable treatment of claimants by defining certain minimum standards for the settlement of claims which, if violated with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices in the business of insurance.

Case Notes

Immunity provided to New Jersey Full Insurance Underwriting Association servicing carriers for judgments arising from policy claims does not extend to acts outside scope of duties under contract that rise to level of bad faith. *Miglicio v. HCM Claim Management Corp.*, 288 N.J.Super. 331, 672 A.2d 266 (L.1995).

11:2-17.2 Scope

This subchapter applies to all persons and all policies except the following: ocean marine, fidelity and surety, boiler and machinery and workers' compensation. It shall also not apply to commercial property and liability policies for which the annual premium is more than \$10,000 and where the claim is made by the commercial insured. This subchapter is not exclusive, and other acts, not herein specified, may also be found to constitute unfair claims settlement practices. This subchapter is not intended to supersede any other rule or regulation.

11:2-17.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"After market part" means sheet metal or plastic parts which constitute the exterior of an automobile, including inner and outer panels, manufactured by any manufacturer other than the original manufacturer of the part. Examples of after market parts include, but are not limited to, the following: doors, hoods, fenders, trunk lids, grills and bumper components.

"Catastrophe" means a calamity or other disastrous event that causes widespread losses resulting in excessive claims volume.

"Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

"Claims settlement" means all the activities of an insurer relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy, and which result in a claim payment or acceptance, compromise or rejection.

"First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or less covered by such policy or contract.

"Insurer" means any person, corporation, association, partnership, company, fraternal benefit society, eligible unauthorized surplus lines insurer and any other legal entity engaged as an indemnitor or contractor in the business of insurance. For the purposes of this subchapter, "insurer" shall include any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

"Investigation" means all activities of an insurer related directly or indirectly to the determination of liabilities under coverages afforded by an insurance policy.

"Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

"Pertinent communication" means all correspondence as well as conversations or other forms of communication that are materially related to the handling of a claim.

"Policy" means any contract of insurance and includes, but is not limited to, all policies, contracts, certificates, riders and endorsements which provide insurance coverage.

"Proof of loss" means the necessary documentation required from a claimant to establish entitlement to payment or benefits under a policy.

"Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

"Workers' compensation" includes, but is not limited to, Longshoreman's and Harbor Workers' Compensation.

Amended by R.1988 d.480, effective October 17, 1988.

See: 20 N.J.R. 1159(a), 20 N.J.R. 2578(a).

Added definition "after market part".

Petition for Rulemaking.

See: 25 N.J.R. 6065(a).

11:2-17.4 Miscellaneous rules

(a) Every insurer shall distribute copies of this subchapter to every person directly responsible for the handling and settlement of claims subject to this subchapter. Every insurer shall satisfy itself that all such responsible persons are thoroughly conversant with and are complying with this subchapter.

(b) All correspondence to a claimant required of an insurer pursuant to this subchapter shall be written in easy to read and understandable terms. This subsection shall not apply to correspondence to a claimant's legal representative.

11:2-17.5 Misrepresentation of policy provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent, broker, or insurer shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.