CHAPTER 2

INSURANCE GROUP

Authority

N.J.S.A. 17:1C-6(e).

Source and Effective Date

R.1991 d.4, effective November 30, 1990.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).

Executive Order 66(1978) Expiration Date

Chapter 2, Insurance Group, expires on November 30, 1995.

Chapter Historical Note

Chapter 2, Insurance Group, was originally filed and became effective prior to September 1, 1969. 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. See: Source and Effective Date.

See subchapter and section annotations for specific rulemaking activity.

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

Authority

N.J.S.A. 17:1C-6(e) and (i), 17:1-8 and 8.1, 17B:17-1 et seq., 17B:23-1 et seq., and 17B:23-5.

Source and Effective Date

R.1995 d.80, effective February 6, 1995.
See: 26 N.J.R. 4586(a), 27 N.J.R. 559(a).

Subchapter Historical Note

Subchapter 1, originally Educational Requirements for Licensing, was repealed by R.1989 d.192, effective April 3, 1989. See: 20 N.J.R. 1152(a), 21 N.J.R. 899(b).

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:

(1) The applicant is a wholly-owned subsidiary of a life and health insurer which has been authorized to transact the business of insurance in this State for at least five years or is an affiliate of a life and health insurer which has the same ultimate parent and which has been authorized to transact the business of insurance in this State for at least five years. The Commissioner shall be satisfied as to the financial condition and methods of operation of the authorized insurer who shall effectively guaranty, by a resolution in a form prescribed by the Commissioner and passed by its board of directors, the minimum capital and surplus requirements required by law of the applicant during the first 10 years of its operation in this State. In the case of an authorized affiliate with the same ultimate parent, the Commissioner may require that the guarantee be provided by the ultimate parent. The applicant shall also be required to demonstrate a sound plan of operation and that surplus has not decreased over the five-year period in question, or such shorter time as the applicant has been operating under current control, except as provided in (a)5ii(2) above.

(2) The applicant is a wholly-owned subsidiary of an insurer which has been authorized to transact the business of insurance in this State for at least one year, and secured admission into this State by having been in operation for at least five years pursuant to (a)5i and ii above. The Commissioner shall be satisfied as to the financial condition and methods of operation of the authorized insurer, which shall effectively guaranty, by a resolution in a form prescribed by the Commissioner and passed by its board of directors, the minimum capital and surplus requirements required by law of the applicant during the first 10 years of its operation in this State. The insurer parent shall also be required to have either an evaluation acceptable to the Department from Dun and Bradstreet, or one of the top two ratings from at least one of the following: Standard and Poor's, Duff and Phelps, Moody's, A.M. Best or other nationally recognized rating agency.

(3) The applicant is the continuing corporation resulting from a merger or consolidation of insurers, at least one of which has been authorized in this State to transact the kind(s) of insurance business for which the applicant seeks a New Jersey certificate of authority and has been actively engaged in such insurance business for at least five years and is currently in good standing. The applicant shall also be required to demonstrate a sound plan of operation.

(4) The applicant, being an insurance company with a non-insurance company parent, has completed three full years of operation without a change in control, and, subsequent to its first two years of operation, has available a filed examination report conducted by its state of domicile, which report is in accordance with Department standards for examinations. The first two full years of operation covered by the examination report shall be sufficient to make the report useful and meaningful to the Department. The applicant shall also be required to have experienced profitable operations in two of the three years, including the most current year of business, and shall demonstrate a sound plan of operation. Additionally, the applicant shall obtain or satisfy all of the following:

(A) A financial guaranty from its ultimate parent, in a form prescribed by the Commissioner, that the applicant will maintain the minimum capital and surplus required by law for a period of 10 years from the date of admission;

(B) The ultimate parent must be a United States corporation actively engaged in business for a period of not less than five years prior to the date of application for the New Jersey certificate of authority;

(C) The ultimate parent shall have either an evaluation acceptable to the Department from Dun and Bradstreet or one of the top two ratings from at least two of the following for at least three years prior to application: Standard and Poor's, Duff and Phelps, and Moody's; and

(D) The ultimate parent shall have a net worth of at least $25,000,000, excluding investments in insurance or insurance related subsidiaries, which amount shall be set by the Commissioner upon his or her consideration of the general financial condition of the parent and relevant underwriting factors such as, but not limited to, the volume to be written and the type of risk, and any other factors which the Commissioner, in his or her discretion, shall consider to be appropriate.

iv. The Commissioner may initiate proceedings to revoke authorization for non-compliance with the requirements set forth in (a)5iii above.

6. The applicant shall procure a New Jersey certificate of authority by establishing compliance with the applicable requirements of N.J.S.A. 17B:17–1 et seq. and 17B:23–1 et seq. relating to authorization of foreign and alien insurers to transact the business of life and health insurance in this State, and by successfully completing an admissions process which shall include a detailed review by the Commissioner of the business affairs and financial condition of the applicant as provided by this subchapter.

(b) An applicant shall submit a letter of intent consisting of the preliminary information set forth in N.J.A.C. 11:2–1.5 prior to making a formal application for admission.

11:2–1.5 Letter of intent

(a) Prior to the acceptance of a final application for a certificate of authority in this State, all foreign and alien insurers who desire to transact the business of life and health insurance in this State shall submit, as a preliminary application, a letter of intent, which shall include, where applicable, the information required in (a)1 through 9 below.

1. The name of the applicant;

2. The name of any person, as defined in this subchapter, or other entity, by whom the applicant is controlled;

3. The applicant's insurance holding company registration statements including the holding company systems chart for the most recent five years;

4. The name of any insurer(s) currently licensed, or applying for admission, in this State with whom the applicant is affiliated;

5. The kind(s) of insurance proposed to be written by the applicant in this State;

6. A certified copy of the applicant's most recent annual statement, prepared on the NAIC annual statement forms used by New Jersey domestic insurers;

7. A certified copy of the applicant's current certificate of authority from its place of domicile;

8. The results of the most recent NAIC IRIS tests and related communications concerning the applicant, which shall satisfy the requirements of N.J.A.C. 11:2–1.4(a)4i–ii; and

9. The risk-based capital report as of December 31 for the calendar year next preceding its application date, as filed with the insurance regulatory official of its state of domicile. If the state of domicile does not have a risk-based capital statute or regulation substantially similar to N.J.A.C. 11:2–39, the applicant shall submit a risk-based capital report prepared in accordance with N.J.A.C. 11:2–39.

11:2–1.6 Final application

(a) After the submission of the letter of intent as required by N.J.A.C. 11:2–1.5, the applicant, upon notice from the Department, shall file the following items:

1. A copy of its charter as currently in force, certified by the lawful custodian of the original document;

2. A copy of its bylaws as currently in force, certified by a senior officer of the insurer;

3. Seven copies of the current annual statement, including all supplemental exhibits;

4. One copy of the annual statement for each of the past four years, including all supplemental exhibits;

5. An analysis of par/non-par profits and surplus;

6. A certificate of valuation, certified by the insurance commissioner of the insurer's state or country of domicile;

7. A certificate of compliance certified by the insurance commissioner of the insurer's place of domicile;

8. A certified copy of a report of the most recent examination of the insurer's affairs by the Department or its equivalent, of the place in which the insurer is domiciled;

9. A document appointing the Commissioner as attorney for service of process;

10. An application for admission, on a form to be prescribed and provided by the Department, including the payment of a non-refundable application fee of $5,000 for an admissions application and $2,500 for an application for an extension of authority;

11. A copy of the applicant's quarterly financial statements for the current year, in the NAIC format, and for such other periods of time as shall be required by the Commissioner;

12. Where applicable, a certified copy of the filing made pursuant to the holding company act of the place of domicile, for the last fiscal period, supplemented as necessary to meet the requirements of N.J.S.A. 17:27A–3(a) and (b) and applicable Securities and Exchange Commission filing requirements;

13. A statement of ownership of the applicant which shall include all shareholders of record who control five percent or more of the outstanding shares of the applicant, directly or indirectly;

14. A copy of any agreements by which the right to conduct or influence any of the affairs of the applicant is transferred to others;

15. Any employment or deferred compensation agreements in which any officer, director or shareholder who controls five percent or more of the outstanding shares of the applicant, directly or indirectly, participates;

16. Any tender offer materials (advertisements, invitations, etc.), if any tender offer has been made by the insurer or its parent to acquire another company within the three years preceding;

17. Biographical affidavits, to be completed by all directors and senior officers on a form prescribed and provided by the Department;

18. A calculation of adjusted surplus as described in N.J.A.C. 11:2–1.4(a)2i and completed in accordance with the instructions and worksheets provided by the Department;

19. Details of any circumstances within the past three years where the applicant has received a rating of less than one of the top three ratings from any rating agency or an indication that less than one of the top three ratings would be given if published;

20. A corporate plan of operation consisting of:

i. A schedule listing the following:

(1) All jurisdictions in which the applicant has applied for authorization to transact the business of insurance during the preceding 10 years and the dates and results of such applications;

(2) All jurisdictions from which the applicant has withdrawn during the preceding 10 years, and the reasons for withdrawal; and

(3) All administrative, civil or criminal actions, orders, proceedings and determinations thereof to which the applicant, or its affiliates, or any of its directors or principal officers has been subject, due to an alleged violation of any law governing insurance operations in any jurisdiction during the preceding 10 years. Where the alleged violation is a felony (or its equivalent in a jurisdiction which does not use this designation of a crime) such actions, orders, proceedings and determinations shall include violations not related to insurance operations. If a license has been refused, suspended or revoked by any jurisdiction, the applicant shall furnish an explanation and a copy of any orders, proceedings, and determinations related thereto;

ii. A description of the applicant's present business plan(s) for conducting an insurance business, including, but not limited to:

(1) Geographical areas in which business is being written;

(2) The types of insurance to be written;

(3) Marketing methods;

(4) A summary of the methods of establishing premium rates;

(5) Investment strategy, including a description of controls in place to ensure that the strategy is followed;

(6) Five-year financial projections including premium volume and income by line of business; capital, surplus and risk-based capital levels; and

(7) A description of agency systems, including any managing general agency contracts;

iii. A description of the applicant's proposed plan for conducting an insurance business in this State, including, but not limited to:

(1) The geographical area in which business is intended to be done;

(2) The types of insurance intended to be written;

(3) Proposed marketing methods;

(4) Proposed methods for the establishment of premium rates;

(5) A five-year forecast of anticipated premiums in this State by line of business; and

(6) Proposed agency systems;

iv. A summary of the applicant's reinsurance program on assumed business, indicating the name of the ceding insurers, retentions, maximum risks, types of business, types of agreements, and any other information which may, in the opinion of the Department, be relevant to this part of the applicant's operations. Additional information may be requested by the Department in order to supplement or clarify information already provided by the applicant;

v. A summary of the applicant's reinsurance program on ceded business, indicating the name of the reinsurers, retentions, maximum risks, types of business, types of contracts, and any other information which may, in the opinion of the Department, be relevant to this part of the applicant's operations. Additional information may be requested by the Department in order to supplement or clarify information already provided by the applicant;

vi. The number and ratio of complaints as defined by the place of domicile to the number of policies in the place of domicile, for those lines of business in which the state or country of domicile makes such determinations; and

vii. Copies of all management, exclusive agency, administrative services, or any other operating contracts with affiliates or non-affiliates, where applicable, signed by the parties and certified to by the insurer's secretary and chief operating officer;

21. If the applicant is a foreign insurer, evidence of a certificate of deposit, certified by the commissioner of the place of domicile, confirming the deposit made therewith and that such deposit satisfies the requirements of the insurer's place of domicile;

22. If a United States branch of an alien insurer, the applicant shall provide the Department with:

i. A certificate of deposit certified by its insurance commissioner showing the amount in trust for policyholders which shall be sufficient to satisfy the requirements of N.J.S.A. 17B:22–3;

ii. A certified copy of power of attorney in favor of its United States manager; and

iii. A certified copy of a deed of trust to the trustee of the applicant's funds; and

23. If the applicant is an alien insurer, a statement of trusteed surplus in the United States.

11:2–1.7 Review procedures; appeals

(a) Upon receipt of a final application, the Commissioner shall conduct a thorough background investigation and review which shall include the information contained in N.J.A.C. 11:2–1.4, 1.5 and 1.6, inquiries regarding claims settlement practices and any other information which, in the opinion of the Commissioner, may be necessary to make an appropriate decision regarding the application.

(b) The applicant shall ensure that all filings submitted to the Department are current. Any amendment, changes or replacements to documents on file shall be timely updated.

(c) Applications accepted after November 1 of each year shall not be reviewed until the next annual statement becomes available and is received for review. The review of such applications shall begin as of April 1 of each year, after the receipt of annual statements which shall be submitted no later than March 1 of each year.

(d) Before a decision on an application is made, the Department may request from an applicant, in writing, any additional information it may require. Failure by an applicant to respond to written inquiries by the Department within 45 days may be considered grounds for rejection of the application.

(e) Application reviews shall be conducted by the Department on a monthly basis. The Department's Committee on Admissions shall make a recommendation to the Commissioner concerning each application which has been reviewed. The Commissioner shall consider the recommendation and make his or her decision on the application within 10 working days from receipt of the recommendation. Written notice of the decision shall be mailed to the applicant by certified mail within 10 working days of the date of the Commissioner's decision.

(f) When the Commissioner rejects an application, the notice of rejection shall include a statement specifying the reasons for the rejection. Such notice shall inform the applicant of the right:

1. To request an informal Departmental review of the rejection within 20 days of receipt of the notice of rejection; and

2. To provide the Department with a written statement, including supporting documentation, if any, disputing with specificity the reasons for rejection within 30 days of the receipt of the notice of rejection.

(g) Upon timely receipt of the request for Departmental review and the written statement of the applicant, if any, the Department shall promptly review the application, attached documents, Department records and the written statement. In appropriate circumstances, the Commissioner may provide the applicant with an opportunity to present its position in person. If, after reviewing the record, the Commissioner determines that the applicant has failed to qualify, the Commissioner shall promptly so inform the applicant.

(h) Where an application has been rejected, the applicant shall not be eligible to reapply until there is one full year or more of acceptable experience.

11:2–1.8 Compliance

This subchapter shall apply to all applicants submitting a letter of intent on or after April 1, 1995. Applicants whose applications have been received by the Department prior to April 1, 1995, may elect to proceed under this subchapter if they so notify the Department no later than May 1, 1995. Applicants whose letters of intent have been received by the Department prior to April 1, 1995, who do not timely notify the Department that they wish to proceed under this subchapter, shall have their application reviewed under the procedures preexisting this subchapter.

11:2–1.9 Severability

If any provisions of this subchapter or the application thereof to any person or circumstance is held invalid, the remainder of the subchapter and the application of such

provision to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 2. INSURANCE ON FINANCED AUTOMOBILES

11:2–2.1 Return of unearned premiums

(a) N.J.S.A. 17:16D–14(a) requires that whenever a financial insurance contract is cancelled, the insurer on notice of such financing shall return whatever gross unearned premiums are due under the insurance contract to the premium finance company for the account of the insured or insureds.

(b) Upon the effective date of this regulation, such unearned premiums shall be remitted by insurers to finance companies not later than 60 days after the effective date of cancellation, or 60 days after the completion of any payroll audit necessary to determine the amount of premium earned while the policy was in force. Such audit shall be performed within 30 days after the effective date of cancellation.

As amended, R.1982 d.167, effective August 25, 1972.
See: 4 N.J.R. 103(d), 4 N.J.R. 221(a).

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

Subchapter Historical Note

Unless otherwise expressly noted, all provisions of this Subchapter 3 were adopted by the Commissioner, Department of Insurance, pursuant to authority delegated at N.J.S.A. 17:29B–1 to 17:29N–14, Chapter 169, P.L. 1958 and Chapter 40, P.L. 1958, and were filed and became effective April 2, 1959.

11:2–3.1 Scope

All life insurance and all accident and health insurance sold in connection with loans or other credit transactions shall be subject to the provisions of this subchapter except such insurance sold in connection with first mortgage loans made to individual borrowers for the purpose of purchasing residential real estate.

Amended by R.1990 d.44, effective January 16, 1990 (operative March 18, 1990).
See: 21 N.J.R. 3052(a), 22 N.J.R. 233(a), 22 N.J.R. 392(a).
Deleted text specifying a loan or other credit transaction of more than five years' duration and replaced with phrase: "first mortgage ... real estate."

11:2–3.2 Definitions

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

"Commissioner" means Commissioner of Insurance.

"Credit accident and health 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.

"Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction and may include disability benefits commonly described as "waiver of premiums" or "extended death benefit" if provided without a separate premium charge. This definition shall not prevent the inclusion in a life insurance contract of other disability benefits, but such other benefits shall be considered credit accident and health insurance for the purposes of this subchapter.

"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.

"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.

"Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

11:2–3.3 Forms

(a) Credit life insurance and credit accident and health insurance shall be issued only in either of the following forms:

1. Individual policies of life insurance issued to debtors on the term plan;

2. Individual policies of accident and health insurance issued to debtors on a term plan, or disability provisions in individual policies of credit life insurance;

3. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; or

4. Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability provisions in group life policies to provide such coverage.

11:2–3.4 Amount

(a) The amount of credit life insurance issued in connection with a specific loan or other credit transaction shall not exceed the indebtedness.

(b) Where an indebtedness repayable in substantially equal installments is secured by an individual policy of credit life insurance, the amount of insurance shall at no time exceed the approximate unpaid indebtedness and, where secured by a group policy of credit life insurance shall at no time exceed the exact amount of unpaid indebtedness.

(c) The amount of indemnity payable in connection with a specific loan or other credit transaction by credit accident and health 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 payment shall not exceed the original indebtedness divided by the number of periodic installments.

11:2–3.5 Term

(a) The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor which may be deemed to be the date from which interest or finance charges on the indebtedness accrue, if 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.

(b) Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, then if such evidence is determined by the insurer to be satisfactory, the term of the insurance shall commence on the date on which such evidence is furnished, and in such event that there shall be an appropriate refund or adjustment of any charge to the debtor for the insurance.

(c) 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.

(d) If the indebtedness is discharged due to prepayment, the insurance in force shall be terminated and, 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.

(e) In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in Section 3.14 (Refund) of this Chapter.

11:2–3.6 Policy provisions; disclosure to debtors

(a) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or in the case of group insurance, by a certificate of group insurance which shall be delivered to the insured debtor at the time the indebtedness is incurred or within 30 days thereafter, except as provided in Section 3.8 (Application or notice of proposed insurance) of this Chapter.

(b) Each individual policy or certificate of group insurance shall, in addition to other requirements of law, set forth the following information:

1. The name and home office address of the insurer;

2. The identity of the person or persons insured, by name or otherwise;

3. The amount and term of the coverage which, in the case of group insurance, may be by description rather than by stated amount and term;

4. The payment for insurance, in the case of an individual policy, or the rate or amount of payment, in the case of a group policy, if any, collected from the debtor separately in connection with credit life insurance and credit accident and health insurance;

5. The circumstances under which refunds of premiums or payments for insurance collected from debtors are payable pursuant to the provisions of Section 3.14 (Refunds) of this Chapter; and

6. A description of the insurance coverage including any exceptions, limitations or restrictions, and in addition a statement that the benefits shall be paid to the creditor to reduce or extinguish any unpaid indebtedness to the creditor and, where the amount of insurance exceeds any such unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor, or to his estate.

(c) A payment for such insurance is deemed to have been collected from the debtor if an amount therefor is separately stated or is included in a total charge for insurance and other services.

11:2–3.7 Delivery of policy; procedures

The insurer shall arrange with the creditor for the establishment of procedures for delivery of the individual policy or certificate of group insurance to the debtor upon the insurance becoming effective, or within 30 days of the date upon which the indebtedness is incurred and shall make periodic reviews to determine the effectiveness of such procedures.

11:2–3.8 Application or notice of proposed insurance

(a) If an individual policy or certificate of group insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or

a notice of proposed insurance signed by the debtor shall be delivered to the debtor at the time such indebtedness is incurred, setting forth the following information:

1. The name and home office address of the insurer;

2. The name or names of the debtor proposed for insurance;

3. The rate or amount of payment, if any, collected from the debtor separately in connection with credit life insurance and credit accident and health insurance;

4. The amount and term of the coverage provided which, in the case of group insurance, may be by description rather than by stated amount and term; and

5. A brief description of the coverage provided.

(b) Such application for an individual policy or notice of proposed group insurance shall include in substance a statement that, if the insurance is declined by the insurer or otherwise does not become effective, any premium or payment for insurance collected from the debtor will be refunded to him pursuant to the provisions of Section 3.14 (Refunds) of this Chapter.

(c) The copy of the application for an individual policy and the notice of proposed insurance shall refer exclusively to insurance coverage and be set forth in a separate instrument, except that it may be included in the loan, sale or other credit statement of account, agreement or other such instrument if set forth therein in type at least equal in size and prominence to the type used for the other provisions thereof.

(d) If included in the loan, sale or other credit statement of account, agreement or other such instrument, such application or notice must be set forth in a separate provision, except that the name of the debtor proposed for insurance, any figures relating to the amount and term of the coverage, and the rate or amount of payment, if any, collected from the debtor may be set forth elsewhere in the instrument.

(e) The application or notice of proposed insurance shall provide that, upon acceptance by the insurer, the insurance coverage provided shall become effective at the time determined as set forth in Section 3.5 (Term) of this Chapter.

11:2–3.9 Filing

No individual or group policy of credit life insurance or credit accident and health insurance shall be issued for delivery in this State, and no application, binder, endorsement, rider, certificate of group insurance, notice of proposed insurance, or other form pertaining to credit life insurance or credit accident and health insurance under such policy shall be issued for delivery or used in this State, on or after the effective date of this Subchapter unless such forms and the premium rates and refund formulas therefor have been filed with the Commissioner and such filing has been acknowledged in writing by him prior to such issuance or use, and has not been disapproved.

11:2–3.10 Group policy; delivery

(a) No credit life insurance or credit accident and health insurance shall be effected in this State on a debtor under a group policy, regardless of where or when issued, commencing with the effective date of this Subchapter in the case of a new policy and with the policy anniversary date on or after the effective date of this Subchapter in the case of an existing policy, unless a certificate of group insurance or a notice of proposed insurance as required by Sections 3.6 (Policy provision; disclosure to debtors) and 3.8 (Application or notice of proposed insurance) of this Chapter, is delivered to the debtor.

(b) The certificate or notice of proposed insurance shall be on a form filed with the Commissioner together with the refund formula applicable thereto and acknowledged in writing and not disapproved by him.

(c) If a payment for insurance is collected from the debtor, the amount thereof may not exceed the amount permitted by Section 3.13 (Maximum payment by debtors) of this Chapter, and no such certificate of group insurance or notice of proposed insurance shall be delivered unless the schedule of premiums is also filed with the Commissioner and acknowledged in writing by him.

11:2–3.11 Disapproval by Commissioner

(a) The Commissioner may disapprove any form filed with him pursuant to the provisions of Section 3.9 (Filing) and 3.10 (Group policy; delivery) of this Chapter, for the following reasons:

1. The benefits provided are not reasonable in relation to the premium charge; or

2. It contains provisions which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation.

(b) The issuance or use by an insurer of any form so disapproved is unlawful.

11:2–3.12 Standards for premium rates

(a) The fact that standards are set forth in this Section does not indicate that premium charges in excess of those standards will furnish cause for disapproval of policy forms, as described in Section 3.11 (Disapproval by Commissioner) of this Chapter.

(b) The standards set forth in this Section are derived from studies made by the Department, and are provided to serve as a guide to insurers in preparing filings for credit life insurance and credit accident and health insurance on the term plan.

(c) The benefits to be provided in connection with forms filed with the Commissioner in accordance with Section 3.9 (Filing) of this Chapter shall be deemed prima facie reasonable in relation to the premium charge if the schedule of rates filed with such forms does not exceed the standards set forth in in this Section.

(d) This Section shall not preclude an insurer from filing rates which exceed the standards set forth if the filing conforms to the requirements of N.J.S.A. 17:38A–7.

(e) In determining whether any filing shall be disapproved, the Commissioner will give consideration to available mortality and morbidity data pertaining to the class or classes of debtors to be insured; previous experience, if any, on the debtors of a particular creditor, including the experience of any subsidiary or affiliate of such creditor; available age data and a reasonable rate of expense.

(f) Standards for premium rates for credit life insurance shall be as follows:

1. If premiums are paid monthly on outstanding balances, the monthly premium rate per $1,000 of insurance in force is $0.62.

2. If premiums are paid in one sum for the entire duration of the indebtedness:

Single Premium Rates (Discounted for Interest and Mortality) Per $100.00 of Initial Insured Indebtedness Repayable in Indicated Number of Equal Monthly Installments	
6	$0.22
12	0.40
24	0.75
36	1.09
48	1.42
60	1.74
72	2.05
84	2.35
96	2.64
108	2.92
120	3.19

3. For the purpose of computing the average amount of insurance in force on all debtors of a creditor in paragraphs 1 and 2 of this subsection, there shall be included the insurance in force on all debtors of any subsidiary or affiliate of the creditor whether provided by one or more insurers, unless the Commissioner determines that it is inequitable to do so.

4. As an alternative to the standards set forth in paragraphs 1 and 2 of this subsection, an insurer may, where age data applicable to the insured persons are available, determine premium rates based on such age data and computed in a manner consistent with paragraphs 1 and 2 of this subsection.

5. Standards for premium rates for indebtedness repayable in installments other than as indicated in this subsection shall be the equivalent of the standards set forth in paragraphs 1 and 2 of this subsection.

6. The standards for premium rates set forth in paragraphs 1 and 2 of this subsection are applicable to the type of credit life insurance contract customarily offered for sale. Standards for premium rates in the case of forms which vary in any material respect from this standard type of credit life insurance contract shall reflect such variations to the extent that there is a measurable difference in the cost of the coverage provided.

(g) Standards for premium rates for credit accident and health insurance shall be as follows:

1. If premiums are paid in one sum for the entire duration of the indebtedness, the following rates per $100.00 of initial indebtedness repayable in indicated number of equal monthly installments:

Number of Equal Monthly Installments	Single Premium Rates per $100.00 of Initial Indebtedness	
	Column I	Column II
6	$1.28	$1.43
12	1.71	1.90
24	2.05	2.28
36	2.26	2.52
48	2.49	2.76
60	2.66	2.95
72	2.80	3.12
84	2.95	3.29
96	3.11	3.45
108	3.24	3.60
120	3.35	3.72

2. The premium rates set forth in paragraph 1 of this subsection are for contracts providing benefits commensurate with the amount of insured indebtedness payable after the 14th day of disability retroactive to the first day of disability, and shall be applicable as follows:

i. Column I shall be applicable for such contracts which contain a provision excluding or denying claim for disability resulting from preexisting illness, disease or physical condition, whether or not by name or specific description, which totally disabled the debtor at any time during the six-month period immediately preceding the effective date of the debtor's coverage, but contain no other provision which excludes or restricts liability in the event of disability caused in a certain specified manner, except as further provided in this paragraph.

ii. Column II shall be applicable for such contracts which contain a provision that no claim for disability shall be reduced or denied on the ground that an illness, disease or physical condition of a debtor, not excluded from coverage at the time the debtor's insurance becomes effective by name or specific description in an amendment or rider signed by the debtor, had existed prior to the effective date of the debtor's coverage, but contain no other provision which excludes or restricts liability in the event of disability caused in a certain specified manner, except as further provided in this paragraph.

iii. Any contract to which either Column I or Column II rates apply may, however, contain provisions excluding or restricting coverage in the event of pregnancy, intentionally self-inflicted injuries, foreign travel or residence, travel or flight in nonscheduled aircraft, war or military service.

3. Standards for premium rates for indebtedness repayable in installments other than as indicated in paragraph 1 of this subsection shall be consistent with the above standards.

4. If premium rates are payable other than in one sum, an insurer may determine such rates on a basis consistent with the above rates, taking into consideration interest and mortality.

5. The standards for premium rates set forth in paragraphs 1 and 2 of this subsection are applicable to the two forms of credit accident and health insurance described which are illustrative of the kinds of coverage that may be issued. Nothing in this subsection, however, shall preclude an insurer from filing other forms of credit accident and health insurance for the consideration of the Commissioner. Standards for premium rates for contracts providing benefits on a basis different from those described in this subsection shall be consistent with the standards set forth in this subsection.

(h) Standards for premium rates for contracts combining credit life and credit accident and health coverage in one policy shall be consistent with the standards set forth in subsection (f) and (g) of this Section.

(i) Commencing with the policy anniversary date of a group policy which occurs on or after the effective date of this Subchapter, the insurer shall use certificates of group insurance and notices of proposed insurance as required by this Subchapter with a premium rate for the coverage provided which does not exceed the applicable schedules filed with the Commissioner.

(j) An insurer may from time to time revise its schedule of premium rates for policies of credit life insurance and credit accident and health insurance and shall file such revised schedules with the Commissioner.

Amended by R.1990 d.44, effective January 16, 1990 (operative date March 18, 1990).
See: 21 N.J.R. 3052(a), 22 N.J.R. 233(a), 22 N.J.R. 392(a).
In (f)1: deleted tables for insurance amounts and monthly premium rates and added text, "the monthly ... is $0.62."
In (f)2: deleted tables for insurance amounts and single premium rates and added revised table for "single premium rates ...."
In (g)1: revised table of monthly installments and single premium rates by changing rates for monthly installments ranging from 6 to 36 months and adding rates for installments from 48 to 120 months.

11:2–3.13 Maximum payments by debtors

(a) The amount collected from a debtor for credit life or credit accident and health insurance shall not exceed the premium charged by the insurer; provided, that if the amount collected from a debtor is determined in a single sum but the premium charged by the insurer is not, the amount so collected from a debtor shall not exceed the lesser of:

1. The single premium rate set forth in Section 3.12 (Standards for premium rates) of this Chapter, or such higher single premium rate consistent with such premiums to be charged by the insurer pursuant to that Section; and

2. The aggregate of the premiums to be charged by the insurer.

(b) The amount determined in accordance with either subsection (a)1 or 2 of this Section shall be computed as of the time the amount collected from the debtor is determined.

(c) Nothing in this Subchapter shall be construed to legalize any charge now illegal under any statute or rule of law governing credit transactions.

11:2–3.14 Refunds

(a) Each individual policy or group certificate of credit life insurance and credit accident and health insurance for which a payment is collected from the debtor shall provide that, in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund due of premium or of an amount collected from the debtor for insurance shall be paid or credited promptly to the insured debtor.

(b) If a creditor collects a payment from a debtor for credit life insurance and credit accident and health insurance and such insurance does not become effective, the creditor shall immediately give written notice to such debtor and shall promptly refund to or credit to the account of the debtor the amount collected from him for such insurance.

(c) The filing requirement set forth in Section 3.9 (Filing) of this Chapter will be considered satisfied if such refund formulas are set forth in the individual policy or certificate of group insurance filed for the coverages to which such refund formulas relate and the filing of said forms has been acknowledged and not disapproved by the Commissioner.

(d) In the event that the refund formula to be so set forth is the "sum of digits" formula commonly known as the "Rule of 78", it shall be sufficient to so refer to it.

(e) As a guide to insurers in preparing refund formulas, the following system of formulas is acceptable to the Commissioner.

1. The refund of premiums in the case of reducing term credit life insurance on which premiums are payable other than by a single premium and of level-term credit life insurance shall be equal to the pro rata unearned gross premium, and in the case of reducing term credit life insurance paid by a single premium and of credit accident and health insurance shall be equal to the amount computed by the "sum of digits" formula, commonly known as the "Rule of 78".

2. The refund of the amount collected from the debtor for insurance in the case of reducing term credit life insurance where such amount is payable other than in a single sum and of level-term credit life insurance shall be equal to the pro rata unearned gross amount to be collected, and in the case of reducing term credit life insurance where the whole amount thereof is collected from the debtor in a single sum and of credit accident and health insurance shall be equal to the amount computed by the "sum of digits" formula, commonly known as the "Rule of 78".

(f) Nothing contained in subsection (e) of this Section shall preclude insurers from filing other formulas which produce a just, fair and equitable result.

(g) In no event need a refund or credit be made if the amount thereof is less than $1.00.

(h) An insurer shall promptly refund to an individual policyholder and refund or credit to a group policyholder any refund of premium due on termination of insurance prior to the scheduled maturity date of the indebtedness, and a group policyholder or creditor shall promptly refund or credit to the debtor any refund due pursuant to this Section.

11:2–3.15 Maintenance of statistics

(a) Each insurer writing credit life insurance and credit accident and health insurance shall maintain statistics, subject to call by the Commissioner from time to time, on a policy-year basis for group policies and on a calendar-year basis for individual policies with respect to each creditor on whose debtors term insurance is provided, showing on an accrual basis, separately for credit life insurance and credit accident and health insurance and separately for direct business and reinsurance assumed, the following:

1. Gross premiums received;
2. Refunds of premium on terminated insurance;
3. Increase in unearned premium reserve;
4. Earned premiums;
5. Claims paid;
6. Increase in claim reserve;
7. Claims incurred;
8. Reserve increases other than the increases described in paragraphs 3 and 6 of this subsection;
9. Commissions;
10. Fees and other allowances;
11. Dividends and experience rating refunds;
12. Mean amount of life insurance in force; and
13. Mean number of individual policies in force during the calendar year.

(b) With respect to credit accident and health insurance, each insurer shall keep a record for each creditor which, in addition to the statistics set forth in subsection (a) of this Section, shall show the nature of the benefits payable, the applicable waiting period and the rate at which premiums are charged therefor.

11:2–3.16 Issuance of policies

All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.

11:2–3.17 Payment of claims

(a) 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.

(b) 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.

(c) 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.

(d) 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 claim due to the group policyholder subject to audit and review by the insurer.

(e) The insurer shall make periodic audits of claim payments made on its behalf by claim representatives or group policyholders.

11:2–3.18 Existing insurance; choice of insurer

When credit life insurance or credit accident and health 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.

Note Cases

Coborrower failed to produce sufficient direct evidence to raise genuine issue of material fact concerning the validity of primary borrower's consent; charge not proved unconscionable. Jefferson Loan Co., Inc. v. Livesay, 175 N.J.Super. 470, 417 A.2d 1164 (Dist.Ct. 1980).

11:2–3.19 Separability

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

SUBCHAPTER 4. ELECTRONIC DATA PROCESSING EQUIPMENT

Authority

Unless otherwise expressly noted, all provisions of this Subchapter 4 were adopted by the Commissioner, Department of Insurance pursuant to authority delegated at N.J.S.A. 17:23–1, as amended, and were filed and became effective January 5, 1961.

11:2–4.1 Cost of equipment as admitted asset

In determining the financial condition of a domestic or foreign insurance company or the United States branch of an alien insurance company, there shall be allowed as admitted assets the cost of electronic data processing equipment (hardware) purchased by the company, provided that such cost shall be amortized in full over a period not to exceed five calendar years, and provided further that where software is necessary to operate the system, such software shall be included as an asset.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Added provisions necessary in determining hardware and software as assets.

SUBCHAPTER 5. PROXIES, CONSENTS AND AUTHORIZATIONS

11:2–5.1 Applicability

(a) This Subchapter is applicable to all domestic stock insurers having 100 or more stockholders; provided, however, that this Subchapter shall not apply to any insurer if 95 per cent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than 500 stockholders.

(b) A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities and Exchange Act of 1934 and the Securities and Exchange Acts Amendments of 1964 and Regulation X–14 of the Securities and Exchange Commission promulgated thereunder shall be exempt from the provisions of this Subchapter.

11:2–5.2 Solicitation; prohibition

No domestic stock insurer, or any director, officer or employee of such insurer subject to Section 4.1 (Applicability) of this Chapter, or any other person, shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent or authorization in respect of any stock of such insurer in contravention of this Subchapter, and Subchapter 6 (Information Generally) required in proxy statement, and Subchapter 7 (Information Required by Participants in Proxy Solicitation in Election Contest) of this Chapter.

11:2–5.3 Disclosure of equivalent information

Unless proxies, consents or authorizations in respect of a stock of a domestic insurer subject to Section 4.1 (Applicability) of this Chapter are solicited by or on behalf of the management of such insurer from the holders of records of stock of such insurer in accordance with this Subchapter and Subchapter 6 (Information Required in Proxy Statement, Generally) and Subchapter 7 (Information Required by Participants in Proxy Solicitation in Election Contest) prior to any annual or other meeting, such insurer shall, in accordance with this Subchapter, and for such further regulations as the Commissioner may adopt, file with the Commissioner and transmit to all stockholders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

11:2–5.4 Definitions

(a) The definitions and instructions set out in Schedule SIS, as promulgated by the National Association of Insurance Commissioners, shall be applicable for purpose of this Subchapter.

(b) The terms "solicit" and "solicitation" for purposes of this Subchapter include:

1. Any request for a proxy, whether or not accompanied by or included in a form of proxy;

2. Any request to execute or not to execute, or to revoke, a proxy; or

3. The furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(c) The terms "solicit" and "solicitation" shall not include:

1. Any solicitation by a person in respect of stock of which he is the beneficial owner;

2. Action by a broker or other person in respect to stock carried in his name or in the name of his nominee in forwarding to the beneficial owner of such stock soliciting material received from the company; or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy; or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date; or

3. The furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

11:2–5.5 Information to be furnished to stockholders

(a) No solicitation subject to this Subchapter shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Subchapter 6 (Information Required in Proxy Statement, Generally) of this Chapter.

(b) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection (a) of this Section shall be accompanied or preceded by an annual report, in preliminary or final form, to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS under the heading "Financial Reporting to Stockholders." Subject to the requirements of this subsection with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

(c) Two copies of each report sent to the stockholders pursuant to this Section shall be mailed to the Commissioner not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the Commissioner pursuant to subsection (a) of Section 5.7 (Material required to be filed) of this Chapter, whichever date is later.

11:2–5.6 Proxy requirements

(a) The following requirements shall be included in the form of proxy:

1. An indication in boldface type as to whether or not the proxy is solicited on behalf of the management;

2. A specifically designated blank space for dating the proxy; and

3. Clear and impartial identification of each matter or group of related matters intended to be acted upon, whether proposed by the management or stockholders.

(c) Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in boldface type how it is intended to vote the shares or authorization represented by the proxy in each such case.

(d) A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

(e) No proxy shall confer authority either:

1. To vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement; or

2. To vote at any annual meeting other than the next annual meeting, or any adjournment thereof, to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

(f) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to subsection (c) of this Section a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

(g) The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements shall be clearly and legibly presented.

11:2–5.7 Material required to be filed

(a) Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished concurrently to stockholders shall be filed with the Commissioner at least ten days prior to the date definitive copies of such materials are first sent or given to stockholders, of such shorter period prior to that date as the Commissioner may authorize upon a showing of good cause.

(b) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the Commissioner at least two

days, exclusive of Saturdays, Sundays or holidays, prior to the date copies of this material are first sent or given to stockholders, or a shorter period prior to such date as the Commissioner may authorize upon a showing of good cause.

(c) Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the Commissioner not later than the date such material is first sent or given to the stockholders.

(d) Where any proxy statement, form of proxy or other material filed pursuant to this Subchapter is amended or revised, two of the copies shall be marked to clearly show such changes.

(e) Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this Section.

(f) Notwithstanding the provisions of subsections (a) and (b) of this Section, and of subsection (k) of Section 5.10 (Election contests, special provisions) of this Chapter, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by subsection (c) of this Section not later than the date such material is used or published. The provisions of subsections (a) and (b) of this Section and subsection (k) of Section 5.10 (Election contests; special provisions) of this Chapter shall apply, however, to any reprints or reproductions of all or any part of such material.

11:2–5.8 False or misleading statements

No solicitation subject to this Subchapter shall be made by means of any proxy statement, form of proxy, notice of meeting, or other communication, written or oral, containing any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the solicitation of a proxy for the same meeting or subject matter which has become false or misleading.

11:2–5.9 Undated or postdated proxy; prohibition

No person making a solicitation which is subject to this Subchapter shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

11:2–5.10 Election contests; special provisions

(a) This Section shall apply to any solicitation subject to this Subchapter by any person or group for the purpose of opposing a solicitation subject to this Subchapter by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

(b) For purposes of this Section the terms "participant" and "participant in a solicitation" include:

1. The insurer;

2. Any director of the insurer, and any nominee for whose election as a director proxies are solicited; or

3. Any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(c) For the purposes of this Section the terms "participant" and "participant in a solicitation" do not include:

1. A bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant;

2. Any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy solicitating material or performs ministerial or clerical duties;

3. Any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;

4. Any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or

5. Any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

(d) No solicitation subject to this Section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the Commissioner may authorize upon a showing of good cause, there has been filed with the Commissioner by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by Subchapter 7 (Information required by participants in proxy solicitation in election contest) of this Chapter and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Commissioner's comments have been received and complied with.

(e) Within five business days after a solicitation subject to this Section is made by the management of an insurer, or such longer period as the Commissioner may authorize upon a showing of good cause, there shall be filed with the Commissioner, by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Subchapter 7 (Information Required by Participants in Proxy Solicitation in Election Contest) of this Chapter.

(f) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this Section in opposition thereto, a statement in duplicate containing the information specified in Subchapter 7 (Information Required by Participants in Proxy Solicitation in Election Contest) of this Chapter shall be filed with the Commissioner, by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(g) If subsequent to the filing of the statements required by subsections (d) through (f) of this Section, additional persons become participants in a solicitation subject to this Section, there shall be filed with the Commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Subchapter 7 (Information Required by Participants in Proxy Solicitation in Election Contest) of this Chapter, within three business days after such person becomes a participant, or such longer period as the Commissioner may authorize upon a showing of good cause.

(h) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the Commissioner.

(i) Each statement and amendment thereto filed pursuant to subsections (d) through (h) of this Section shall be part of the public files of the Commissioner.

(j) Notwithstanding the provisions of Section 4.5(a) (Information to be furnished to stockholder) of this Chapter, a solicitation subject to this Section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Subchapter 6 (Information Required in Proxy Statement, Generally) of this Chapter, with respect to such solicitation provided that:

1. The statements required by paragraph 3 of this subsection are filed by or on behalf of each participant in such solicitation;

2. No form of proxy is furnished to stockholders prior to the time the written proxy statement required by Section 4.5(a) (Information to be furnished to stockholder) of this Chapter, is furnished to such persons; however, this paragraph shall not apply where a proxy statement then meeting the requirements of Subchapter 6 (Information Required in Proxy Statement, Generally) of this Chapter, has been furnished;

3. At least the information specified in subsections (e) and (f) of this Section, to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

4. A written proxy statement containing the information specified in Subchapter 6 (Information Required in Proxy Statement, Generally) of this Chapter, with respect to a solicitation is sent or given stockholders at the earliest practicable date.

(k) Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by Section 4.5(a) (Information to be furnished to stockholders) of this Chapter shall be filed with the Commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the Commissioner may authorize upon a showing of good cause.

(*l*) Notwithstanding the provisions of Section 4.5(b) and (c) (Information to be furnished to stockholders) of this Chapter, two copies of any portion of the report referred to in Section 4.5(b) (Information to be furnished to stockholders) of this Chapter which comments upon or refers to any solicitation subject to this Section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Commissioner as proxy material subject to this Subchapter. Such portion of the report shall be filed with the Commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to stockholders.

SUBCHAPTER 6. INFORMATION REQUIRED IN PROXY STATEMENT, GENERALLY

11:2–6.1 Revocability of proxy

(a) The proxy statement shall state whether or not the person giving the proxy has the power to revoke it.

(b) If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, the proxy statement shall briefly describe such limitation or procedure.

11:2–6.2 Dissenters' rights of appraisal

(a) The proxy statement shall outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any

statutory procedure required to be followed by such stockholders in order to perfect their rights.

(b) Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, the proxy statement shall state whether the person solicited will be notified of such date.

11:2–6.3 Solicitation by management

(a) If the solicitation is made by the management of the insurer, the proxy statement shall so state.

(b) The proxy statement shall state the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management, and shall indicate the action which he intends to oppose.

11:2–6.4 Solicitation by nonmanagement

(a) If the solicitation is made other than by the management of the insurer, the proxy statement shall state:

1. The names and addresses of the persons by whom and on whose behalf it is made; and

2. The names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

11:2–6.5 Solicitation by specially engaged employees or paid solicitors

(a) If the solicitation is to be made by specially engaged employees or paid solicitors, the proxy statement shall state:

1. The material features of any contract or arrangement for such solicitation and identify the parties; and

2. The cost or anticipated cost thereof.

11:2–6.6 Disclosure of interests of solicitors

The proxy statement shall describe briefly any substantial interest, direct or indirect, by stockholdings or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made other than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

11:2–6.7 Stocks and principal stockholders

(a) As to each class of voting stock of the insurer entitled to be voted at the meeting, the proxy statement shall state:

1. The number of shares outstanding; and

2. The number of votes to which each class is entitled.

(b) The proxy statement shall give the date as of which the record list of stockholders entitled to vote at the meeting will be determined.

(c) If the right to vote is not limited to stockholders of record on that date, the proxy statement shall indicate the conditions under which other stockholders may be entitled to vote.

(d) If action is to be taken with respect to the election of directors, and if the persons solicited have cumulative voting rights, the proxy statement shall state:

1. That they have such rights; and

2. The conditions precedent to the exercise thereof.

11:2–6.8 Nominees and directors

(a) If action is to be taken with respect to the election of directors, the proxy statement shall furnish the following information (in tabular form to the extent practicable) with respect to each person nominated for election as a director and with respect to every other person whose term of office as a director will continue after the meeting:

1. The name of each such person;

2. When his term of office or the term of office for which he is a nominee will expire;

3. All other positions and offices with the insurer presently held by him;

4. Which persons are nominees for election as directors at the meeting;

5. His present principal occupation or employment and the name and principal business of any corporation or other organization in which such employment is carried on;

6. Similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of stockholders at a meeting for which proxies were solicited under this regulation;

7. If he is or has previously been a director of the insurer, the period or periods during which he has served as such; and

8. As of the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such stocks make a statement to that effect.

11:2–6.9 Remuneration and other transactions with management and others

(a) The proxy statement shall furnish the information reported or required in item 1 of Schedule SIS under the heading "Information regarding management and directors" if action is to be taken with respect to:

1. The election of directors;

2. Any remuneration plan, contract or arrangement in which any director, nominee or election as a director, or officer of the insurer will participate;

3. Any pension or retirement plan in which any such person will participate; or

4. The granting or extension to any such person of any options, warrants or rights to purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro rata basis.

(b) If the solicitation is made on behalf of persons other than the management, information shall be furnished only as to Item 1–A of the aforesaid heading of Schedule SIS.

11:2–6.10 Bonus, profit sharing and other remuneration plans

(a) If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan, the insurer furnish the following information:

1. A brief description of the material features of the plan;

2. Each class of persons who will participate therein and the approximate number of persons in each such class;

3. The basis of such participation;

4. The amounts which would have been distributable under the plan during the last calendar year to:

i. Each person named in Section 6.9 (Remuneration and other transactions with management and others) of this Chapter;

ii. Directors and officers as a group; and

iii. All other employees as a group, if the plan had been in effect.

(b) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph 4 of subsection (a) of this Section the nature of such amendments should be specified.

11:2–6.11 Pension and retirement plan

(a) If action is to be taken with respect to any pension or retirement plan of the insurer, the proxy statement shall furnish the following information:

1. A brief description of the material features of the plan;

2. Each class of persons who will participate therein;

3. The approximate number of persons in each such class; and

4. The basis of such participation;

5. The approximate total amount necessary to fund the plan with respect to:

i. Past services;

ii. The period over which such amount is to be paid; and

iii. The estimated annual payments necessary to pay the total amount over such period; the estimated annual payment to be made with respect to current services.

6. The amount of such annual payments to be made for the benefit of:

i. Each person named in Section 6.9 (Remuneration and other transactions with management and others) of this Chapter;

ii. Directors and officers as a group; and

iii. Employees as a group.

(b) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer, or to materially alter the allocation of the benefits as between the groups specified in paragraph 6 of subsection (a) of this Section, the nature of such amendments should be specified.

11:2–6.12 Options, warrants or rights

(a) If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or of any subsidiary or affiliate, other than warrants issued to all stockholders on a pro rata basis, the proxy statement shall furnish the following information:

1. The title and amount of stock called for or to be called for;

2. The prices, expiration dates and other material conditions upon which the warrants may be exercised;

3. The consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants; and

4. The market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

(b) If known, the proxy statement shall state separately the amount of stock called for or to be called for by warrants received or to be received by the following persons, naming each such person:

1. Each person named in Section 6.9 (Remuneration and other transactions with management and others) of this Chapter; and

2. Each other person who will be entitled to acquire five per cent or more of the stock called for or to be called for by such warrants.

(c) If known, the proxy statement shall state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group, and by all such employees, without naming them.

11:2–6.13 Authorization or issuance of stock

(a) If action is to be taken with respect to the authorization or issuance of any stock of the insurer, the proxy statement shall furnish the title, amount and description of the stock to be authorized or issued.

(b) If the shares of stock are other than additional shares of common stock of a class outstanding, the proxy statement shall furnish a brief summary of the following, if applicable:

1. Dividend rights;
2. Voting rights;
3. Liquidation rights;
4. Preemptive rights;
5. Conversion rights;
6. Redemption and sinking fund provisions; and
7. Interest rate and date of maturity.

(c) If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial statements comparable to those contained in the annual report.

11:2–6.14 Mergers, consolidations, acquisitions and similar matters

(a) If action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, the proxy statement shall furnish, in brief outline, the following information:

1. The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon;
2. Any procedure required to be followed by dissenting stockholders in order to perfect such rights;
3. The material features of the plan or agreement;
4. The business done by the company to be acquired or whose assets are being acquired;
5. The high and low sales prices for each quarterly period within two years (if available); and
6. The percentage of outstanding shares which must approve the transaction before it is consummated.

(b) For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

1. A comparative balance sheet as of the close of the last two fiscal years.
2. A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earning per share after related taxes and cash dividends paid per share.
3. A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

11:2–6.15 Restatement of accounts

(a) If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, the proxy statement shall furnish the following information:

1. The nature of the restatement;
2. The date as of which it is to be effective;
3. The reasons for the restatement and for the selection of the particular effective date; and
4. The name and amount of each account affected by the restatement and the effect of the restatement thereon.

11:2–6.16 Matters not required to be submitted

(a) If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, the proxy statement shall state:

1. The nature of such matter;
2. The reason for submitting it to a vote of stockholders; and
3. That action which is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

11:2–6.17 Amendment of charter, bylaws or other documents

If action is to be taken with respect to any amendment of the insurer's charter, bylaws or other documents as to which information is not required above, the proxy statement shall state briefly the reasons for and general effect of such amendment, and the vote needed for its approval.

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

11:2–7.1 Required information

(a) Statements filed by or on behalf of a participant (other than the insurer) in a proxy solicitation in an election contest shall include the following information:

1. The name and address of the insurer.

2. The participant's name and business address.

3. The participant's present principal occupation or employment, and the name, principal business and address of any corporation or other organization in which such employment is carried on.

4. The participant's residence address.

5. Information as to all the participant's material occupations, positions, officers or employments during the last ten years, including:

i. Starting and ending dates of each; and

ii. The name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

6. Whether or not the participant is or has been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, the proxy statement shall:

i. Identify the principals;

ii. State the subject matter;

iii. Describe the participant's relationship to the parties; and

iv. State the outcome.

7. Whether or not during the past ten years the participant has been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors). If so, the proxy statement shall state:

i. The date(s) of conviction;

ii. The nature of conviction;

iii. The name and location of the court; and

iv. The penalty imposed or other disposition of the case.

8. A negative answer to paragraph 7 of this subsection need not be included in the proxy statement or other proxy soliciting material.

9. The amount of each class of stock of the insurer which the participant owns beneficially, directly or indirectly.

10. the amount of each class of stock of the insurer which the participant owns of record but not beneficially.

11. With respect to the stock specified in paragraphs 9 and 10 of this subsection, the proxy statement shall state:

i. The amounts acquired within the past two years;

ii. The dates of acquisition; and

iii. The amounts acquired on each date.

12. If any part of the purchase price or market value of any of the stock specified in paragraphs 9 and 10 of this subsection is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, the proxy statement shall so state and shall indicate the amount of the indebtedness as of the latest practicable date.

13. If any part of the purchase price or market value of any of the stock specified in paragraphs 9 and 10 of this subsection were borrowed or obtained other than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, the proxy statement shall briefly describe the transaction, and state the names of the parties.

14. Whether or not the participant is a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer.

i. If so, the proxy statement shall:

(1) Name the persons with whom such contracts, arrangements or understandings exist; and

(2) Give the details thereof.

ii. Such contracts, arrangements, or understandings include, but are not limited to:

(1) Joint ventures;

(2) Loan or option arrangements;

(3) Puts or calls;

(4) Guarantees against loss or guarantees of profits;

(5) Division of losses or profits; or

(6) The giving or withholding of proxies.

15. The amount of stock of the insurer owned beneficially, directly or indirectly, by each of the participant's associates, and the name and address of each such associate.

16. The amount of each class of stock of any parent, subsidiary or affiliate of the insurer which the participant owns beneficially, directly or indirectly.

17. The time and circumstances under which the participant became a participant in the solicitation, and the nature and extent of the participant's activities or proposed activities as a participant.

18. The approximate amount of any material interest, direct or indirect, of the participant and of each of the participant's associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions to which the company or any of its subsidiaries or affiliates was or is to be a party (where practicable).

19. Whether or not the participant or any of the participant's associates have any arrangement or understanding with any person with respect to:

i. Any future employment by the insurer or its subsidiaries or affiliates; or

ii. Any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

20. If the participant or the participant's associates have such arrangement as described in paragraph 19 of this subsection, the proxy statement shall:

i. Describe such arrangement or understanding; and

ii. State the names of the parties thereto.

21. The signature of the participant and the date, which shall be executed in the following manner:

I certify that the statements made in the above statement are true, complete, and correct, to the best of my knowledge and belief.

(Date) (Signature of participant or authorized representative)

SUBCHAPTER 8. (RESERVED)

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

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

Authority

N.J.S.A. 17:1–8.1 *et seq.*

11:2–9.1 Definitions

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

"Act" means Chapter 57, Public Laws of New Jersey 1965.

"Class" includes all securities of an insurer which are of substantially similar character, and the holders of which enjoy substantially similar rights and privileges.

"Equity security" means:

1. Any stock or similar security,

2. Any voting trust certificate or certificate of deposit for such a security;

3. Any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security;

4. Any such warrant or right.

"Insurer" means any domestic stock insurance company with an equity security subject to the provisions of Chapter 57, Public Laws of New Jersey 1965.

"Officer" means a president, vice president, treasurer, actuary, secretary, controller, or any other person who performs such functions for the insurer which correspond to those performed by the foregoing officers.

Securities "held of record"

1. For the purpose of determining whether the equity securities of an insurer are "held of record" by 100 or more persons, securities shall be deemed to be "held of record" by each person who is identified as the owner of such securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

i. In any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as such an owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record.

ii. Securities identified as held of record by a corporation, a partnership, a trust (whether or not the trustees are named), or other organization shall be included as so held by one person.

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

iv. Securities held by two or more persons as coowners shall be included as held by one person.

v. Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if such securities were registered under the provisions of this rule, they would be held of record by a lesser number of persons.

vi. Securities registered in substantially similar names, where the insurer has reason to believe because of the address or other indications that such names represent the same person, may be included as held of record by one person.

2. Notwithstanding subsection (a) of this Section:

i. Securities held, to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement, shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidence of interest in such securities; provided however, that the insurer may rely in good faith on such information as is received in response to its request from a nonaffiliated insurer of the certificates or evidences of interest.

ii. If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the Act, the beneficial owners of such securities shall be deemed to be the record owners thereof.

11:2–9.2 Transactions exempted from the operation of Section 2 of Act

With respect to the equity securities of the insurer, any acquisition or disposition of any equity security by a director or officer of the insurer within six months prior to the date on which the Act shall first become applicable shall not be subject to the operation of Section 2 of the Act.

11:2–9.3 Filing of statements under Section 1 of Act

(a) Initial statements of beneficial ownership of equity securities required by Section 1 of the Act shall be filed on Form A.

(b) Statements of changes in such beneficial ownership required by Section 1 shall be filed on Form B.

(c) All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

11:2–9.4 Ownership of more than ten per cent of an equity security under Section 1 of Act

(a) In determining, for the purpose of Section 1 of the Act, whether a person is the beneficial owner, directly or indirectly, of more than ten per cent of any class of any equity security (except voting trust certificates or certificates of deposit for equity securities), such class shall be deemed to consist of the total amount of such class outstanding, exclusive of any securities of such class held by or for the account of the insurer or a subsidiary of the insurer.

(b) For the purpose of determining percentage ownership of voting trust certificates or certificates of deposit for equity securities, the class of voting trust certificates or certificates of deposit shall be deemed to consist of the amount of voting trust certificates or certificates of deposit issuable, with respect to the total amount of outstanding equity securities of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not all of such outstanding securities have been so deposited.

(c) For the purpose of this Section a person acting in good faith may rely on the information contained in the latest Convention Form Statement filed with the Commissioner with respect to the amount of securities of a class outstanding, or in the case of voting trust certificates or certificates of deposit, the amount thereof issuable.

11:2–9.5 Disclaimer of beneficial ownership under Section 1 of Act

Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that such person is, for the purpose of the Act, the beneficial owner of any equity securities covered by the statement.

11:2–9.6 Exemptions from Sections 1 and 2 of Act

(a) During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from Sections 1 and 2 of the Act:

1. Executors or administrators of the estate of a decedent;

2. Guardians or committees for an incompetent; and

3. Receivers, trustees in bankruptcy, assignees for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

(b) After the 12–month period following their appointment or qualification, the persons listed in subsection (a) of this Section shall be required to file reports with respect to the securities held by the estates which they administer under Section 1 of the Act. Persons listed in subsection (a) of this Section shall be liable for profits realized from trading in such securities pursuant to Section 2 of the Act only when the estate being administered is a beneficial owner of more than ten per cent of any class of equity security of an insurer subject to the Act.

(c) Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt from Sections 1 and 2 during the time they are held by the insurer.

11:2–9.7 Exemption from Act of securities purchased or sold by odd-lot dealers

Securities purchased or sold by an odd-lot dealer (1) in odd lots so far as reasonably necessary to carry on odd-lot transactions or (2) in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from the provisions of the Act with respect to participation by such odd-lot dealer in such transactions.

11:2–9.8 Transferable options, puts, calls, spreads and straddles

(a) The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed such a change in the beneficial ownership of the security to which such privilege relates as to require the filing of a statement reflecting the acquisition or disposition of such privilege.

(b) Nothing in this Section, however, shall exempt any person from filing the statements required upon the exercise of such option, put, call, spread or straddle.

11:2–9.9 Ownership of securities held in trust

(a) Beneficial ownership of a security for the purpose of Section 1 shall include:

1. The ownership of securities as a trustee where either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust;

2. The ownership of a vested beneficial interest in a trust; and

3. The ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(b) In the event that ten per cent of any class of any equity security of an insurer is held in a trust, that trust and the trustees thereof as such shall be deemed a person required to file the reports specified in Section 1 of the Act, except:

1. Beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of Section 1 where less than 20 per cent in market value of the securities having a readily ascertainable market value held by such trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required;

2. With respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of such securities by the trust is made without prior approval by the settlor or beneficiary.

(c) No exemption pursuant to this Section shall be acquired or lost solely as a result of changes in the value of trust assets during any fiscal year, or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of Section 1.

(d) Not more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or ten per cent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided, that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or ten per cent stockholders.

(e) A person having an interest only as a beneficiary of a trust shall not be required to file any such report so long as he relies in good faith upon an understanding that the trustee of such trust will file whatever reports might otherwise be required of such beneficiary.

(f) As used in this Section the "immediate family" of a trustee means:

1. A son or daughter of the trustee, or a descendant of either;

2. A stepson or stepdaughter of the trustee;

3. The father or mother of the trustee, or an ancestor of either;

4. A stepfather or stepmother of the trustee; or

5. A spouse of the trustee.

(g) For the purpose of determining whether any of the relationships as set forth in subsection (f) of this Section exists, a legally adopted child of a person shall be considered a child of such person by blood.

(h) In determining, for the purpose of Section 1 of the Act, whether a person is the beneficial owner, directly or indirectly, of more than ten per cent of any class of any equity security, the interest of such person in the remainder of a trust shall be excluded from the computation.

(i) No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under Section 1, with respect to his indirect interest in portfolio securities held by:

1. A pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan; or

2. A business trust with over 25 beneficiaries.

(j) Nothing in this Section shall be deemed to impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date.

11:2–9.10 Exemption from Section 1; small transactions

(a) Any acquisition of securities shall be exempt from Section 1 where:

1. The person effecting the acquisition does not within six months thereafter effect any disposition, other than by way of gift, of securities of the same class; and

2. The person effecting such acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six month period during which the acquisition occurs.

(b) Any acquisition or disposition of securities by way of gift, where the total amount of such gifts does not exceed $3,000 in market value for any six-month period, shall be exempt from Section 1 and may be excluded from the computations prescribed in paragraph (a)(2).

(c) Any person exempted by subsection (a) or (b) of this Section shall include in the first report filed by him after a transaction within the exemption a statement showing his acquisitions and dispositions for each six-month period or portion thereof which has elapsed since his last filing.

11:2–9.11 Exemption from Section 2 of Act of transactions which need not be reported under Section 1

Any transaction which has been or shall be exempted from the requirements of Section 1 of the Act shall, insofar as it is otherwise subject to the provisions of Section 2, be likewise exempted from Section 2.

11:2–9.12 Exemption from Section 2—certain transactions effected in connection with a distribution

(a) Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of Section 2 of the Act, to the extent specified in this subsection as not comprehended within the purpose of said Section of the Act, upon the following conditions:

1. The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith in the distribution of such block of securities and in the ordinary course of such business;

2. The security involved in the transaction is:

i. A part of such block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of such block of securities; or

ii. A security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed, or to cover an over-allotment or other short position created in connection with such distribution; and

3. Other persons not within the purview of Section 2 of the Act are participating in the distribution of such block of securities on terms at least as favorable as those on which such person is participating, and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 2 of the Act by this Section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this Section.

(b) The exemption of a transaction pursuant to this Section with respect to the participation therein of one party thereto shall not render such transaction exempt with respect to participation of any other party therein, unless such other party also meets the conditions of this Section.

11:2–9.13 Exemption from Section 2—acquisitions of shares of stock and stock options under certain stock bonus, stock option or similar plans

(a) Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan; or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan; or a stock option pursuant to an employee stock purchase plan; by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of Section 2 of the Act if the plan meets the conditions as set forth in subsections (b) through (e) of this Section.

(b) The plan has been approved, directly or indirectly, in one of the following ways;

1. By the affirmative votes of the holders of a majority of the securities of such insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the State of New Jersey; or

2. By the written consent of the holders of a majority of the securities of such insurer entitled to vote.

(c) If such vote or written consent as stated in subsection (b) of this Section was not solicited substantially in accordance with the proxy rules and regulations prescribed by the National Association of Insurance Commissioners, if any, in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of:

1. The date of the Act first applies to such insurer; or

2. The acquisition of an equity security for which exemption is claimed.

(d) Written information as required by subsection (c) of this Section may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with, or mailed for filing to, the Commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this subsection, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(e) If the selection of any director or officer of the insurer to whom stock may be allocated; or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan; or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer is subject to the discretion of any person, then such discretion shall be exercised only as follows:

1. With respect to the participation of directors:

i. By the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

ii. By, or only in accordance with the recommendations of a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

iii. Otherwise in accordance with the plan, if the plan:

(1) Specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or

(2) Sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

2. With respect to the participation of officers who are not directors:

i. By the board of directors of the insurer, or by a committee of three or more directors; or

ii. By, or only in accordance with the recommendations of a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

3. For the purpose of paragraph 2 of this subsection, a director or committee member shall be deemed to be a disinterested person only if such person is not, at the time such discretion is exercised, eligible, and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated; or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

4. The provisions of paragraph 3 of this subsection shall not apply with respect to any option granted, or other equity security acquired, prior to the date that Sections 1, 2 and 3 of the Act first become applicable with respect to any class of equity securities of any insurer.

(f) As to each participant or as to all participants, the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis or for the duration of the plan, whether or not the plan has a fixed termination date, and may be determined either by fixed or maximum dollar amounts, or by fixed or maximum numbers of shares, or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan, or of stock allocable, or of options outstanding thereunder to prevent dilution or enlargement of rights.

(g) Unless the context otherwise requires, all terms used in this Section shall have the same meaning as in the Act and in Section 1 of these regulations. In addition, the following definitions apply:

1. The term "plan" includes any plan, whether or not set forth in any formal written document or documents, and whether or not approved in its entirety at one time;

2. The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in Sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this Section. The term "restricted stock option" as defined in Section 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this Section, provided however, that for the purposes of this Section an option which meets all of the conditions of Section 424(b) of the Internal Revenue Code of 1954, as amended, other than the date of issuance shall be deemed to be a "restricted stock option."

11:2–9.14 Exemption from Section 2—certain transactions in which securities are received by redeeming other securities

(a) Any acquisition of an equity security (other than a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of Section 2 of the Act upon condition that:

1. The equity security is acquired by way of redemption of another security of an insurer, substantially all of whose assets other than cash (or Government bonds) consist of securities of the insurer issuing the equity security so acquired, and which:

i. Represented substantially and in practical effect a stated or readily ascertainable amount of such equity security;

ii. Had a value which was substantially determined by the value of such equity security; and

iii. Conferred upon the holder the right to receive such equity security without the payment of any consideration other than the security redeemed.

2. No security of the same class as the security redeemed was acquired by the director or officer within six months prior to such redemption or is acquired within six months after such redemption.

3. The insurer issuing the equity security acquired has recognized the applicability of subsection (a) of this Section by appropriate corporate action.

11:2–9.15 Exemption of long-term profits incident to sales within six months of exercise of an option

(a) To the extent specified in subsection (b) of this Section, the Commissioner hereby exempts as not comprehended within the purposes of Section 2 of the Act any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where such purchase is pursuant to the exercise of an option or similar right either:

1. Acquired more than six months before its exercise; or

2. Acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

(b) In respect of transactions specified in subsection (a) of this Section, the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in this Section shall be deemed to enlarge the amount of profit which would inure to such insurer in the absence of this Section.

(c) The Commissioner also hereby exempts, as not comprehended within the purposes of Section 2 of the Act, the disposition of a security, purchased in a transaction specified in subsection (a) of this Section, pursuant to a plan or agreement:

1. For merger or consolidation;

2. Reclassification of the insurer's securities;

3. For the exchange of its securities for the securities of another person which has acquired its assets; or

4. Which is in control, as defined in Section 368(c) of the Internal Revenue Code of 1954, of a person who has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer, except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

(d) The exemptions provided by this Section shall not apply to any transaction made unlawful by Section 3 of the Act, or by any rules and regulations thereunder.

(e) The burden of establishing market price of a security for the purpose of this Section shall rest upon the person claiming the exemption.

11:2–9.16 Exemption from Section 2—certain acquisitions and dispositions of securities pursuant to merger or consolidations

(a) The following transactions shall be exempt from the provisions of Section 2 of the Act as not comprehended within the purpose of said Section:

1. The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, owned 85 per cent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

2. The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to said merger or consolidation, owned 85 per cent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

3. The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, held over 85 per cent of the combined assets of all the companies undergoing merger or consolidation. The percentage of the combined assets so held shall be computed according to their book values prior to the merger or consolidation, as determined by reference to their most

recent available financial statements for a 12–month period prior to the merger or consolidation.

4. The disposition of a security pursuant to a merger or consolidation of an insurer which, prior to said merger or consolidation, held over 85 per cent of the combined assets of all the companies undergoing merger or consolidation. The percentage of the combined assets so held shall be computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a 12–month period prior to the merger or consolidation.

(b) A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock, which is then distributed to the security holders of the insurer which sold its assets.

(c) Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by this Section) of a security in any company involved in the merger or consolidation, and any sale (other than a sale exempted by this Section) of a security in any other company involved in the merger or consolidation within any period of less than six months during which the merger or consolidation took place, the exemption provided by this Section shall be unavailable to such officer, director, or stockholder.

11:2–9.17 Exemption from Section 2—certain securities received upon surrender of similar equity securities

(a) Where a person receives shares of stock of a class having general voting power from an insurer, upon the person's surrender of an equal number of shares of stock of the insurer of a class which does not have general voting power, pursuant to provisions of the insurer's certificate of incorporation, for the purpose of a sale of the shares (either accompanied simultaneously or followed immediately) so received, such transaction shall be exempt from the operation of Section 2 of the Act as a transaction not comprehended within the purpose of said Section, if the following conditions exist:

1. The person so receiving such shares is not an officer or director, or the beneficial owner, directly or indirectly, immediately prior to such receipt, of more than ten per cent of an equity security of the insurer;

2. The shares surrendered and the shares issued upon such surrender shall be of classes which are freely transferable and which entitle the holders thereof to participate equally per share in all distributions of earnings and assets;

3. The surrender and issuance are made pursuant to provisions of a certificate of incorporation which require that the shares issued upon such surrender shall be registered upon issuance in the name of a person or persons other than the holder of the shares surrendered, and may be required to be issued as of right only in connection with the public offering, sale and distribution of such shares and the immediate sale by such holder of such shares for that purpose, or in connection with a gift of such shares;

4. The shares surrendered are not or have not been purchased (otherwise than in a transaction exempted by this Section) by the person surrendering such shares within six months before or after such surrender. "Shares surrendered," as used in this paragraph, refers to:

i. The shares actually surrendered;

ii. Shares of the same class as those surrendered;

iii. Shares of the same class as those issued upon surrender.

11:2–9.18 Exemption from Section 2—certain transactions involving exchange of similar securities

(a) Any acquisition or disposition of securities made in an exchange of shares of a class (or series thereof) of stock of an insurer for an equivalent number of shares of another class (or series thereof) of stock of the same insurer, pursuant to a right of conversion under the terms of the insurer's charter or other governing instruments, shall be exempt from the operation of Section 2 of the Act if:

1. The shares surrendered and those acquired in exchange therefor evidence substantially the same rights and privileges except that, pursuant to the provisions of the insurer's charter or other governing instruments, the board of directors may declare and pay a lesser dividend per share on shares of the class surrendered than on shares of the class acquired in exchange therefor, or may declare and pay no dividend on shares of the class surrendered; and

2. The transaction was affected in contemplation of a public sale of the shares acquired in the exchange; provided, that this Section shall not be construed to exempt from the operation of Section 2 any purchase or sale of shares of the class surrendered, and any sale or purchase of shares of the class acquired in the exchange (otherwise than in the transaction of exchange exempted by this Section), within a period of less than six months.

11:2–9.19 Exemption from Section 3—certain securities

Any security shall be exempt from the operation of Section 3 of the Act to the extent necessary to render lawful under such Section the execution by a broker of an order for an account in which he has no direct or indirect interest.

11:2–9.20 Exemption from Section 3—certain transactions effected in connection with a distribution

(a) Any security shall be exempt from the operation of Section 3 of the Act to the extent necessary to render lawful under such Section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

1. The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting-dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

2. Other persons not within the purview of Section 3 of the Act are participating in the distribution of such block of securities on terms at least as favorable as those on which such dealer is participating, and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 3 of the Act by this Section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this Section.

11:2–9.21 Exemption from Section 3—sales of securities to be acquired

(a) Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of Section 3, provided that:

1. The sale is made subject to the same conditions as those attaching to the right of acquisition;

2. Such person exercises reasonable diligence to deliver such security to the purchaser promptly after his right of acquisition matures; and

3. Such person reports the sale on the appropriate form for reporting transactions by persons subject to Section 1 of the Act.

(b) This Section shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when-issued" or "when-distributed" security, if the two transactions when combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition.

11:2–9.22 Arbitrage transactions under Section 5 of the Act

It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of such insurer, unless he shall include such transaction in the statements required by Section 1 of the Act, and shall account to such insurer for the profits arising from such transaction, as provided in Section 2 thereof. The provisions of Section 3 shall not apply to such arbitrage transactions. The provisions of the Act shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than such director or officer of the insurer.

11:2–9.23 Instructions for Form A

(a) A statement on this form is required to be filed by every person who is directly or indirectly the beneficial owner of more than ten per cent of any class of any equity security of a New Jersey stock insurance company, or who is a director or an officer of such a company.

(b) Persons who hold any of the relationships specified in subsection (a) are required to file a statement by January 31, 1966, or within ten days after assuming such relationship, whichever date is later. However, the tentative form sent out under date of August 5, 1965 can be used prior to July 1, 1966.

(c) Statements are not deemed to have been filed with the Commissioner until they have actually been received by him.

(d) One signed copy of each statement shall be filed with the Commissioner of Banking and Insurance, State House Annex, Trenton, New Jersey 08625.

(e) A separate statement shall be filed with respect to the securities of each company.

(f) Indicate clearly the relationship of the reporting person to the Company; for example, "Director", "Director and Vice President", "Beneficial owner of more than ten per cent of the company's common stock", and so forth.

(g) The information as to beneficial ownership of securities shall be given as of January 31, 1966, or, in the case of persons who subsequently assume any of the relationships specified in subsection (a), as of the date that relationship was assumed.

(h) The statement of the title of a security shall be such as clearly to identify the security even though there may be only one class; for example, "Class A common stock", "$6 convertible preferred stock", "5 per cent debentures due 1965", and so forth.

(i) Under "Nature of ownership", state whether ownership of the securities is "direct" or "indirect". If the ownership is indirect, that is, through a partnership, corporation,

trust or other entity, indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

(j) In stating the amount of securities beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote, or other appropriate manner, the extent of his interest in the partnership, corporation, trust or other entity.

(k) A statement may include any additional information or explanation deemed relevant by the person filing the statement.

(*l*) If the statement is filed for a corporation, partnership, trust, and so forth, the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

11:2–9.24 Form A

For copies of Form A, write to the Department of Insurance, CN 325, Trenton, New Jersey 08625–0325.

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

11:2–9.25 Instructions for Form B

(a) Statements on this form are required to be filed by every person who, at any time during any calendar month, was directly or indirectly the beneficial owner of more than ten per cent of any class of equity security of a New Jersey stock insurance company, or a director or officer of the company which is the issuer of such securities, and who during such month had any change in his beneficial ownership of any class of equity security of such company.

(b) Statements are required to be filed on or before the tenth day after the end of each month in which any change in beneficial ownership has occurred. Statements are not deemed to have been filed with the Commissioner until they have actually been received by him.

(c) One signed copy of each statement shall be filed with the Commissioner of Insurance, CN 325, Trenton, New Jersey 08625–0325.

(d) A separate statement shall be filed with respect to the securities of each company.

(e) Indicate clearly the relationship of the reporting person to the company; for example, "Director", "Director and Vice President", "Beneficial owner of more than ten per cent of the company's common stock", and so forth.

(f) Every transaction shall be reported even though purchases and sales during the month are equal or the change involves only the nature of ownership; for example, from direct to indirect ownership. Beneficial ownership at the end of the month of all classes of securities required to be reported shall be shown even though there has been no change during the month in the ownership of securities of one or more classes.

(g) The statement of the title of the security shall be such as clearly to identify the security even though there may be only one class; for example, "Class A common stock", "$6 convertible preferred stock", "5 per cent debentures due 1965", and so forth.

(h) The exact date (month, day and year) of each transaction shall be stated opposite the amount involved in the transaction.

(i) In stating the amount of the securities acquired, disposed of, or beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, such as through a partnership, corporation, trust or other entity, the entire amount of securities involved in the transaction or owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote, or other appropriate manner, the extent of his interest in the transaction or holdings of the partnership, corporation, trust or other entity.

(j) Under "Nature of ownership", state whether ownership of the securities is "direct" or "indirect". If the ownership is indirect, that is, through a partnership, corporation, trust or other entity, indicate in a footnote, or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

(k) If the transaction was with the issuer of the securities, so state. If it involved the purchase of securities through the exercise of options, so state and give the exercise price per share. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character; for example, gift, five per cent stock dividend, and so forth, as the case may be. The foregoing information may be appropriately set forth in the table or under "Remarks" at the end of the table.

(*l*) A statement may include any additional information or explanation deemed relevant by the person filing the statement.

(m) If the statement is filed for a corporation, partnership, trust, and so forth, the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Corrected address at (c).

11:2–9.26 Form B

For copies of Form B, write to the Department of Insurance, CN 325, Trenton, New Jersey 08625–0325.

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

SUBCHAPTER 10. (RESERVED)

Historical Note

All provisions of this Subchapter 10, Casualty Insurers, Personal Lines Insurance were filed and became effective June 26, 1970 as R.1970 d.71. This subchapter was repealed effective February 19, 1985 as R.1985 d.71. See: 16 N.J.R. 2920(a), 17 N.J.R. 458(b).

SUBCHAPTER 11. RULES GOVERNING ADVERTISEMENT OF HEALTH INSURANCE

Authority

Unless otherwise expressly noted, all provisions of this Subchapter 11 were adopted by the Commissioner, Department of Insurance, pursuant to authority delegated at 17:1–8.1 and 17:1C–6(e) and were filed and became effective May 16, 1972 as R.1972 d.95. See: 4 N.J.R. 69(b), 4 N.J.R. 128(d).

11:2–11.1 General provisions and definitions

(a) An advertisement for the purpose of these rules shall include:

1. Printed and published material and descriptive literature of an insurer used in newspapers, magazines, radio, and TV (including CATV), billboards and similar displays;

2. Descriptive literature and sales aids of all kinds issued by an insurer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustration, and form letters; and

3. Prepared sales talks, presentations and material for use by agents, brokers, and solicitors and representations made by agents, brokers, and solicitors in accordance therewith.

(b) Policy for the purpose of these rules shall include any policy of health insurance as defined in N.J.S.A. 17B:17–4, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on a cash indemnity, reimbursement, or service basis, except when issued in connection with another kind of insurance other than life, and except disability and double indemnity benefits included in life insurance and annuity contracts.

(c) Insurer for the purpose of these rules shall include any individual corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.

(d) "Endorsement" means any appraisal, analysis, testimonial or other public statement describing or expressing approval of any insurance product or of the terms, benefits or any other aspect of any insurance product.

(e) "Person" means any individual, insurer, company, association, organization, society, partnership, syndicate, trust, business trust, corporation and every legal entity.

(f) These rules shall also apply to agents and brokers to the extent that they are responsible for the advertisements of any policy.

Amended by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a), 21 N.J.R. 2289(c).
New (d) and (e) added definitions of "endorsement" and "person"; old (d) recodified to (f).

11:2–11.2 Advertisements in general

Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used.

11:2–11.3 Advertisements of benefits payable, losses covered or premiums payable

(a) Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered or premium payable.

(b) An advertisement relating to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.

(c) When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

11:2–11.4 Necessity for disclosing policy provisions relating to renewability, cancellability and termination

An advertisement which refers to renewability, cancellability or termination of a policy, or which refers to a policy benefit, or which shows or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

11:2–11.5 Method of disclosure of required information

All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements in which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

11:2–11.6 Endorsements by third parties

(a) Endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using an endorsement, adopts as its own all of the statements contained therein, and the advertisement, including such statements, shall be subject to all of the provisions of this subchapter.

(b) A person shall be a "spokesperson" if either his or her image, voice or words are used in making an endorsement and if the person:

1. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

2. Is an entity formed by the insurer, or is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

3. Is in a policymaking position and is affiliated with the insurer in any of the capacities in (b)1 or 2 above; or

4. Is in any way directly or indirectly compensated for making the endorsement.

(c) Any person acting as a spokesperson as defined in (b) above, who transacts the business of or holds himself or herself out to the public as being an insurance producer as defined at N.J.S.A. 17:22A–2, and who is required to have a license pursuant to N.J.S.A. 17:22A–3, shall be considered to be an insurance producer and shall be required to be licensed pursuant to and shall submit to the requirements of N.J.S.A. 17:22A–1 et seq. and any implementing rules.

(d) Where, pursuant to (c) above, a spokesperson required to be licensed as an insurance producer is not licensed as an insurance producer, the advertisement shall include, in the manner prescribed by (e) below, the following statement: "This offer is not available in New Jersey." The requirements of this subsection shall apply to cases where the advertisement originates in or emanates from another state but is received or appears in New Jersey, and to advertisements which originate in or emanate from New Jersey.

(e) The fact of a financial interest, or the proprietary or representative capacity of a spokesperson, shall be disclosed in an advertisement. In both television and radio advertising the disclosure shall be spoken by the spokesperson and, in the case of television, visually presented consistent with the requirements for print advertising in this subsection. In print advertising, the disclosure shall be presented in a type style and size that is at least equal to the largest type otherwise used in the advertisement. The disclosure required by this subsection shall be accomplished in the introductory portion of the endorsement and shall be given prominence.

(f) If a spokesperson is directly or indirectly compensated for making an endorsement, such fact shall be disclosed by use of the phrase "This is a Paid Endorsement" or by words of similar meaning, in the manner provided by (e) above. The requirements of this subsection do not apply where the spokesperson is a company officer, a company director or an employee who is paid generally, but not specifically, for making the advertisement.

(g) The disclosure requirements in (e) and (f) above shall not apply where the sole financial interest or compensation of a spokesperson, for all endorsements made on behalf of the insurer, consists of the payment of union "scale" wages required by union rules, and if the payment is actually for such "scale" for television or radio performances.

(h) An advertisement shall not state or imply that an insurer, a policy or contract, or any type or line of insurance has been approved or endorsed by any individual, group of individuals, society, association, organization, governmental agency or other entity, unless such is the fact and any proprietary relationship between such individual(s) or entity and the insurer is disclosed and the prior written approval of the individual, group of individuals, society, association, organization, governmental agency or other entity has been secured. Prior written approval shall not be required in cases where the endorsing individual is a company officer, company director or an employee.

(i) If the person making the endorsement in (h) above has been formed by the insurer or is owned or controlled by the insurer, or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policymaking position in the association, that fact shall also be disclosed.

(j) When an endorsement refers to benefits received under a policy for a specific claim, the claim date, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection until the completion by the Department of Insurance of the next market conduct examination of the insurer.

(k) Endorsements which do not correctly reflect the present practices of the insurer or which are not applicable to the policy or benefits being advertised shall not be used.

(*l*) Endorsements concerning Medicare supplement insurance shall be filed with the Division of Life and Health of the Department of Insurance at least 30 days prior to their first use. Radio and television endorsements shall be filed in transcribed form.

(m) An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency unless such is the fact and without prior written approval.

Repealed and replaced by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a), 21 N.J.R. 2289(c).
Section formerly entitled "testimonials"; new rule greatly expanded the regulation of third party endorsements.

11:2–11.7 Use of statistics

(a) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used unless it accurately reflects all of the relevant facts.

(b) Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact.

11:2–11.8 Inspection of policy

An offer in an advertisement of free inspection of policy or offer of a premium refund is not a cure for misleading or deceptive statements contained in such advertisement.

11:2–11.9 Identification of plan or number of policies

(a) When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

(b) When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

11:2–11.10 Disparaging comparisons and statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services or business methods.

11:2–11.11 Jurisdictional licensing

(a) An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(b) Such advertisements by direct mail insurers shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of some language such as "This Company is licensed only in State A" or "This Company is not licensed in State B".

11:2–11.12 Identity of insurer

(a) The identity of the insurer shall be made clear in all of its advertisements.

(b) An advertisement shall not use a trade name, service mark, slogan, symbol or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.

11:2–11.13 Group or quasi-group implications

An advertisement of a particular policy shall not state or imply that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges, unless such is the fact.

11:2–11.14 Introductory, initial or special offers

An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.

11:2–11.15 (Reserved)

Repealed by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a).
Section formerly entitled "Approval or endorsement by third parties"; substance of section readopted at N.J.A.C. 11:2–11.6.

11:2–11.16 Service facilities

An advertisement shall not contain untrue statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy.

11:2–11.17 Statements about an insurer

An advertisement shall not contain statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age or relative position in the insurance business.

11:2–11.18 Insurers' responsibility and control; advertising file; certificate of compliance

(a) All advertisements, regardless of by whom written, created or designed, shall be the responsibility of the insurer sponsoring the same.

(b) Every insurer shall at all times maintain complete control over the content, form and method of dissemination of all advertisements of its contracts.

(c) Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of individual policies and typical printed, published or prepared advertisements of blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised.

(d) Such file shall be subject to regular and periodical inspection by this department.

(e) All such advertisements shall be maintained in said file for a period of five years from their last use.

(f) Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this regulation must file with this department together with its annual statement, a certificate executed by an authorized officer of the insurer where it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of this State as implemented and interpreted by this regulation.

Amended by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a), 21 N.J.R. 2289(c).
At (e) deleted requirement to retain file for at least a four year period.

11:2–11.19 Penalties

Failure to comply with the provisions of this regulation shall constitute a violation of the Insurance Laws of this State and shall subject any individual or company so failing to comply to all the penalties provided by law.

11:2–11.20 Prior regulation superseded

This regulation supersedes in its entirety the Regulation which was previously issued by the Insurance Department on February 1, 1956.

11:2–11.21 Effective date

This regulation shall become effective upon the date of publication of its adoption in the New Jersey Register.

11:2–11.22 Severability

If any provision of clause of this regulation or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the regulation which can be given effect without the invalid provision or application, and to this end the provisions of this regulation are declared to be severable.

SUBCHAPTER 12. MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE

Authority

Unless otherwise expressly noted, all provisions of this Subchapter were adopted pursuant to authority delegated at N.J.S.A. 17:1–8.1 and 17:1C–6(e) and were filed and became effective September 25, 1974, as R.1974 d.271. See: 6 N.J.R. 313(d), 6 N.J.R. 408(a).

11:2–12.1 Introduction

The purpose of this regulation is to prescribe rules to prevent abuses in connection with the sale of personal property-liability insurance in this State pursuant to mass marketing plans, while preserving for consumers the potential benefits of this form of marketing.

11:2–12.2 Definitions

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

"Mass marketing plan" means a method of selling personal property-liability insurance wherein:

1. Such insurance is offered to employees of particular employers or to members of particular associations or organizations;

2. The employer, association or organization, if any, has agreed to or otherwise affiliated itself with the sale of such insurance to its employees or members;

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 to be reviewed by the Division of Consumer Services.

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

Authority

Unless otherwise expressly noted, all provisions of this Subchapter were adopted pursuant to authority delegated at N.J.S.A. 17:1–8.1 and 17:1C–6(e) and were filed September 26, 1974, as R.1974 d.272 to become effective February 1, 1975. See: 5 N.J.R. 342(c), 6 N.J.R. 409(a).

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, eff. 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 nonconfinement 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, eff. 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, eff. 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

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:29B–1 et seq. and 17B:30–1 et seq.

Source and Effective Date

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).
Petition for Rulemaking. See: 26 N.J.R. 2487(b).

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.

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.

(c) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(d) No insurer shall request a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(e) No insurer shall issue checks or drafts in partial settlement of a loss or claim using language which releases the insurer or its insured from its total liability.

11:2–17.6 Rules for replying to pertinent communications

(a) All claims must be reported to the designated insurer by a broker no later than three working days following receipt of notification of claim by the broker. For the purposes of this subsection, "broker" shall include a producer of record with respect to any residual market mechanism created by statute.

(b) Every insurer, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such period of time. This acknowledgement shall include the address and telephone number of the insurer claims office or authorized claims representative which will handle the claim. Notification given to an agent of an insurer shall be considered notice to the insurer.

(c) Every insurer, upon receiving notification of claim, shall promptly provide first party claimants with necessary claim forms, instructions, and reasonable assistance so that such claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection (c) within 10 working days of notification of a claim shall constitute compliance with (b) above.

(d) Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim shall, within 15 working days of receipt of such inquiry furnish the Department with, based on the information available to the insurer, a complete and accurate written response to the inquiry.

(e) An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Deleted references to "New Jersey Automobile Insurance Plan and the New Jersey Insurance Underwriting Association".

11:2–17.7 Rules for prompt investigation and settlement of claims

(a) Every insurer shall commence an investigation on all claims other than auto physical damage within 10 working days of receipt of notification of claim.

(b) The maximum payment period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same; provided, however, that an insurer may secure a 45–day extension in accordance with N.J.S.A. 39:6A–5.

(c) Unless a clear justification exists, or unless otherwise provided by law, the maximum payment periods for property/liability claims shall be as follows:

1. For all first party claims other than personal injury protection (PIP) and auto physical damage (see N.J.A.C. 11:3–10.5(a)), 30 calendar days from receipt by the insurer of properly executed proofs of loss.

2. For all third party property damage claims, 45 calendar days from receipt by the insurer of notification of claim.

3. For all third party bodily injury claims, 90 calendar days from receipt by the insurer of notification of claim.

(d) Unless a clear justification exists, or unless otherwise provided by the policy, all life insurance claims shall be paid within a maximum payment period of 30 calendar days. The payment period is defined as the period between the date proof of loss is received by the insurer and the date of claims settlement.

(e) Except as provided in (e)1 below, all health insurance claims shall be paid no later than 60 calendar days after the insurer receives written notice of the claim.

1. The maximum payment period for health insurance claims may be extended under the following circumstances:

i. The health insurer contests a claim, and the insurer sends written notice of such fact to the insured or insured's assignee within 45 calendar days of the insurer's receipt of the claim. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. If only a portion of a claim is contested, the insurer shall remit payment for the uncontested portion in accordance with (e) above; or

ii. The health insurer requests additional information from the insured concerning a claim that the insurer is contesting. After the insurer receives the additional information requested, the insurer shall either pay or deny the claim within 90 calendar days of the insurer's receipt of the additional information.

2. Payment of a health insurance claim shall be considered to have been made either:

i. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or

ii. If not posted pursuant to (e)2i above, on the date of delivery of a draft or other valid instrument equivalent to payment.

3. If the health insurer fails to make payment on a claim within the time limits set forth in this subsection, the insurer shall pay simple interest on the amount of the overdue payment at the rate of 10 percent per year.

(f) If the insurer is unable to settle the claim within the time periods specified in (c) through (e) above, the insurer must send the claimant written notice by the end of the payment periods specified in (c) through (e) above. The written notice must state the reasons additional time is needed, and must include the address of the office responsible for handling the claim and the insured's policy number and claim number. This notice shall also include a telephone number which is toll free, or which can be called collect, or which is within the claimant's area code. This number shall provide direct access to the responsible claims office or shall enable the claimant to gain such access at no greater expense than the cost of a telephone call within his or her area code. An updated written notice setting forth the reasons additional time is needed shall be sent within 45 days after the initial notice and within every 45 days thereafter until all elements of the claim are either honored or rejected. This subsection shall not apply after a claimant has filed a lawsuit pursuant to his or her claim.

(g) Unless otherwise provided by law, every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than 10 working days from either the receipt of such agreement by the insurer or the date of the performance by the claimant of any conditions set by such agreement, whichever is later.

(h) Where there is a reasonable basis supported by specific information available for review by the Department of Insurance that the first party claimant has fraudulently caused or contributed to the loss by arson, or other fraudulent schemes, the insurer shall be relieved from the requirements of (c) through (f) above. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

Amended by R.1982 d.400, effective November 15, 1982.
See: 14 N.J.R. 966(a), 14 N.J.R. 1307(b).
Amended by R.1992 d.93, effective February 18, 1992.
See: 23 N.J.R. 2830(a), 24 N.J.R. 622(a).
Maximum payment period for personal claims specified at (b).
Amended by R.1992 d.493, effective December 7, 1992.
See: 23 N.J.R. 3196(c), 24 N.J.R. 4391(a).
Subsection (d) added to provide for payment of all health insurance claims within 60 days, with certain exceptions as specified.
Petition for Rulemaking.
See: 25 N.J.R. 6065(a).

11:2–17.8 Rules for fair and equitable settlements and reasonable explanations applicable to all insurance

(a) No insurer shall deny or offer to compromise a claim because of a policy provision, including any concerning liability, a condition, or an exclusion without providing a specific reference to such language and a statement of the facts which make that language operative.

(b) Any denial or offers of compromise to the claimant shall be confirmed in writing and shall be kept in the appropriate claim file.

(c) In any case where a first party claim is denied or a compromise is offered, the insurer shall notify the first party claimant of any applicable policy provision limiting such claimant's right to sue the insurer.

(d) Insurer shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by law or policy provisions such as Workers' Compensation exclusions, or coordination of benefits provisions.

(e) If a claimant is actively negotiating with an insurer for settlement of a claim, and the claimant's rights may be affected by a statute of limitations or a policy time limit, the insurer shall provide the claimant with written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to claimants 60 calendar days before the date on which such time limit may expire. This rule shall only apply if the insurer is negotiating a claims settlement with a person who is neither an attorney nor represented by an attorney.

(f) No insurer shall make statements which indicate that the rights of a claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the claimant of any applicable law or policy provision.

(g) Unless otherwise provided by law, in any case where there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

(h) An insurer shall not compel claimants to institute litigation to recover amounts due under an insurance policy by offering substantially less than amounts recovered in actions brought by such claimants.

(i) No insurer shall deny payment of a claim when it is reasonably clear that either full or partial benefits are payable.

(j) No claim shall be denied or compromised based on an exclusion, reduction or limitation in a policy unless documentation of facts rendering the exclusion, reduction or limitation operative can be obtained. If such documentation is not made a part of the claim file, the insurer shall place in the claim file a written notation explaining how documentation may be obtained.

(k) With respect to first party claims, insurers shall make claim payments by check or draft with a statement setting forth the coverage under which payment is made and in sufficient detail so that first party claimants can reasonably understand the benefits included within the claim payment. The details should include an explanation of how the benefit payment was calculated. This subsection shall not apply to claims in which the claim payment figure was arrived at through negotiations between the insurer and the first party claimant.

(*l*) If a first party claimant or a third party claimant not represented by an attorney does not submit sufficient information to establish his or her entitlement to the benefits claimed, then the insurer shall provide the claimant with a general description of the information and documentation needed to establish such entitlement.

11:2–17.9 Rules for fair and equitable settlements applicable to life and health insurance

(a) No insurer shall indicate on a payment draft, check or in any accompanying cover letter that said payment is "final" if additional benefits relating to the claim for which benefits are being paid are payable under the policy.

(b) When it is apparent to the insurer that additional benefits would be payable under a policy upon receipt of additional proofs of loss from the claimant, the insurer shall explain to the claimant in writing or by telephone the additional proofs or information needed to establish entitlement to additional benefits.

(c) No insurer shall undertake any activity that has the effect of coercing the insured to settle a disability claim on a lump sum basis.

(d) No insurer shall pay a claim involving both a covered and noncovered condition on a percentage basis of contributing loss, unless said percentage is reasonable.

(e) Settlement of claims for a fraction of an indemnity period shall be on a pro rata basis unless the policy specifically excludes pro-rata payments.

(f) If it is found that an insured's age is overstated on an individual life or health policy or understated on an annuity, benefits shall be adjusted upward under a policy which contains a misstatement of age provision specified in N.J.S.A. 17B:25–6 and N.J.S.A. 17B:26–18.

(g) No insurer shall request a claimant to sign an agreement which releases the insurer from all future claims under an insurance policy unless no other benefits are payable under it.

(h) Unless otherwise provided by the policy, no insurer may terminate disability benefits based solely on lack of regular medical attendance when the disability has been verified by a physician and can reasonably be expected to continue beyond the date through which benefits have been paid.

(i) No policy shall be rescinded and claim denied for loss incurred during the contestable period based on material misrepresentation by the applicant unless the application is a part of the contract.

(j) No policy shall be rescinded and claim denied for loss incurred during the contestable period based on omission of material information when such information is not specifically requested on the application.

(k) When an application for a life/health policy contains only one medical question or declaration as to general status of the insured's health, such as, "Are you now in good health?", an insurer shall not rescind a policy or deny a claim for loss incurred during the contestable period on the basis of material misrepresentation, if based on the totality of circumstances, the insured responded to the best of his/her knowledge and belief that the general status of his/her health was satisfactory.

Petition for Rulemaking.
See: 25 N.J.R. 6065(a).

11:2–17.10 Rules for fair and equitable settlements applicable to property and liability insurance

(a) This section, unless otherwise noted in this subchapter, is applicable to claims arising under all property/liability coverages. This section is organized so that the requirements for all lines of property/liability insurance are found in (a)1 through 6 below; for automobile insurance only, in (a)7 through 13 below; and for other than automobile insurance only, in (a)14 and 15 below. The requirements of this section with respect to motor vehicle claims are in addition to the requirements of N.J.A.C. 11:3–10. In addition to the provisions of this section, the requirements for auto physical damage first party claims found in N.J.A.C. 11:3–10.1 through 10.4 shall also be construed to apply to automobile property damage third party claims from the time that liability becomes reasonably clear. The requirements are as follows:

1. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy.

2. When the amount claimed is reduced because of betterment or depreciation, all information and calculations for such deduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amounts and shall be fair and equitable.

3. Unless the question has been specifically negotiated, the insurer remains liable for hidden damage directly related to the loss giving rise to the claim subject to policy terms, conditions and limits.

4. No insurer shall refuse to grant advance payments on a claim primarily because the claimant has retained an attorney for the purpose of facilitating recovery on his/her behalf.

5. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

6. Unless the insurer is exercising a right under the policy to repair damaged property, it shall not require as a condition to payment of claims that repairs be made by a particular contractor or repair shop.

7. In all automobile physical damage claims, the first party claimant shall be notified at the time of the insurer's acknowledgement of the claim, or sooner if inquiry is made, whether coverage exists for the rental of an automobile subject to policy terms and conditions.

8. When an insurer acknowledges receipt of an automobile property damage liability claim, or sooner if the claimant inquires, it shall inform the claimant whether and to what extent he or she will be entitled, if the insurer's liability later becomes reasonably clear, to payment for the rental of an automobile or other substitute transportation. Such payment will ordinarily be for the rental of an automobile at a reasonable price until the damaged vehicle is repaired or, in the event of a total loss, until the claim is settled. When an insurer uses the doctrine of comparative negligence to determine its responsibility for the cost of substitute transportation, it shall, as soon as is practicable, advise the claimant of the extent of its liability.

9. An insurer shall provide notice to a claimant three working days prior to the termination of payment for automobile storage charges and place a copy of such notice in a claim file.

10. All after market parts manufactured after October 17, 1988 used in the repair of an automobile where insurance proceeds provide the basis of payment therefor shall carry sufficient permanent identification so as to identify the manufacturer thereof. Such identification shall be accessible after installation to the extent possible.

11. No insurer shall require the use of after market parts in the repair of an automobile unless the after market part is warranted by the manufacturer in a reasonable manner as to duration and coverage and at least equal in like kind and quality to replacement parts available from the original manufacturer of the part in terms of fit, quality and performance. Use of after market parts which have been certified by an independent testing laboratory as being of like kind and quality to the original manufactured part will be deemed to be in compliance with the requirements of this paragraph.

12. Insurers specifying the use of after market parts shall pay for any modifications which may become necessary in making the repair.

13. Where the insurer specifies the use of after market parts, the insurer shall disclose to the claimant, in writing, either on the estimate or on a separate document attached to the estimate, the following information, which shall appear in print no smaller than 10 point type:

THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN LIKE KIND AND QUALITY IN TERMS OF FIT, QUALITY AND PERFORMANCE TO REPLACEMENT PARTS AVAILABLE FROM THE ORIGINAL MANUFACTURER.

The insurer shall clearly identify on the estimate of such repair all after market parts installed on the vehicle.

14. If the insurer intends to exercise its right to inspect, or cause to be inspected by an independent appraiser, damages prior to repair, it shall have 10 working days following receipt of notification of claim to inspect the claimant's damaged property at a place and time reasonably convenient to the claimant, provided that the claimant has not refused to make the property available for inspection. For third-party property damage claims, this paragraph shall apply once the insured's liability is reasonably clear. This paragraph does not apply to losses caused by a catastrophe.

15. If any loss other than a motor vehicle loss subject to N.J.A.C. 11:3–10 is to be settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply to the claimant before beginning negotiations a copy of the estimate upon which the settlement is to be based.

i. Such estimate prepared by or for the insurer shall be reasonable, and of an amount which will allow for repairs to be made in accordance with generally accepted standards for safe and proper repairs, subject to policy conditions, such as limits, deductible, depreciation, and prior damage.

ii. If the claimant subsequently claims, based upon a written estimate which he/she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the company shall review the written estimate and respond to the claimant within 10 working days, and may provide or, if requested, must provide the claimant with the name of the repair shop or contractor that will make the repairs in accordance with generally accepted standards for safe and proper repairs.

Amended by R.1988 d.480, effective October 17, 1988.
See: 20 N.J.R. 1159(a), 20 N.J.R. 2578(a).
Added new 10–13; renumbered old 10–11 as 14–15.
Administrative Correction to (a)13.
See: 21 N.J.R. 3666(a).

11:2–17.11 Written notice by insurers of payment of third-party claims

(a) Upon payment of $5,000 or more in settlement of any third-party liability claim, where the claimant is a natural person, the insurer or its representative (including the insurer's attorney) shall mail to the third-party claimant written notice of payment at the same time payment is made to the third-party claimant's attorney or other representative.

(b) The written notice referred to in (a) above shall be mailed to the claimant by regular mail at the claimant's last known address, and shall include at least the following information:

1. The amount of the payment;

2. The party or parties to whom the check is made payable;

3. The party to whom the check was mailed; and

4. The address of the party to whom the check was mailed.

(c) Nothing in (a) above shall create, or be construed to create, a cause of action for any person or entity, other than the Department of Insurance, against the insurer or its representative based upon a failure to serve such notice, or the defective service of such notice. Nothing in (a) above shall establish, or be construed to establish, a defense for any party to any cause of action based upon a failure by the insurer or its representative to serve such notice, or the defective service of such notice.

New Rule, R.1993 d.681, effective December 20, 1993.
See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

11:2–17.12 Examinations

(a) Each insurer's claim files are subject to examination and inspection by the Commissioner or by his duly appointed designees pursuant to N.J.S.A. 17:23–4, 17:29B–5, 17B:21–3 and 17B:30–16.

(b) Detailed documentation and/or evidence shall be contained in each claim file in order to permit the Commissioner or his designated examiners or investigators to reconstruct the company's activities relative to the claims settlement. Such documentation shall include but is not necessarily limited to all investigative reports, payment vouchers, transactions, notices, memoranda and work papers. With respect to automobile damage claims, file documentation also shall include the name, address, telephone number and license number of any auto body repair facility that has been utilized by the insurer in the adjustment of the loss or repair of the automobile. All such documentation shall be properly dated and, for investigative reports, notes, memoranda and work papers, the parties preparing such documents shall be identified.

(c) Every insurer shall maintain records of all pertinent communications relating to a claim. The records must identify the date of the communication and the parties, and describe the substance of the communication.

Amended by R.1987 d.249, effective June 15, 1987.
See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).
Inserted new text in (b) "With respect to ... of the automobile."
Recodified from 11:2–17.11 by R.1993 d.681, effective December 20, 1993.
See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

11:2–17.13 Special claims reports

(a) If the Department of Insurance observes that an insurer's claims settlement practices are not meeting the standards established by statute or by this subchapter, the Department may require such insurer to file periodic reports. Depending on the nature and extent of an insurer's deviations from such standards and with due consideration of the insurer's data capabilities, the Commissioner in his discretion may require the report to include some or all of the statistics listed below:

1. The total number of claims submitted;

2. The original amount claimed;

3. The classification by line or insurance of each individual claim;

4. The total number of claims denied;

5. The total number of claims paid;

6. The total number of claims compromised;

7. The amount of each settlement;

8. The total number of claims for which lawsuits are instituted against the insurer, the reason for the lawsuit, and the amount of the final adjudication; and

9. An individual listing showing the disposition and other information for each claim.

Recodified from 11:2–17.12 by R.1993 d.681, effective December 20, 1993.
See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

11:2–17.14 Separability

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

Recodified from 11:2–17.13 by R.1993 d.681, effective December 20, 1993.
See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

11:2–17.15 Penalties

(a) If, after notice and hearing, the Commissioner finds that a person has violated this subchapter, he shall make his findings in writing and shall issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such violation. The Commissioner may order payment of a penalty not to exceed $1,000 for each and every violation unless the person knew or reasonably should have known he was in violation of this subchapter, in which case the penalty shall not be more than $5,000 for every violation. The Commissioner shall collect the penalty in the name of the State in a summary proceeding in accordance with "the penalty enforcement law" (N.J.S.A. 2A:58–1 et seq.).

(b) Any person who violates a cease and desist order of the Commissioner under (a) above, after it has become final, and while such order is in effect, shall be liable to a penalty not exceeding $5,000 for each violation, which may be recovered in a civil action. In determining the amount

of the penalty the question of whether the violation was willful shall be taken into consideration.

(c) The penalties provided herein shall be in addition to any other penalties authorized by law.

Repeal and New Rule, R.1987 d.249, effective June 15, 1987.
See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).
Petition for Rulemaking.
See: 25 N.J.R. 6065(a).
Recodified from 11:2–17.14 by R.1993 d.681, effective December 20, 1993.
See: 25 N.J.R. 3921(a), 25 N.J.R. 5929(b).

SUBCHAPTER 18. READABLE POLICIES

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and 56:12–1 et seq.

Source and Effective Date

R.1982 d.410, eff. November 15, 1982.
See: 14 N.J.R. 967(a), 14 N.J.R. 1307(c).

11:2–18.1 Purpose

The Plain Language Law (N.J.S.A. 56:12–1 et seq., as amended) requires certain insurance policies to be written in a "simple, clear, understandable and easily readable way." N.J.S.A. 39:6A–23 requires that each buyer's guide and coverage selection form required by that section to be issued to insureds and prospective insureds for automobile insurance be written in plain language. This subchapter provides rules for the implementation of these provisions.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Added statutory cite and requirements for buyer's guide and coverage selection form.

11:2–18.2 Scope

(a) This subchapter applies to all insurance policies which are issued to individuals to provide coverage for personal, family, or household purposes except life, health and annuity policies defined in N.J.S.A. 17B:17–19a, the "Life and Health Policy Language Simplification Act." Examples of coverage for personal, family or household purposes are:

1. Policies used solely to provide homeowners insurance, dwelling fire insurance on one to four family units, or individual fire insurance on dwelling contents;

2. Policies principally used to provide primary insurance on private passenger automobiles which are individually owned and used for personal or family needs; and

3. Policies of personal inland marine, personal theft, residence glass, and personal liability insurance.

(b) Coverage for personal, family or household purposes does not mean policies used to cover business, professional or other commercial risks, such as farm owners, business owners, and commercial multi-peril policies.

(c) This subchapter does not supersede any other law, regulation or filing procedure.

11:2–18.3 Definitions

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

"Buyer's Guide" means part of a written notice required to be given to insureds and prospective insureds for automobile insurance, pursuant to N.J.S.A. 39:6A–23, which provides a brief description of all available policy coverages and benefit limits, identifies which coverages are optional and mandatory, and identifies all options offered by the insurer.

"Commissioner" means the Commissioner of Insurance.

"Coverage Selection Form" means part of a written notice required to be given to insureds and prospective insureds for automobile insurance, pursuant to N.J.S.A. 39:6A–23, which provides information required by the Commissioner pursuant to N.J.A.C. 11:3–15.7.

"Insurer" means any person, corporation, company, association, partnership, title insurance company, eligible authorized surplus lines insurer, or any other legal entity issuing a contract of insurance subject to this subchapter. In this subchapter, "insurer" also includes rating organizations.

"Policy" means any contract of insurance subject to this subchapter and includes, but is not limited to, all policies, contracts, certificates, riders and endorsements that provide insurance coverage to individuals. "Policy" also includes applications to be signed by the applicant and all other writings required to complete the insurance transaction.

"Text" means all printed matter in a policy, except the name and address of the insurer; the name, number and title of the policy; the table of contents or index, captions or subcaptions; applications; specification or declarations pages; and schedules or tables. "Text" does not include the Coverage Selection Form or specific language required, permitted or approved by a law, regulation, rule or published interpretation of a State or Federal agency.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Added definitions for "Buyer's Guide" and "coverage selection form"; modified "text".

11:2–18.4 Minimum readability standards

(a) The Plain Language Law provides, at N.J.S.A. 56:12–10, certain "examples of guidelines" that the Commissioner may consider in determining whether a contract complies with the Act. The readability standards in this section are in addition to the standards enumerated in the Act.

(b) A policy, Buyer's Guide and Coverage Selection Form shall be printed in legible type style with adequate contract between paper and ink. Captions, headings and spacing shall be used to increase overall readability.

(c) A policy and Buyer's Guide shall be printed in not less than 10 point type, one point leading. This rule shall not apply to schedules and tables; specification or declaration pages; or applications.

(d) Applications to be signed by the applicant shall be printed in not less than 8 point type, one point leading. Provided, however, that conditions or exceptions to the main promise of the agreement contained in an application shall be printed in at least 10 point type. (See N.J.S.A. 56:12b.(1).)

1. The 8 point type, one point leading standard set forth in (d) above shall become operative on July 1, 1983.

(e) Policies and Buyer's Guides with 3,000 or more words, or with four or more pages, shall contain a table of contents or alphabetical index.

(f) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text or to any endorsements or riders.

(g) Each section of a policy, Buyer's Guide and Coverage Selection Form shall be self-contained and independent. However, general provisions applicable to more than one section may be included in a common section.

(h) Policies shall contain only essential provisions.

(i) Policies, the Buyer's Guide and the Coverage Selection Form shall be written in everyday, conversational language with a personal style, and technical terms or words with a special meaning shall be avoided wherever possible.

(j) The text of a policy and Buyer's Guide shall achieve a score of at least 40 on the Flesch reading ease test or an equivalent score on a comparable test authorized for use by the Commissioner.

1. For the purpose of this subsection, a Flesch reading ease test score shall be measured by the following method:

i. For policy forms and Buyer's Guides containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms and Buyer's Guides containing more than 10,000 words, the readability of two 200 word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

ii. The number of words and sentences in the text or sample shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

iii. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

iv. The sum of the figures computed under ii and iii above subtracted from 206.835 equals the Flesch reading ease score for the policy form or Buyer's Guide.

v. In measuring the Flesch test score, the following special rules shall be observed when counting syllables, words and sentences:

(1) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables shall be used;

(2) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word; and

(3) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

2. At the option of the insurer, riders, endorsements, and other forms made a part of the policy may be scored as separate forms or as part of the policy.

3. A score lower than 40 on a Flesch reading ease test may be permitted whenever the Commissioner finds a lower score is warranted by the nature of a particular policy form or type or class of policy forms.

As amended, R.1982 d.410, eff. November 15, 1982.
See: 14 N.J.R. 967(a), 14 N.J.R. 1307(c), 14 N.J.R. 1398(b).
(c) deleted "not required ... the applicant."
(d) added. Old (d) through (i) changed to (e) through (j).
Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Added references throughout to Buyer's Guide and Coverage Selection Form.

11:2–18.5 Procedures for requesting an opinion of compliance with the Plain Language Law

(a) An insurer may request an opinion from the Commissioner as to whether an insurance policy and related "writings required to complete the consumer transaction", a Buyer's Guide and a Coverage Selection Form are in compliance with the Plain Language Law. The Commissioner shall consider the Law's provisions and the implementing provisions of this subchapter in responding to such requests.

(b) For each policy form and related writings, Buyer's Guide and Coverage Selection Form for which an opinion is desired, an insurer shall prepare the Request for Opinion shown in Exhibit A of the Appendix to this subchapter. For related writings (including riders and endorsements) submitted separately from a basic contract to which they will apply, one Request for Opinion Form shall be prepared for each writing or group of writings applicable to one policy form.

The insurer shall also provide two copies (where possible, "specimen" or "proof" copies) of the policy and related writings, Buyer's Guide and Coverage Selection Form to be reviewed.

(c) An officer of the insurer shall complete and submit the Affidavit of Compliance shown in Exhibit B of the Appendix to this subchapter for each policy and related writings, or for each separately submitted writing or group of writings applicable to one policy form. An officer of a rating organization which requests an opinion as to compliance may complete and sign the affidavit on behalf of the member companies of the rating organizations.

(d) An opinion as to compliance should not be requested for a policy form to be issued on a nationwide basis unless the policy form will be issued in New Jersey.

(e) Pursuant to N.J.S.A. 56:12–5, an insurer need not request an opinion as to compliance with the Plain Language Law for policy forms identical to those which have already been certified for some other insurer or rating organization.

(f) Any insurance policy, Buyer's Guide and Coverage Selection Form whose language is revised for any reason, including compliance with the Plain Language Law, must be approved by the Commissioner pursuant to insurance laws and regulations before it can be issued:

1. The Commissioner's opinion as to compliance with the Plain Language Law is distinct from his or her approval of a policy, Buyer's Guide and Coverage Selection Form pursuant to insurance laws and regulations.

2. Filings for review and approval of policies, Buyer's Guides and Coverage Selection Forms pursuant to insurance laws and regulations should be prepared in accordance with existing filing procedures.

3. Ordinarily, a request for an opinion as to a policy's, Buyer's Guide's or Coverage Selection Form's compliance with the Plain Language Law and a filing for approval pursuant to insurance laws and regulations should be submitted to the Commissioner at the same time and in the same package.

4. If an insurer has already received approval of a policy, Buyer's Guide and Coverage Selection Form pursuant to insurance laws and regulations, and believes that the policy, Buyer's Guide and Coverage Selection Form complies with the Plain Language Law without further revision, it may resubmit it for the sole purpose of requesting an opinion as to compliance with the Plain Language Law. In completing the Request for Opinion Form (Exhibit A), an insurer should provide information necessary to confirm the previous approval of the policy, Buyer's Guide and Coverage Selection Form pursuant to insurance laws and regulations.

Amended by R.1991 d.4, effective January 7, 1991.

See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Added references to Buyer's Guide and Coverage Selection Form.

11:2–18.6 Enforcement

The Commissioner may seek injunctive relief to enforce this subchapter. The court may authorize reasonable attorney's fees and costs in such a proceeding.

11:2–18.7 Separability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall be affected.

APPENDIX

EXHIBIT A

REQUEST FOR OPINION AS TO COMPLIANCE WITH PLAIN LANGUAGE LAW

(N.J.S.A. 56:12–1 et seq., as amended)

NAME OF INSURER: _____ FORM NUMBER: _____
ADDRESS: _____ DATE OF SUBMITTAL: _____
TELEPHONE: _____

I. PURPOSE OF SUBMISSION

1. Is an opinion as to whether the form, Buyer's Guide or Coverage Selection Form complies with the Plain Language Law being requested pursuant to N.J.S.A. 56:12–8?

YES NO

2. Is filing and approval pursuant to insurance laws and regulations by the Department of Insurance also being requested?

YES NO

Note: Filings for approval of policies pursuant to insurance laws and regulations should be prepared in accordance with the Department's existing procedures. Requests for readability certification should include Exhibits A and B; two copies of the policy (including related writings), Buyer's Guide or Coverage Selection Form to be reviewed; and any appropriate attachments.

3. If the form, Buyer's Guide or Coverage Selection Form you are submitting has already been approved by the Department of Insurance pursuant to insurance laws and regulations, please indicate the following information:

DEPARTMENT FILE NUMBER:_____

DATE OF DEPARTMENT OF INSURANCE APPROVAL:_____

II. REFERENCE TO OTHER FORMS

Pursuant to N.J.S.A. 56:12–5, an insurer need not request an opinion as to compliance with the Plain Language Law for policy forms identical to those which have already been certified for some other insurers or rating organization or if, in the case of a Buyer's Guide and Coverage Selection Form, the language does not differ from N.J.A.C. 11:3–15.6 or N.J.A.C. 11:3–15.7.

1. If a policy, Buyer's Guide or Coverage Selection Form, is similar but not identical to a previously certified policy, Buyer's Guide or Coverage Selection Form, please identify the previously certified policy, Buyer's Guide or Coverage Selection Form, as specifically as possible. Include the following information if available.

FILER:_____

FORM NUMBER:_____

DEPARTMENT FILING NUMBER:_____

DATE OF CERTIFICATION:_____

2. Indicate how the material now submitted for review differs from the previously certified materials by the use of brackets for deleted material and underlining for new material.

III. FLESCH READING EASE TEST

1. Identify any language not considered "text" as defined in N.J.A.C. 11:2–18.3 of the regulation on policy readability. This language may be identified by reference to the policy section numbers.

2. If any of the language identified in item 1 is required, permitted or approved by a law, regulation, rule or published interpretation of a State or Federal agency, identifying both the language and the law, rule or interpretation.

3. If the text of the policy or Buyer's Guide does not score at least 40 on the Flesch reading ease test, provide an explanation to enable the Commissioner to determine whether the lower score is warranted by the nature of the policy form (N.J.A.C. 11:2–18.4(i)3 of the regulation). A lower score will be accepted only in exceptional circumstances.

_____
Name and Title of Person Completing Form

_____
Signature

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Recodified as an appendix to Subchapter 18.

EXHIBIT B

AFFIDAVIT OF COMPLIANCE

NAME OF INSURER: _____ FORM NUMBER: _____

I certify that this contract and related writings comply with the Plain Language Law (N.J.S.A. 56:12–1 et seq.) and with N.J.A.C. 11:2–18.

I certify that the score of the text of the form on the Flesch reading ease test is _____ and that the test score has been accurately calculated as required by N.J.A.C. 11:2–18.

I also certify that the form(s) or Buyer's Guide is printed in not less than 10 point type, one point leading and/or the application is not less than 8 point type, one point leading as required by N.J.A.C. 11:2–18.4 and N.J.A.C. 11:3–15.6.

I also certify that any Coverage Selection Form submitted is not less than 12 point type, as required by N.J.A.C. 11:3–15.7.

Date: _____

_____
Name and Title of Insurer's Officer

_____
Signature

Amended by R.1984 d.514, effective November 5, 1984.
See: 16 N.J.R. 1945(a), 16 N.J.R. 3037(a).
Added "I also certify ... N.J.A.C. 11:2–18.4."
Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Recodified as an appendix to Subchapter 18.

SUBCHAPTER 19. (RESERVED)

Historical Note

Pursuant to authority of N.J.S.A. 17:1–8.1; 17:1C–6(e); 17B:22–13(a) as amended by P.L. 1983 c.533, sec. 9; 17:22–6.6, Subchapter 19 was adopted as R.1985 d.608, effective December 2, 1985. See: 16 N.J.R. 2920(b), 17 N.J.R. 2901(b). Pursuant to the authority of N.J.S.A. 17:1C–6, 17:1–8.1 and P.L. 1987, c.293 (N.J.S.A. 17:22A–1 et seq., 17:22A–4(c) and 24), Subchapter 19 was repealed by R.1989 d.192, effective April 3, 1989. See: 20 N.J.R. 1152(a), 21 N.J.R. 899(b).

SUBCHAPTERS 20 THROUGH 22. (RESERVED)

SUBCHAPTER 23. ADVERTISEMENT OF LIFE INSURANCE AND ANNUITIES

Authority

N.J.S.A. 17:1–8.1; 17:1C–6(e); 17B:30–1 et seq.; 17B:30–15.

Source and Effective Date

R.1985 d.600, effective November 18, 1985.
See: 16 N.J.R. 2626(a), 17 N.J.R. 2776(a).

11:2–23.1 Purpose

The purpose of this subchapter is to implement N.J.S.A. 17B:30–1 et seq. through guidelines intended to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

11:2–23.2 Applicability

(a) This subchapter shall apply to any life insurance or annuity advertisement distributed in this State.

(b) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer.

(c) This subchapter shall also apply to agents and brokers to the extent that they are responsible for the advertisements of any policy.

11:2–23.3 Definitions

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

"Advertisement" means material designed to create public interest in life insurance or annuities or in an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy, and for the purpose of this subchapter, includes:

1. Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters;

3. Material used for the recruitment, training and education of an insurer's sales personnel, agents, solicitors, and brokers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, or retain a policy; or

4. Prepared sales talks, presentations, and material for use by sales personnel, agents, solicitors, and brokers.

"Advertisement" for the purpose of this subchapter shall not mean:

1. Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

2. Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy;

3. A general announcement from a group or blanket policyholder to eligible individuals who are currently employees or members of the group that a policy or program has been written or arranged; provided that the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage; or

4. Any disclosure required under any rules currently in force or subsequently adopted in New Jersey governing specific aspects of the sale or replacement of life insurance including, but not limited to, rules dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance, replacement of life insurance policies, and rules concerning annuities and deposit funds.

"Endorsement" means any appraisal, analysis, testimonial or other public statement describing or expressing approval of any insurance product or the terms, benefits or any other aspect of any insurance product.

"Insurer" shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an "Insurer" in the insurance laws of this State or which issues life insurance or annuities in this State and is engaged in the advertisement of a policy.

"Person" means any individual, insurer, company, association, organization, society, partnership, syndicate, trust, corporation and every legal entity.

"Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

Amended by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a), 21 N.J.R. 2289(c).
Definitions of "endorsement" and "person" added.

11:2–23.4 Form and content of advertisements in general

(a) Advertisements shall be truthful and not misleading in fact or by implication. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive.

(b) Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(c) No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "savings," "savings plan," or other similar terms in connection with a policy when they have the tendency to mislead a purchaser or prospective purchaser into believing that he will receive something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

(d) The fact that the policy offered is made available to a prospective insured prior to consummation of the sale or that an offer is made to refund the premium if the purchaser is not satisfied does not remedy misleading statements.

11:2–23.5 Disclosure requirements

(a) All information required to be disclosed by this subchapter shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure, or presented in an ambiguous fashion, or intermingled with the context of the advertisements so as to be confusing or misleading.

(b) No advertisement shall omit material information or use words, phrases, statements, references, or illustrations if such omission or such use has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or State or Federal tax consequences.

(c) An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

(d) An advertisement for a policy with non-level premiums shall prominently describe the premium changes.

(e) Advertisements referring to dividends must comply with the following requirements:

1. An advertisement shall not utilize or describe dividends in a manner which is misleading or has the capacity or tendency to mislead;

2. An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends are illustrated, they must be based on the insurer's current dividend scale and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of dividends to be paid in the future; and

3. An advertisement shall not state or imply that illustrated dividends under a participating policy and/or pure endowments will be or can be sufficient at any future time to assure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains:

i. What benefits or coverage would be provided at such time; and

ii. Under what conditions this would occur.

(f) An advertisement shall not state a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general assets of the company.

(g) In the event an advertisement uses "Non–Medical," "No–Medical Examination Required," or similar terms where issuance of a policy is not guaranteed, such terms shall be accompanied by further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions.

(h) An advertisement shall not use as the name or title of a life insurance policy any phrase which does not include the words "life insurance" unless accompanied by other language clearly indicating that it is life insurance.

(i) An advertisement shall prominently describe the type of policy advertised, such as group, term, whole life, etc.

(j) An advertisement of an insurance policy marketed by direct response techniques, such as direct mail or toll-free telephone, shall not state or imply that because there is no agent or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the Commissioner of Insurance. Such justification must be available to the Commissioner upon request.

(k) Endorsements by third parties must comply with the following requirements:

1. Endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using an endorsement, adopts as its own all of the statements contained therein, and the advertisement, including such statements, shall be subject to all of the provisions of this subchapter.

2. A person shall be a "spokesperson" if either his or her image, voice or words are used in making an endorsement and if the person:

i. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

ii. Is an entity formed by the insurer, or is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

iii. Is in a policymaking position and is affiliated with the insurer in any of the capacities in (k)2i and ii above; or

iv. Is in any way directly or indirectly compensated for making the endorsement.

3. Any person acting as a spokesperson as defined in (k)2 above, who acts as or holds himself or herself out to be an insurance producer as defined at N.J.S.A. 17:22A, and who is required to have a license pursuant to N.J.S.A. 17:22A–3, shall be considered to be an insurance producer and shall be required to be licensed pursuant to and shall submit to the requirements of N.J.S.A. 17:22A–1 et seq. and any implementing rules.

4. Where, pursuant to (k)3 above, a spokesperson required to be licensed as an insurance producer is not licensed as an insurance producer, the advertisement shall include, in the manner prescribed by (k)5 below, the following statement: "This offer is not available in New Jersey." The requirements of this paragraph shall apply to cases where the advertisement originates in or emanates from another state but is received or appears in New Jersey and to advertisements which originate in or emanate from New Jersey.

5. The fact of a financial interest, or the proprietary or representative capacity of a spokesperson, shall be disclosed in an advertisement. In both television and radio advertising, the disclosure shall be spoken by the spokesperson and, in the case of television, visually presented consistent with the requirements for print advertising in this subsection. In print advertising, the disclosure shall be presented in a type style and size that is at least equal to the largest type otherwise used in the advertisement. The disclosure required by this paragraph shall be accomplished in the introductory portion of the endorsement and shall be given prominence.

6. If a spokesperson is directly or indirectly compensated for making an endorsement, such fact shall be disclosed by use of the phrase "This is a Paid Endorsement" or by words of similar meaning in the manner provided by (k)5 above. The requirements of this paragraph do not apply where the spokesperson is a company officer, a company director or an employee who is paid generally, but not specifically, for making the advertisement.

7. The disclosure requirements of this subchapter shall not apply where the sole financial interest or compensation of a spokesperson, for all endorsements made on behalf of the insurer, consists of the payment of union "scale" wages required by union rules, and if the payment is actually for such "scale" for television or radio performances.

8. An advertisement shall not state or imply that an insurer, policy or contract, or any type or line of insurance has been approved or endorsed by any individual, group of individuals, society, association, organization, governmental agency or other entity, unless such is the fact and any proprietary relationship between such individual(s) or entity and the insurer is disclosed and the prior written approval of the individual, group of individuals, society, association, organization, governmental agency or other person has been secured. Prior written approval shall not be required in cases where the endorsing individual is a company officer, company director or employee.

9. If the person making the endorsement in (k)8 above has been formed by the insurer or is owned, or controlled by the insurer, or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policymaking position in the association, that fact shall also be disclosed.

10. When an endorsement refers to benefits received under a policy for a specific claim, the claim date, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection until the completion by the Department of Insurance of the next market conduct examination of the insurer.

11. Endorsements which do not correctly reflect the present practices of the insurer or which are not applicable to the policy or benefits being advertised shall not be used.

12. An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency unless such is the fact and without prior written approval.

(*l*) An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

(m) Advertisements referring to introductory, initial, or special offers and enrollment periods must comply with the following requirements:

1. An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies;

2. An advertisement shall not state or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;

3. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised; and

4. An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered in New Jersey unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date on which such enrollment period is advertised for the first time.

i. Paragraph (m)4 above applies to all advertising media, that is, mail, newspapers, radio, television, magazines, and periodicals, by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

ii. Paragraph (m)4 above does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his or her request.

iii. Paragraph (m)4 above is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the New Jersey insurance laws for group or blanket insurance.

iv. In cases where an insurance product is marketed on a direct basis to prospective insureds by reason of some common relationship with a sponsoring organization, this rule shall be applied separately to each sponsoring organization.

(n) An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends, or underwriting privileges, unless such is the fact.

(*o*) An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends, or rates of other insurers. An advertisement shall not falsely or unfairly describe other insurers, their policies, services, or methods of marketing.

Amended by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a), 21 N.J.R. 2289(c).
At (k), requirements regarding third party endorsements greatly expanded.

11:2–23.6 Identification of insurer, plan and number of policies

(a) The name of the insurer shall be clearly identified, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. An advertisement shall not use a trade name, an insurance group designation, name of a parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

(b) No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols, or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

(c) When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

(d) When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

11:2–23.7 Jurisdictional licensing and status of insurer; statements about the insurer

(a) An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond such limits.

(b) An advertisement may state that an insurer is licensed in the state where the advertisement appears, provided that it does not exaggerate such fact or suggest or imply that competing insurers may not be so licensed.

(c) Such advertisements by direct mail insurers shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of some language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."

(d) An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. If a governmental entity has recommended or endorsed a policy form or plan, however, such fact may be stated if the entity authorized its recommendation or endorsement to be used in an advertisement and if the advertisement clearly defines the scope and extent of the recommendation.

(e) An advertisement shall not contain statements, pictures, or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

11:2–23.8 Insurers' responsibility and control; advertising file; certificate of compliance

(a) All advertisements, regardless of by whom written, created or designed, shall be the responsibility of the insurer sponsoring the same.

(b) Every insurer shall at all times maintain complete control over the content, form and method of distribution of all advertisements of its contracts.

(c) Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of blanket, franchise, and group policies hereafter distributed in this state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised.

(d) Such file shall be subject to regular and periodic inspection by the Department of Insurance.

(e) All such advertisements shall be maintained in said file for a period of five years from their last use.

(f) Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this subchapter must file with the Department of Insurance, together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief the advertisements were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of this State as implemented and interpreted by this subchapter.

Amended by R.1989 d.391, effective July 17, 1989.
See: 21 N.J.R. 970(a), 21 N.J.R. 2039(a), 21 N.J.R. 2290(a).
Deleted requirement that files be maintained for not less than four years.

11:2–23.9 Failure to comply

Failure to comply with the provisions of this subchapter shall subject the offender to the penalties set forth under N.J.S.A. 17B:30–17 and any other penalty authorized by law.

11:2–23.10 Severability

If any provision or clause of this subchapter or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the subchapter which can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are declared to be severable.

SUBCHAPTERS 24 THROUGH 25. (RESERVED)

SUBCHAPTER 26. ANNUAL AUDITED FINANCIAL REPORTS

Authority

N.J.S.A. 17:1–8.1; 17:1C–6(e); 17:23–1 et seq. and 17B:21–1 et seq.

Source and Effective Date

R.1989 d.612, effective December 18, 1989.
See: 21 N.J.R. 3054(a), 21 N.J.R. 3919(b).

11:2–26.1 Purpose

The purpose of this subchapter is to improve the Department's surveillance of the financial position of insurers by requiring an annual examination by independent certified public accountants of the financial statements reporting the financial position and the results of operations of insurers.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Financial "condition" changed to financial "position".

11:2–26.2 Scope

This subchapter shall apply to all insurers transacting business in the State of New Jersey except as provided at N.J.A.C. 11:2–26.14.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Citation corrected.

11:2–26.3 Definitions

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

"Alien insurer" means an insurer formed under the laws of any country other than the United States of America, its states, districts, territories, commonwealths or possessions.

"Audited financial report" means and includes those items specified in N.J.A.C. 11:2–26.5.

"Accountant" and "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which they are licensed to practice; for alien insurers, it means a chartered or similarly certified accountant.

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

"Department" means the Department of Insurance.

"Insurer" means any person, association, partnership or corporation licensed, authorized or eligible to transact the business of insurance in this State pursuant to Subtitle 3 of Title 17 or Subtitle 3 of Title 17B of the Revised Statutes of the State of New Jersey including, but not limited to, eligible surplus lines insurers, interinsurance exchanges and all risk retention groups as defined in 15 U.S.C. section 3901 doing business in New Jersey. Insurer does not include any statutory mechanism for providing insurance coverage in this State, including, but not limited to municipal joint insurance funds formed pursuant to N.J.S.A. 40A:10–36 et seq.

"Workpapers" means the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to his or her examination of the financial statements of an insurer. Workpapers may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her examination of the financial statements of an insurer and which support his or her opinion thereof.

Amended by R.1991 d.4, effective January 7, 1991.
See: 22 N.J.R. 1673(a), 23 N.J.R. 103(a).
Deleted reference to New Jersey Automobile Full Insurance Underwriting Association, in definition of "insurer".
Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Added "certified" to accountant and "audit planning documentation" to workpapers.

11:2–26.4 Filing of annual audited financial reports; extensions

(a) All insurers (unless exempted pursuant to N.J.A.C. 11:2–26.14) shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the Commissioner on or before June 1 for the year ended December 31 immediately preceding. The Commissioner may require an insurer to file an audited financial report earlier than June 1 upon 90 days advance written notice to the insurer.

(b) Extensions of the June 1 filing date may be granted by the Commissioner for 30 day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the Commissioner of good cause for an extension. The request for an extension must be submitted in writing not less than 10 days prior to the due date of the financial report in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Filing date changed to June 1, or earlier, if 90 day notice is given to the filer.

11:2–26.5 Contents of annual audited financial report

(a) The annual audited financial report shall reflect the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for such calendar year in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department.

(b) The annual audited financial report shall include:

1. A report of an independent certified public accountant;

2. A balance sheet reporting admitted assets, liabilities, capital and surplus;

3. A statement of operations;

4. A statement of cash flows;

5. A statement of changes in capital and surplus; and

6. Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and any other notes required by generally accepted accounting principles and shall also include:

i. A reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to N.J.S.A. 17:23–1 and 17B:21–1 with a written description of the nature of these differences;

ii. A summary of ownership and relationships of the insurer and all affiliated companies; and

iii. Such other information as may be specifically requested.

(c) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement filed with the Commissioner:

1. The financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. (However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.)

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
NAIC requirements added to (b)6; rounding and combining provisions at (c)2 and 3 deleted.

11:2–26.6 Qualifications of independent certified public accountant

(a) The Commissioner shall not recognize any person or firm as a qualified independent certified public accountant unless they are in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant is licensed to practice or, for alien insurers, that is not a chartered similarly certified accountant.

(b) Except as otherwise provided herein, an independent certified public accountant shall be recognized as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and Rules and Regulations, Code of Ethics and Rules of Professional Conduct of the New Jersey Board of Public Accountancy or similar code.

(c) No partner or other person responsible for rendering a report may act in that capacity for more than seven consecutive years. Following any period of service such person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of two years. An insurer may make application to the Commissioner for relief from the above rotation requirement on the basis of unusual circumstances. The Commissioner may consider the following factors in determining if the relief should be granted:

1. The number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

2. The premium volume of the insurer; or

3. The number of jurisdictions in which the insurer transacts business.

(d) The Commissioner shall not recognize as a qualified independent certified public accountant, nor accept any annual Audited Financial Report, prepared in whole or in part by, any natural person who:

1. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organization Act, 18 U.S.C. Sections 1961–1968, or any dishonest conduct or practices under Federal or state law, or similar conduct under any foreign law;

2. Has been found to have violated the insurance laws of this State with respect to any previous reports submitted under this rule; or

3. Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this subchapter.

(e) Whenever it appears that the certified public accountant or accounting firm retained by the insurer to conduct the annual audit is not a qualified independent certified public accountant as provided under these rules, the Department shall notify the insurer that it does not recognize the certified public accountant or accounting firm as qualified, and the Department will not accept any annual audited Financial Report prepared by that accountant or accounting firm.

1. Upon receipt of such notice from the Department, the insurer may, within 20 days, request an administrative review on the issue of the qualifications of the independent certified public accountant or accounting firm retained by the insurer.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
"Qualified" specified at (a) and (b); subsections (c)-(e) added to specify qualifications necessary.

11:2–26.7 Certification by independent certified public accountant

(a) Each insurer required by this subchapter to file an annual audited financial report shall within 60 days after becoming subject to such requirement, register with the Commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this subchapter. Insurers not retaining an independent certified public accountant on the effective date of this rule as amended shall register the name and address of their retained certified public accountant not less than six months before the date when the audited financial report is to be filed.

(b) The insurer shall also obtain a letter from the accountant, and file a copy with the Commissioner, stating that the accountant is aware of the provisions of the insurance statutes and administrative rules of this State that relate to accounting and financial matters. The accountant shall also certify that he or she will express his or her opinion on the financial statements in the terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the Department and specify such exceptions as he or she may believe appropriate.

(c) In addition to the requirements in (a) and (b) above, if the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five business days notify the Department of this event. The insurer shall also furnish the Commissioner with a separate letter within 10 business days of the above notification stating whether in the 24 months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him to make reference to the subject matter of the disagreement in connection with his opinion. The disagreements required to be reported in response to this subsection include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this subsection are those that occur at the decision-making level (that is, between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report). The insurer shall also request in writing that such former accountant furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he does not agree; and the insurer shall furnish such responsive letter from the former accountant to the Commissioner together with its own.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Requirements to register independent accountant added.

11:2–26.8 Consolidated or combined audits

(a) An insurer may make written application to the Commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report as follows:

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

2. Amounts for each insurer subject to this section shall be stated separately;

3. Noninsurance operations may be shown on the worksheet on a combined or individual basis;

4. Explanations of consolidating and eliminating entries shall be included; and

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

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Pool requirement added for consolidated statements.

11:2–26.9 Scope of examination and report

Financial statements furnished pursuant to N.J.A.C. 11:2–26.5 shall be examined by an independent certified public accountant. The examination of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. Consideration should also be given to such other procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Stylistic changes.

11:2–26.10 Notification of adverse financial condition

(a) An insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report in writing within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Commissioner as of the balance sheet date currently under examination or that the insurer does not meet the minimum capital and surplus requirements as of that date. An insurer who has received a report pursuant to this section shall forward a copy of the report to the Commissioner within five business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Commissioner. If the independent certified public accountant fails to receive such evidence within the required five business day period, the independent certified public accountant shall furnish to the Commissioner a copy of its report within the next five business days. No independent public accountant shall be liable in any manner to any person for any statement made in connection with this subsection if such statement is made in good faith in compliance with this subsection.

(b) If the accountant, subsequent to the date of the audited financial report filed pursuant to this subchapter, becomes aware of facts which might have affected his or her report, the accountant shall take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the American Institute of Certified Public Accountants, incorporated herein by reference.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Processing of notice of adverse condition specified further at (a).

11:2–26.11 Report on significant deficiencies in internal controls

(a) In addition to the annual audited financial report, each insurer shall file with the Commissioner a written report prepared by the accountant describing any significant deficiencies known as "reportable conditions" in the insurer's internal control structure noted by the accountant during the audit which an accountant is required to report to appropriate parties within an entity pursuant to SAS No. 60, Communication of Internal Control Structure Matters Noted in an Audit (AU Section 325 of the Professional Standards of the American Institute of Certified Public Accountants).

(b) No report should be issued if the accountant does not identify one or more significant deficiencies.

(c) If one or more significant deficiencies are noted, the written report shall be filed annually by the insurer with the Department within 60 days after the filing of the annual audited financial report. The insurer shall provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on evaluation of accounting procedures and system of internal control deleted; new rule on report on significant deficiencies in internal controls added.

11:2–26.12 Accountant's letter of qualifications

(a) The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

1. That the accountant is independent with respect to the insurer and conforms to the standards of the profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and the Rules of Professional Conduct of the New Jersey Board of Public Accountancy, or similar code;

2. The background and experience in general, and the experience in insurance audits of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this rule shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where such use is consistent with the standards prescribed by generally accepted auditing standards;

3. That the accountant understands the annual audited financial report and the accountant's opinion thereon will be filed in compliance with this subchapter, and that the Commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

4. That the accountant consents to the requirements of N.J.A.C. 11:2–26.13 and that the accountant consents and agrees to make available for review by the Commissioner, his or her designee or his or her appointed agent, the workpapers, as defined in N.J.A.C. 11:2–26.3;

5. A representation that the accountant is properly licensed by an appropriate state licensing authority and that he is a member in good standing in the American Institute of Certified Public Accountants; and

6. A representation that the accountant is in compliance with the requirements of N.J.A.C. 11:2–26.6.

New Rule, R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Prior rule on availability and maintenance of workpapers recodified to 26.13.

11:2–26.13 Availability and maintenance of workpapers

(a) Every insurer required to file an audited financial report pursuant to this subchapter shall require the accountant to make available for review by the Commissioner, all the workpapers prepared in the conduct of his or her examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department or at any other reasonable place designated by the Commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the Department has filed a Report on Examination covering the period of the audit and determined that the audit workpapers and communications need no longer be retained or for no longer than 10 years from the date the accountant submits the audit report to the insurer, whichever occurs first.

(b) In the conduct of the periodic review by the Commissioner, photocopies of pertinent audit workpapers may be made and retained by the Commissioner. Such reviews by the Commissioner shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the Department.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on exemptions recodified to 26.14; rule on availability and maintenance of workpapers recodified from 26.12, with amendments added regarding all communications regarding the audit and confidentiality of all workpapers and communications.

11:2–26.14 Exemptions

(a) Insurers having direct premiums written in this State of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year shall be exempt from this subchapter for such year (unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

(b) Foreign or alien insurers having direct premiums written in this State of less than $250,000 in any year and having less than 500 policyholders in this State at the end of any year are exempt from compliance with this subchapter for such year (unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out statutory responsibilities).

(c) Insurers filing audited financial reports in another state, pursuant to such other state's requirement of audited financial reports which have been found by the Commissioner to be substantially similar to the requirements herein, are exempt from compliance with this subchapter if:

1. A copy of the audited financial report, the report on any significant deficiencies in internal controls, and the accountant's letter of qualifications which are filed with such other state are filed with the Commissioner in accordance with the filing dates specified in N.J.A.C. 11:2–26.4, 26.11 and 26.12 respectively (Canadian insurers may submit accountants' reports as filed with the Canadian Dominion Department of Insurance); and

2. A copy of any notification of adverse financial condition report filed with such other state is filed with the Commissioner within the time specified in N.J.A.C. 11:2–26.10.

(d) Upon written application of any insurer, the Commissioner may grant an exemption from compliance with this subchapter if the Commissioner finds, upon review of the application, that compliance would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specific period or periods.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on compliance dates repealed; rule on exemptions recodified from 26.13, with new subsection (a) added.

11:2–26.15 Alien insurers

(a) In the case of alien insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their domiciliary supervision authority duly audited by an independent chartered or similarly certified accountant.

(b) For such insurers, the letter required in N.J.A.C. 11:2–26.6 shall state that the accountant is aware of the requirements relating to the annual audited statement filed with the Commissioner pursuant to N.J.A.C. 11:2–26.4 and shall affirm that the opinion expressed is in conformity with such requirements.

Amended by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on reports prepared in accordance with generally accepted accounting principles repealed; rule on alien insurers recodified from 26.16.

11:2–26.16 Confidentiality of documents

All documents submitted to the Commissioner pursuant to this subchapter are confidential and not public documents as defined in the Public Records Act, N.J.S.A. 47:1A–1 et seq.

Recodified by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on alien insurers recodified to 26.15; rule on confidentiality of documents recodified from 26.17.

11:2–26.17 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as provided by law.
Recodified by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on confidentiality of documents recodified to 26.16; rule on penalties recodified from 26.18.

11:2–26.18 Severability

If any section of this subchapter is held to be invalid, the remaining parts of this subchapter are not to be affected.

Recodified by R.1993 d.68, effective February 1, 1993.
See: 24 N.J.R. 1940(a), 24 N.J.R. 2708(a), 25 N.J.R. 588(a).
Rule on penalties recodified to 26.17; rule on severability recodified from 26.19.

SUBCHAPTER 27. DETERMINATION OF INSURERS IN A HAZARDOUS FINANCIAL CONDITION

Source and Effective Date

R.1992 d.292, effective July 6, 1992.
See: 23 N.J.R. 3197(a), 24 N.J.R. 2456(a).

11:2–27.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the factors which the Commissioner shall consider in determining whether an insurer is in a hazardous financial condition as defined herein. A determination of hazardous financial condition provides one of the grounds upon which the Commissioner may seek an order from the Superior Court to rehabilitate, liquidate the business or conserve the assets within this State of domestic, foreign or alien insurers pursuant to N.J.S.A. 17:30C–1 et seq. and 17B:32–31 et seq., or upon which an insurer may become subject to administrative supervision pursuant to P.L. 1993, c.245, and provides one of the grounds upon which the Commissioner may take action to revoke or nonrenew an insurer's authority to transact insurance in this State, or withdraw the eligibility of an eligible surplus lines insurer to insure surplus lines risks in the State pursuant to law, including, but not limited to, N.J.S.A. 17:32–2, 17B:23–2, and 17:22–6.46.

(b) This subchapter shall apply to all domestic, foreign and alien insurers and all other entities subject to N.J.S.A.

17:30C–1 et seq., 17B:32–31 et seq., or P.L. 1933, c.245; and to all eligible surplus lines insurers.

Emergency Amendment, R.1993 d.447, effective August 16, 1993 (expired October 15, 1993).
See: 25 N.J.R. 4286(a).
Adopted Concurrent Proposal, R.1993 d.556, effective October 15, 1993.
See: 25 N.J.R. 4286(a), 25 N.J.R. 5182(a).

11:2–27.2 Definitions

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

"FAVR" means the asset valuation reserve calculated for purposes of completing the NAIC annual statement in accordance with its instructions and Accounting Practices and Procedures Manual.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the insurer as defined in N.J.S.A. 17:27A–1.

"Department" means the New Jersey Department of Insurance.

"Eligible surplus lines insurer" means an unauthorized insurer in which an insurance coverage is placed or may be placed pursuant to N.J.S.A. 17:22–6.40 et seq.

"Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, an insurer, although not yet financially impaired or insolvent, is unlikely to be able:

1. To meet obligations to policyholders, certificate holders and other insureds with respect to known claims and reasonably anticipated claims; or

2. To pay other obligations in the normal course of business.

"Insurer" means a person subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the Commissioner pursuant to N.J.S.A. 17:30C–1 et seq., 17B:32–31 et seq. or P.L. 1993, c.245, or by the equivalent insurance supervisory official of another state. "Insurer" includes all persons purporting to be engaged in the business of insurance as an insurer in this State and all persons in the process of organization to become insurers.

"Life and health insurer" means an insurer authorized or admitted pursuant to the provisions of Title 17B of the Revised Statutes to solely transact the business of life insurance, health insurance or annuities in this State as those terms are defined in N.J.S.A. 17B:17–3, 17B:17–4 and 17B:17–5, respectively.

"NAIC" means the National Association of Insurance Commissioners.

Emergency Amendment, R.1993 d.447, effective August 16, 1993 (expired October 15, 1993).
See: 25 N.J.R. 4286(a).
Adopted Concurrent Proposal, R.1993 d.556, effective October 15, 1993.
See: 25 N.J.R. 4286(a), 25 N.J.R. 5182(a).

11:2–27.3 Determination of hazardous financial condition; factors

(a) The Commissioner shall consider the following factors, either singly or in a combination of two or more, in determining whether an insurer is in a hazardous financial condition:

1. Adverse findings reported in financial condition and market conduct examination reports and/or failure to comply with recommendations contained therein;

2. Adverse findings from the NAIC Insurance Regulatory Information System and its related reports;

3. The ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annualized premium and net investment income which could lead to an impairment of capital and surplus;

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

5. A finding that an assuming reinsurer is not able to meet the obligations being assumed or that the insurer's reinsurance program does not provide sufficient protection for the company's remaining surplus, after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

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

7. A finding that any parent, affiliate, subsidiary or reinsurer is insolvent, or, in the opinion of the Commissioner, is threatened with insolvency or is delinquent in payment of its monetary or other obligations;

8. A finding that contingent liabilities, pledges or guarantees, either individually or collectively, involve a total amount which, in the opinion of the Commissioner, may affect the solvency of the insurer;

9. A finding that any person controlling an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer;

10. The age and doubtful collectability of receivables;

11. A finding that the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, expertise and reputation deemed necessary by the Commissioner;

12. A finding that the management of an insurer has failed to respond to inquiries from the Commissioner regarding the condition of the insurer or has furnished false and misleading information concerning such inquiries;

13. A finding that the management of an insurer has filed any false or misleading financial statement, has released any false or misleading financial statement to lending institutions or to the general public, has made a false or misleading entry or has omitted an entry of a material amount in the books of the insurer;

14. A finding that, in the opinion of the Commissioner, the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meets its obligations in a timely manner;

15. A finding that, in the opinion of the Commissioner, the company has experienced or will experience in the foreseeable future cash flow and/or liquidity problems;

16. A finding that the surplus as regards policyholders is not adequate in relation to the amount of the insurer's loss and loss adjustment expense reserve liabilities established;

17. A finding that a life insurer's surplus as regards policyholders plus AVR reserves is not adequate in relation to the amount of liabilities less AVR reserves less separate account liabilities;

18. A finding that the insurer does not possess the minimum capital and surplus (in the case of stock insurers) or net assets (in the case of mutual insurers) required by statute to be maintained or as otherwise required by the Commissioner pursuant to law;

19. A finding that the insurer has reinsurance reserve credits, recoverables or receivables due from insurance companies in receivership and such credits, recoverables or receivables are greater than 25 percent of surplus or 15 percent of admitted assets;

20. A finding that a life and health insurer has taken a credit for reserves for business assumed from an insurance company in receivership under a modified co-insurance system or in any other manner in which the ceding insurer withholds assets, and such reserve credit is greater than 25 percent of surplus or 15 percent of admitted assets;

21. A finding that the insurer has issued subordinated premium or surplus debentures to finance its operations without the prior approval of the Commissioner for use as policyholder surplus;

22. A finding that the insurer has failed to maintain books and records sufficient to permit examiners to determine the financial condition of the insurer;

23. A finding that the insurer has moved the location of the books and records necessary to conduct an examination of such insurer without notifying the Department of such location;

24. A finding that the owners or management of an insurer have engaged in unlawful transactions;

25. A finding that the insurer has delegated the administration of an insurance function necessary to such insurer's survival directly or indirectly to a person without adequate controls and/or which creates a conflict of interest;

26. A finding that the insurer has a pattern of not settling valid claims within a reasonable time after due proofs of loss have been received by such insurer;

27. A finding that the insurer has been issued a final administrative or judicial order, initiated by an insurance regulatory agency of another state, with a finding that such insurer is insolvent or in a hazardous financial condition;

28. A finding that the insurer does not follow a policy on rating and underwriting standards appropriate to the risk; and

29. A finding of any other fact or circumstance that indicates that an insurer is in a hazardous financial condition.

(b) The Commissioner shall presume that the factor set forth in (a)4 above exists with respect to a domestic property and casualty insurer if the Commissioner finds the following:

1. The insurer has invested in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, in amounts which exceed the lesser of 10 percent of such insurer's assets or 50 percent of such insurer's surplus as regards policyholders, or that otherwise after such investments that the insurer's surplus as regards policyholders is not reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

i. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries shall be excluded, and there shall be included:

(1) The total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by

the purchase of capital stock or issuance of other securities; and

(2) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation; or

2. The insurer has invested any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, and that each such subsidiary has not agreed to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed the investment limitations described in (b)1 above or in any other applicable provision of N.J.S.A. 17:24–1 et seq. The total investment of the insurer shall include any direct investment by the insurer in an asset, and the insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of such subsidiary.

(c) An insurer may rebut the presumption as set forth in (b) above pursuant to N.J.A.C. 11:2–27.4(b) by demonstrating to the Commissioner that after such investments the insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(d) In making a determination of an insurer's financial condition pursuant to this subchapter, the Commissioner may adjust assets and liabilities as necessary to accurately reflect the insurer's financial position in any manner including, but not limited to, the following:

1. Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding, or which has entered into an invalid reinsurance agreement;

2. Make appropriate adjustments to asset values in its investment portfolio or attributable to investments in or transactions with parents, subsidiaries, or affiliates;

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

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

Emergency Amendment, R.1993 d.447, effective August 16, 1993 (expired October 15, 1993).
See: 25 N.J.R. 4286(a).
Adopted Concurrent Proposal, R.1993 d.556, effective October 15, 1993.
See: 25 N.J.R. 4286(a), 25 N.J.R. 5182(a).
Amended by R.1994 d.550, effective November 7, 1994.
See: 26 N.J.R. 3589(a), 26 N.J.R. 4407(a).

11:2–27.4 Determination of hazardous financial condition; corrective action

(a) If the Commissioner determines that the continued operation of an insurer may be hazardous to the policyholders or public in this State, the Commissioner may, upon such a determination, subject the insurer to administrative supervision pursuant to P.L. 1993, c.245 and may issue an order requiring the insurer to take such actions as the Commissioner deems necessary to abate such determination, including, but not limited to:

1. Reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. Reduce, suspend or limit the volume of business being accepted or renewed;

3. Reduce general insurance and commission expenses by specified methods;

4. Increase the insurer's capital and surplus;

5. Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

6. File reports in a form acceptable to the Commissioner concerning the market value of an insurer's assets;

7. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Commissioner deems necessary;

8. Document the adequacy of premium rates in relation to the risks insured;

9. File, in addition to regular annual statements, interim financial reports on the form adopted by the NAIC or in such format as prescribed by the Commissioner; or

10. Take such other actions as the Commissioner may deem necessary in a particular case to protect the insurer's policyholders and the public.

(b) If an insurer is subject to an order issued by the Commissioner pursuant to (a) above, and the insurer objects to the actions ordered to be taken as set forth therein, the insurer may request a hearing before the Department on the Commissioner's determination within 10 days from the date of receipt of such order as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the manner wherein the action(s) ordered by the Commissioner would not result in improving the condition of the insurer.

2. Pursuant to P.L. 1993, c.245, all proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the supervision of the insurer are confidential, except as otherwise provided by P.L. 1993, c.245. Any confidential proceedings in connection with an order issued pursuant to this rule and P.L. 1993, c.245 shall be held by the Commissioner or his designee at the Department.

3. The Commissioner may open such 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, or make such information public, 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, is in the best interest of the public, or in the best interest of the insurer, its insureds or creditors.

(c) Nothing contained in this section shall be construed to limit or preclude the Commissioner from independently requiring an insurer to take specific actions or limit specified activities pursuant to other provisions of Title 17 or 17B of the Revised Statutes.

Emergency New Rule, R.1993 d.447, effective August 16, 1993 (expired October 15, 1993).
See: 25 N.J.R. 4286(a).
Adopted Concurrent Proposal, R.1993 d.556, effective October 15, 1993.
See: 25 N.J.R. 4286(a), 25 N.J.R. 5182(a).
Changes upon adoption effective November 15, 1993.

SUBCHAPTER 28. CREDIT FOR REINSURANCE

Authority

N.J.S.A. 17:1C–6(e) and P.L. 1993 c.243.

Source and Effective Date

R.1993 d.557, effective October 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

Subchapter Historical Note

Subchapter 28, Credit for Reinsurance, was adopted as emergency new rules R.1993 d.448, effective August 16, 1993 (to expire October 15, 1993). See: 25 N.J.R. 4289(a). The provisions of R.1993 d.448 were readopted as R.1993 d.557. See: Source and Effective Date.

11:2–28.1 Purpose and scope

(a) The purpose of these rules is to implement the provisions of P.L. 1993, c.243 by establishing procedures to be employed by insurers which cede risks to appropriate reinsurers and which assume the risk from the ceding insurers to whom these rules apply.

(b) This subchapter applies to all insurers which transact business in this State, except as described in (b)2 below, including insurers which are domiciled in this State. This subchapter also applies to insurers which are either licensed to transact business in this State or are eligible to write surplus lines insurance in this State, and which in either case are domiciled in a state or country which does not employ standards regarding credit for reinsurance substantially similar to the standards set forth herein.

1. For a life and health ceding insurer to qualify for a credit for reinsurance in accordance with this subchapter, the ceding insurer shall also comply with the requirements of P.L. 1993, c.243 and all administrative rules promulgated thereunder concerning the regulation of life and health reinsurance contracts.

2. Where an insurer which is either licensed to transact business in this State or is an eligible surplus lines insurer in this State and in either case the state in which it is domiciled is accredited by the NAIC or employs standards regarding credit for reinsurance as determined by the Commissioner to be substantially similar to the standards set forth in these rules, the insurer shall comply with the rules regarding credit for reinsurance in its state of domicile.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.2 Definitions

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

"Annual statement" means a statement showing an insurer's financial condition at the close of business on December 31 of the preceding year and its business for that year in the form adopted by the NAIC, prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the NAIC and all applicable provisions of law.

"Assuming insurer" or "reinsurer" means any person which engages in the activity of insuring part or all of an insurance risk from an originating or ceding insurer.

"Authorized officer" means the president of the company whose signature is attested to by the secretary of the company or any such equivalent officers or individuals.

"Beneficiary" as used in connection with the establishment of a trust agreement means the entity for whose sole

benefit the trust has been established and any successor of the beneficiary by operation of law. Where a court of competent jurisdiction appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, conservator, rehabilitator or liquidator.

"Ceding insurer" means an insurer which procures indemnification for itself from an assuming insurer with respect to all or part of an insurance risk associated with one or more policies which it issued should losses be sustained.

"Certificate of eligibility" means a certificate issued by the Commissioner evidencing the authority of an unauthorized insurer to transact the business of surplus lines insurance in this State.

"Clean and unconditional letter of credit" or "clean and unconditional confirmation" means a letter of credit or confirmation which:

1. Makes no reference to any other agreement, document or entity;

2. Provides that a beneficiary need only draw a sight draft under the letter of credit or confirmation and present it to promptly obtain funds and that no other document need be presented; and

3. Indicates that it is not subject to any conditions or qualifications outside of the letter of credit.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Date of the ceding insurer's statutory financial statement" means the period ending date for which the statutory financial statement is rendered.

"Delinquency proceeding" means, for the purpose of this subchapter, any proceeding commenced against a reinsurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such reinsurer.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of the State of New Jersey.

"Eligible surplus lines insurer" means an unauthorized insurer which is issued a certificate of eligibility to transact the business of insurance in this State and in which insurance coverage is placed or may be placed pursuant to N.J.S.A. 17:22–6.40 et seq.

"Evergreen" means a provision in a letter of credit or its confirmation which prevents the expiration of the letter of credit or its confirmation without due advance written notice to the beneficiary from the issuing or confirming bank or trust company.

"Grantor" as used in connection with the establishment of a trust agreement means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

"Insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17–1 et seq. or N.J.S.A. 17B–17–1 et seq.; any medical service corporation operating pursuant to N.J.S.A. 17:48A–1 et seq.; any hospital service corporation operating pursuant to N.J.S.A. 17:48–1 et seq.; any health service corporation operating pursuant to N.J.S.A. 17:48E–1 et seq.; or any dental service corporation operating pursuant to N.J.S.A. 17:48C–1 et seq.

"NAIC" means the National Association of Insurance Commissioners.

"Net assets" means an insurer's total admitted assets less its total reserves and other liabilities.

"Obligations" as used in connection with the establishment of a trust agreement means:

1. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

2. Reserves for reinsured losses reported and outstanding;

3. Reserves for reinsured losses incurred but not reported; and

4. Reserves for allocated reinsured loss expenses and unearned premiums.

"Qualified United States financial institution":

1. As used at N.J.A.C. 11:2–28.8(b)3 and 28.10 means an institution that:

i. Is organized or, in the case of a branch or agency office of a foreign banking organization in the United States, licensed, under the laws of the United States or any state thereof;

ii. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and

iii. Has been determined by either the Commissioner, or 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; or

2. As used elsewhere in this subchapter means an institution that:

i. Is organized or, in the case of a branch or agency office of a foreign banking organization in the United States, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

ii. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

"Reinsurance" means a contractual arrangement, as evidenced by a written agreement, whereby an insurer, for some consideration, agrees to indemnify a ceding insurer, for all or part of a loss which the ceding insurer may incur under one or more policies that the ceding insurer has or will issue.

"Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

"Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, which solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of that insurer unless expressly provided in a broker of record letter.

"Reinsurance intermediary-manager" means a person which has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for that reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term, except that the following persons shall not be considered a reinsurance intermediary-manager, with respect to that reinsurer, for the purposes of this subchapter:

1. An employee of the reinsurer;

2. A United States manager of a United States branch of an alien reinsurer;

3. An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to N.J.S.A. 17:27A–1 et seq., and whose compensation is not solely based on the volume of premiums written;

4. The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner or other similar regulatory officer of the state in which the manager's principal business office is located;

5. A licensed attorney-at-law who negotiates contracts or provides general financial counsel provided no commission or brokerage fee is provided.

"Substantially similar standards" means standards on credit for reinsurance which the Commissioner determines are equal to or exceed the standards of this subchapter.

"Surplus as regards policyholders" means the net assets of the insurer or assuming insurer.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.3 Reinsurer licensed in New Jersey

An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where the assuming insurer is licensed to transact business in this State as of the date of the ceding insurer's statutory financial statement, except as limited in accordance with N.J.A.C. 11:2–27.

11:2–28.4 Reinsurer accredited in New Jersey

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where the assuming insurer is accredited as a reinsurer in this State as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which meets all of the following standards:

1. Files with the Commissioner a letter requesting approval for accreditation and listing the information upon which it will rely and is submitting in connection therewith;

2. Submits a non-refundable filing fee made payable to Treasurer, State of New Jersey, of $1,000 for an initial filing and $1,000 for a renewal filing;

3. Files with the Commissioner a properly executed form AR–1 (incorporated herein by reference as Exhibit 1 in the Appendix) which establishes that it submits to this State's jurisdiction and this State's authority to examine its books and records;

4. Files with the Commissioner a certified copy of a certificate of authority, a certificate of compliance or an equivalent document which has been properly notarized, as evidence that it is currently licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an assuming alien insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

5. Files annually with the Commissioner:

i. A copy of its most recent annual statement filed with the insurance department of its state of domicile;

ii. Its most recent audited financial statement;

iii. A current actuarial opinion which certifies:

(1) For a property and casualty insurer, to the adequacy of the loss and loss adjustment expense reserves; or

(2) For a life and health assuming insurer that:

(A) Its policy reserves are adequate;

(B) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(C) That its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, and attaches any and all documents in support thereof; and

iv. The quarterly statement for the quarter immediately preceding the application, except for renewals which shall require the quarterly statement due May 15;

6. Either:

i. Maintains a surplus as regards policyholders in an amount not less than $20,000,000 and whose accreditation has not been denied by the Commissioner within 120 days of filing its submission with the Commissioner; or

ii. Maintains a surplus as regards policyholders of less than $20,000,000 whose accreditation has been approved by the Commissioner; and

7. Provides any additional information which may include, but is not limited to, information which the Commissioner deems necessary to ensure that the particular reinsurer's condition and methods of operation are not such as would render its operations hazardous to the public or its policyholders.

(b) The above information shall be filed with the Commissioner at:

Attention: Reinsurance Accreditation
Division of Financial Examinations
Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

(c) Except for applicants for accreditation that maintain surplus as regards policyholders of less than $20,000,000, an initial application for accreditation shall be deemed approved unless the Commissioner transmits a letter to the filer, within 120 days from the date of the filing of the completed application identifying the reasons upon which the Commissioner has denied the filer's accreditation. Where a filing is deemed approved, the initial approval shall be valid until August 31. If the initial approval is issued after June 1, it shall be deemed valid until August 31, of the following year.

(d) A reinsurer shall apply for renewal of its accreditation annually at the address in (b) above, to the attention of "Renewal Reinsurance Accreditation." The reinsurer shall file its application for renewal no later than June 1 of any year in which it seeks to continue its accreditation and shall submit updated information as required in (a) above.

(e) A renewal filed in accordance with the above shall be deemed approved unless denied by the Commissioner prior to August 31.

(f) An accredited reinsurer shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

1. Any limitation on its ability to write new or renewal business;

2. Any delinquency proceedings;

3. The suspension, revocation or nonrenewal of its certificate of authority in any state or jurisdiction;

4. An order or any action by any state or jurisdiction which requires it to cease writing new or renewal business; or

5. Any action by any state or jurisdiction requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

(g) Where the Commissioner determines that an assuming insurer has failed to maintain any of the qualifications set forth in (a)1 through 7 and (f) above, after written notice and opportunity for a hearing in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., the Commissioner may revoke or refuse to renew the assuming insurer's accreditation.

(h) The Department shall promulgate annually on October 31, a list of accredited reinsurers. The list shall be published in the New Jersey Register as a public notice.

(i) An insurer shall be prohibited from reporting a credit with respect to reinsurance ceded after 90 days from the date an assuming insurer has had its accreditation denied, revoked or nonrenewed.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).
Public Notice: List of accredited reinsurers.
See: 26 N.J.R. 4836(a).

11:2–28.5 Reinsurer domiciled and licensed in another state or jurisdiction which employs substantially similar standards to this subchapter

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement:

1. Is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer, is entered through and licensed in, a state which employs substantially similar standards regarding credit for reinsurance to those set forth in this subchapter;

2. Submits a non-refundable filing fee of $250.00 made payable to Treasurer, State of New Jersey;

3. Files with the Commissioner a certified copy of a certificate of authority, a certificate of compliance or an equivalent document which has been properly notarized as evidence that it is licensed to transact insurance or reinsurance in its state of domicile or, in the case of a United States branch of an assuming alien insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

4. Files with the Commissioner a properly executed form AR–1 (see Appendix) as evidence that it submits to this State's jurisdiction and authority to examine its books and records;

5. Files with the Commissioner a certification executed by an authorized officer of the reinsurer which certifies that the reinsurer's condition and method of operations are financially sound and will not render its operations hazardous to the public or its policyholders as determined by the factors set forth at N.J.A.C. 11:2–27.4. The officer shall certify that:

i. For a life and health assuming insurer, that:

(1) Its policy reserves are adequate; and

(2) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(3) Its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, and attaches any and all documents in support thereof;

ii. For a property and casualty assuming insurer, that net premium written to surplus as to policyholders does not exceed a 3:1 premium to surplus ratio and loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio as of the date of the certified balance sheet from its most recent annual statement; and

iii. Except for reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system, that it maintains a surplus as regards policyholders in an amount not less than $20,000,000;

6. A reinsurer shall append to the certification set forth in (a)5 above, a certified balance sheet from the reinsurer's most recent annual statement;

7. Within 90 days from the date of receipt of the completed filing, the filing shall either be deemed approved or the Commissioner shall transmit a letter to the filer which identifies the reasons upon which the Commissioner has found that either the reinsurer's state or jurisdiction of domicile does not employ substantially similar standards or the reinsurer otherwise fails to satisfy the requirements of this subchapter;

8. A reinsurer authorized pursuant to this section shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

i. Any limitation on its ability to write new or renewal business;

ii. Any delinquency proceedings;

iii. A suspension, revocation or nonrenewal of its certificate of authority in any state or jurisdiction;

iv. An order or any action by any state or jurisdiction which requires it to cease writing new or renewal business; or

v. Any action, by any state or jurisdiction, requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

9. The above information shall be filed with the Commissioner at:

Attention: Reinsurance—Similar Standards
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

11:2–28.6 Reinsurer maintaining trust funds

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where as of the date of the ceding insurer's statutory financial statement the assuming insurer meets the standards set forth in (a)1 and 2 below, in accordance with the procedures set forth in (a)3 through 8 below:

1. The assuming insurer maintains a trust fund in an amount prescribed in (b) below in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest.

2. The assuming insurer files with the Commissioner a letter requesting authorization to provide reinsurance. The letter shall specify: that the reinsurer seeks authorization based on the fact that it maintains trust funds for the benefit of its ceding insurers and United States policyholders; the location of the trust funds; and a list of documents and information submitted therewith and upon which the assuming insurer shall rely in connection with its request for authorization. The reinsurer shall submit to the Commissioner the following:

i. A nonrefundable filing fee made payable to Treasurer, State of New Jersey of $1,000 for an initial filing and $1,000 for a renewal filing;

ii. A properly executed form AR–1;

iii. A description of which categories of insurance are effected by the cessions;

iv. A certification executed by an authorized officer of the reinsurer which certifies that the reinsurer's condition and method of operations are financially sound and will not render its operations hazardous to the public or its policyholders as determined in accordance with the factors set forth at N.J.A.C. 11:2–27.4. The officer shall certify:

(1) For a life and health assuming insurer, that:

(A) Its policy reserves are adequate;

(B) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(C) Its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, together with any and all documents in support thereof;

(2) For a property and casualty assuming insurer, that net premium written to surplus as to policyholders does not exceed a 3:1 premium to surplus ratio and loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio as of the date of the certified balance sheet from its most recent annual statement; and

(3) To the accuracy of the information required by (b) below;

v. A certified balance sheet from the reinsurer's most recent annual statement; and

vi. A list of the assets of the trust certified by the trustee.

3. The information in (a)1 and 2 shall be filed with the Commissioner at:

Attention: Reinsurance Trust Fund
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

4. A reinsurer shall reapply for authorization annually at the address set forth in (a)3 above no later than June 1 of each year.

5. Within 30 days from receipt of the information in (a)1 and 2 above the Commissioner shall notify the filer of any deficiencies in its submission and the filer shall have 30 days to cure such deficiencies.

6. Within 90 days from the date of receipt of the completed filing, the filing shall either be deemed approved or the Commissioner shall transmit a letter to the filer which identifies the reasons upon which he or she has relied to determine that the filer has not met the requirements of this section and that insurers shall be prohibited from reporting credits for reinsurance for insurance ceded to the filer.

7. A reinsurer authorized pursuant to this section shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

i. Any limitation on its new or renewal business;

ii. Any delinquency proceedings;

iii. Its certificate of authority is suspended, revoked or nonrenewed in any state or jurisdiction;

iv. An order has been entered or any action has been taken by any state or jurisdiction which requires it to cease writing new or renewal business; or

v. Any action, by any state or jurisdiction, requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

8. An assuming insurer shall report annually to the Commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers to be evaluated by the Commissioner, including, but not limited to: a recent actuarial opinion which certifies to the adequacy of the loss and loss adjustment expense reserve liabilities, and, where applicable, life and health reserve liabilities, in order to determine the sufficiency of the trust fund; and any additional information the Commissioner deems necessary to ensure that the assuming insurer's condition and method of operation are not such as would render its operations hazardous to the public or policyholders in this State.

(b) In order to qualify as a reinsurer as provided in (a) above, an assuming insurer shall establish a trust fund. The trust fund established by the assuming insurer shall meet the following standards based upon the following category of assuming insurer into which it falls:

1. The trust fund for a single assuming insurer shall consist of a trusteed account in an amount not less than the assuming insurer's liabilities attributable to business written in the United States, and, in addition, a trusteed surplus of not less than $20,000,000.

2. The trust fund for a group of insurers, which group includes individual unincorporated underwriters, shall consist of a trusteed account in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of not less than $100,000,000 shall be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the Commissioner an annual certification of the solvency of each underwriter for the fiscal period immediately preceding, which fiscal period shall not be less than one year, by the group's domiciliary regulator and its independent certified public accountant.

3. The trust fund for a group of incorporated insurers under common administration which complies with the filing requirements set forth in this section whose members possess aggregate policyholder's surplus of $10,000,000,000, calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC, and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the group's several liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which not less than $100,000,000 shall be held jointly and exclusively for the benefit of the United States ceding insurers of any member of the group. The group shall file a properly executed form AR–1 as evidence of its submission to this State's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the Commissioner annual certifications by the members' domiciliary regulators and their independent certified public accountants of the solvency of each member of the group for the fiscal period immediately preceding which fiscal period shall not be less than one year.

(c) The trust required by (b) above shall be established in a form approved by the Commissioner and in compliance with this section, and the content, location, legal currency and financial institutions shall be acceptable to the Commissioner. The trust instrument shall provide that:

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

2. Legal title to the assets of the trust shall be vested in the trustees of the trust for the benefit of the grantor's United States policyholders and ceding insurers, their assignees and successors in interest;

3. The trust shall be subject to examination as determined by the Commissioner;

4. 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 reinsurance agreements subject to the trust;

5. 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's end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

i. The trust assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender) investments of stocks and bonds listed by the NAIC's Securities Valuation Office or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the grantor, beneficiary, parent, subsidiary or an affiliate of either the grantor or the beneficiary; and

6. No amendment to the trust shall be effective unless filed with and approved in advance by the Commissioner.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.7 Credit for reinsurance required by law

(a) An insurer may be permitted to take a credit for reinsurance ceded to an assuming insurer which does not meet any of the requirements set forth at section 11:2–28.3, 28.4, 28.5 or 28.6, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required or provided by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

(b) A credit may taken for insurance ceded by a ceding insurer to a state owned or controlled insurance or reinsurance company or a ceding company participating in pools, guaranty funds or joint underwriting associations required by statute, regulation or administrative order.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.8 Reduction from liability for reinsurance ceded to an unauthorized assuming insurer

(a) An insurer shall be permitted to take a reduction from liability for reinsurance ceded to an assuming insurer not meeting the requirements of N.J.A.C. 11:2–28.3, 28.4, 28.5, 28.6 or 28.7 in an amount which does not exceed the liabilities carried by the ceding insurer. Such reduction shall be in the amount of the funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security shall be held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer, or in the case of a trust held in a qualified United States financial institution, subject to withdrawal solely by and under the exclusive control of the ceding insurer.

(b) The security shall be in the form of:

1. Cash (United States legal tender);

2. Securities listed by the Securities Valuation Office of the NAIC and qualified as admitted assets;

3. Clean, irrevocable, evergreen, unconditional letters of credit issued or confirmed by a qualified United States institution no later than December 31st of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming qualified United States financial 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, unless the issuer has been declared insolvent under applicable statutory or regulatory provisions; or

4. Any other form of security approved by the Commissioner upon formal request.

11:2-28.9 Trust agreements qualified pursuant to N.J.A.C. 11:2-28.8

(a) An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to N.J.A.C. 11:2-28.8 shall be permitted only when the requirements set forth below and in N.J.A.C. 11:2-28.10 and 28.11 are met.

1. The beneficiary, the grantor and a trustee shall enter into a trust agreement. The trustee shall be a qualified United States financial institution.

2. The trust agreement shall create a trust account into which the trust's assets shall be deposited.

3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this section. If the Commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in 4i below must also be presentable, as a matter of legal right, at the trustee's principal office in the United States. The trust assets shall consist of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), investments of stocks and bonds listed by the NAIC's Securities Valuation Office, or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or an affiliate of either the grantor or the beneficiary.

4. The trust agreement shall provide that:

i. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustees;

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

iii. It is not subject to any conditions or qualifications outside of the trust agreement; and

iv. It shall not contain references to any other agreements or documents except as provided below in (a)11 below.

5. The trust agreement shall be established for the sole benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

i. Receive assets and hold all assets in a safe place;

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

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

iv. Notify the grantor and the beneficiary within ten days, of any deposits to or withdrawals from the trust account;

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

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

7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established and shall at minimum conform to the standards set forth in these rules.

9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

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

11. Notwithstanding other provisions of this subchapter, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer or the inability of the ceding insurer to pay all or any part of a claim, for the following purposes:

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

ii. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

iii. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in (a)11i and (a)11ii above as may remain executory after such withdrawal and for any period after the termination date.

12. The trust agreement shall provide that the trustee shall resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(b) The trust agreement may provide for the following conditions:

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

2. That the trustee may have the authority to invest and accept substitutions of any funds in the account, provided that no investment or substitution may be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in (c)1ii below;

3. The beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets; and

4. Upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(c) A reinsurance agreement may provide provisions to be included in a trust agreement and the trust account established thereunder.

1. A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

i. The assuming insurer may enter into a trust agreement and may establish a trust account for the benefit of the ceding insurer and specify what the agreement is to cover;

ii. Assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of stocks and bonds listed by the NAIC's Securities Valuation Office or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the grantor, beneficiary, parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement shall specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering

risks other than life, annuities and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

iii. The reinsurance agreement entered into in conjunction with the trust agreement may, but need not include the provisions required by (c)1ii above, so long as the conditions required in (a) above are included in the trust agreement.

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

v. All settlements of account between the ceding insurer and the assuming insurer shall be made in cash or its equivalent; and

vi. The assuming insurer and the ceding insurer shall agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer or the inability of the ceding insurer to pay all or any part of a claim, only for the following purposes:

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

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

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

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

2. The reinsurance agreement may also contain provisions that:

i. The assuming insurer may seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, and the ceding insurer shall not unreasonably or arbitrarily withhold its approval provided:

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

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

ii. Any amount withdrawn in excess of the actual amounts required for (c)1vi(1), (2) and (3) or in the case of (c)1vi(4) any amounts that are subsequently determined not to be due shall be returned;

iii. Interest shall be paid at a rate not in excess of the prime rate of interest as reported in the Federal Reserve Bulletin, on the amounts held pursuant to subsection (c)1vi(3); and

iv. An award by any arbitration panel or court of competent jurisdiction shall be permitted for:

(1) Interest at a rate different from that provided in iii above;

(2) Court of arbitration costs;

(3) Attorney's fees; and

(4) Any other reasonable expenses.

3. The reinsurance agreement shall contain a provision, if applicable, which requires that a reinsurance intermediary shall hold any and all funds collected on the reinsurer's behalf, in a fiduciary capacity, in a qualified United States financial institution.

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

(e) Any trust agreement or underlying reinsurance agreement in existence prior to August 16, 1993 shall be acceptable until February 12, 1994, at which time any and all trust agreements shall comply with this subchapter.

(f) The failure of any trust agreement to specifically identify the beneficiary shall not be construed to affect any actions or rights which the Commissioner may take or possess pursuant to the provisions of the laws of this State.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.10 Letters of credit qualified pursuant to N.J.A.C. 11:2–28.8

(a) A letter of credit shall be clean, irrevocable, evergreen, and unconditional and issued or confirmed by a qualified United States financial institution. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. The letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in (i)1 below. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, conservator, rehabilitator or liquidator.

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

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

(d) The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice to the named beneficiary from the issuing financial institution. The "evergreen clause" shall provide for a period of no less than 30 days' notice prior to expiry date or nonrenewal.

(e) The letter of credit shall state whether it is subject to and governed by the laws of this State or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, Publication 400 or any subsequent revisions, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

1. Publication 400 can be obtained by contacting ICC Publishing, Inc. at (212) 206–1150 or by writing to it at 156 Fifth Avenue, STE 820, New York, New York 10010 and remitting the appropriate fees.

(f) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, Publication 400, then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 400 occur.

(g) The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit in accordance with these rules.

(h) Where a letter of credit is issued by a United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in (g), the following additional requirements shall be met:

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

2. The "evergreen clause" shall provide for 30 days' notice to the named beneficiary or its successors in interest from the issuing financial institution prior to expiry date for nonrenewal.

(i) A reinsurance agreement, in conjunction with which a letter of credit is obtained, may contain the following provisions:

1. The assuming insurer shall provide letters of credit to the ceding insurer and specify what they are to cover.

2. The assuming insurer and ceding insurer shall agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

i. To reimburse the ceding insurer or to pay an insolvent ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

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

iii. To fund an account with the ceding insurer in an amount at least equal to the deduction for reinsurance

ceded from the ceding insurer's liabilities for policies ceded under the agreement. Such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves; or

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

3. The provisions of (i)1 and 2 above shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

4. Nothing contained in (i)1 and 2 above shall preclude the ceding insurer and assuming insurer from providing for:

i. An interest payment, at a rate not in excess of the prime rate of interest as reported in the Federal Reserve Bulletin, on the amounts held pursuant to (i)2iii above; or

ii. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of (i)2iv above, any amounts that are subsequently determined not to be due.

5. When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of (i)2 above, require that the parties enter into a "Trust Agreement" which may be incorporated into the reinsurance agreement or be a separate document.

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

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.11 Other security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States in connection with the reinsurance contract under which those funds are withheld, subject to withdrawal solely by the ceding insurer and under its exclusive control.

11:2–28.12 Reinsurance contract

(a) Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of N.J.A.C. 11:2–28.3, 28.4, 28.5, 28.6, or 28.8 of this subchapter unless the reinsurance agreement meets the following standards:

1. Includes a provision that if the assuming insurer is an unauthorized assuming insurer;

i. It has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States;

ii. It has agreed to comply with all requirements necessary to give such court or panel jurisdiction;

iii. It has designated an agent upon whom service of process may be effected; and

iv. It has agreed to abide by the final decision of such court or panel; and

2. Includes an insolvency clause which shall provide the following:

i. In the event of a receivership, the reinsurance recoverables due under any reinsurance contract shall be payable by the reinsurer directly to the receiver, after reasonable provision for verification, on the basis of claims allowed against the insolvent company by any court or competent jurisdiction having authority to allow such claims or allowed by the receiver as a result of the conclusion of the claim filing, approval and appeal process before the receiver. Regardless of any provision in the reinsurance contract or other agreement to the contrary, payment shall be made without diminution because of such insolvency or because the receiver has failed to pay all or a portion of any claims;

ii. The receiver of a ceding insurer shall give or arrange to give to the reinsurer, written notice of the pendency of a claim against the ceding insurer, within a reasonable period of time after the initiation of the receivership. Failure to give such notice shall not excuse the obligation of the reinsurer unless it is substantially prejudiced thereby. 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 company or its receiver. The reasonable 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 the receivership to the extent of a proportionate share of the benefit which may accrue to the ceding insurer in receivership, solely as a result of the defense undertaken by the reinsurer; and

iii. Payments by the reinsurer shall be made directly to the receiver of the ceding insurer except where the contract of insurance or reinsurance specifically provides another payee for such reinsurance in the event of the insolvency of the ceding insurer.

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

11:2–28.13 Contracts affected

All new and renewal reinsurance transactions entered into after February 5, 1994 shall meet the standards set forth in this chapter if credit is to be given to the ceding insurer for such reinsurance.

APPENDIX

FORM AR–1

CERTIFICATE OF ASSUMING INSURER

I, _____ (name of officer), _____ (title of officer) of _____ (name of assuming insurer), the assuming insurer under a reinsurance agreement(s) with one or more insurers domiciled in _____ (name of state), hereby certify that _____ (name of assuming insurer) ("Assuming Insurer"):

1. Submits to the jurisdiction of any court of competent jurisdiction in _____ (ceding insurer's state of domicile) for the adjudication of any issues arising out of the reinsurance agreement(s), agrees to comply with all requirements necessary to given such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement(s) to arbitrate their disputes if such an obligation is created in the agreement(s).

2. Designates the Insurance Commissioner of _____ (ceding insurer's state of domicile) as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement(s) instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Insurance Commissioner of _____ (ceding insurer's state of domicile) to examine its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in _____ (ceding insurer's state of domicile) reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated: _____

_____ (name of assuming insurer)

BY: _____ (name of officer)

_____ (title of officer)

REG11228.A/LRWPC

Amended by R.1993 d.557, effective November 15, 1993.
See: 25 N.J.R. 4289(a), 25 N.J.R. 5184(a).

SUBCHAPTER 29. ORDERLY WITHDRAWAL OF INSURANCE BUSINESS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:17–10 and 17:33B–30.
(P.L. 1990, c.8, sections 71 and 72 and 52:14B–1 et seq.)

Source and Effective Date

R.1991 d.262, effective May 20, 1991.
See: 23 N.J.R. 15(b), 23 N.J.R. 1673(a).

11:2–29.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which insurers may undertake an orderly withdrawal from the business of insurance in this State, thereby minimizing the adverse effects upon policyholders of eliminating coverage; preventing or minimizing the disruption in the marketplace and harm to the public that would otherwise occur in the absence of regulation; and permitting insurers to wind down their business in an orderly fashion as is consistent with N.J.S.A. 17:17–10 and 17:33B–30.

(b) This subchapter applies to all insurers that seek to withdraw from the business of insurance as defined herein.

Case Notes

Commissioner, in setting insurer's price for withdrawing from automobile insurance industry, was not arbitrary or capricious. Matter of Plan for Orderly Withdrawal From New Jersey of Twin City Fire Ins. Co., 248 N.J.Super. 616, 591 A.2d 1005 (A.D.1991), certification granted 127 N.J. 548, 606 A.2d 362, affirmed 129 N.J. 389, 609 A.2d 1248, certiorari denied 113 S.Ct. 1066, 122 L.Ed.2d 370.

11:2–29.2 Definitions

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

"Affiliate" means an insurer that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the insurer that initiates a withdrawal, as defined in N.J.S.A. 17:27A–1.

"Annual statement" means the form of statement that is described in N.J.S.A. 17:23–1.

"Applicant" means the insurer seeking approval to withdraw from the business of insurance in this State.

"Assumption agreement" means a contract between insurers whereby one insurer transfers all or substantially all its rights, duties and obligations arising from certain policies to another insurer.

"Authority" means the power granted by the Commissioner which enables an insurer to transact the business of insurance.

"Automobile" and "automobile insurance" are as defined in N.J.S.A. 17:30E–3.

"Business of insurance" or "insurance" means any kind, line, subline, or a portion thereof authorized by Chapters 17 or 32 of Title 17 of the Revised Statutes.

"Commencement date" of withdrawal means the date which the applicant may begin withdrawing from this State pursuant to the approved plan of orderly withdrawal.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Control" is as defined in N.J.S.A. 17:27A–1.

"Department" means the New Jersey Department of Insurance.

"Effective date" of withdrawal means the date at which the applicant has complied with any and all conditions contained in the approved plan of orderly withdrawal.

"Insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer as defined in N.J.S.A. 17:27A–1.

"Insurance producer" or "producer" means any person engaged in the business of an insurance agent, broker or consultant, as those terms are defined in N.J.S.A. 17:22A–2.

"Insurer" means an insurer or eligible surplus lines insurer, and any insurance affiliates thereof, authorized or admitted pursuant to Chapters 17 or 32 of Title 17 of the Revised Statutes to transact in this State the business of insurance as defined herein.

"Multi-state account" means a single contract or policy of commercial lines insurance as defined in N.J.S.A. 17:29AA–3 which covers risks or locations in both New Jersey and at least one other state; any group policy in which covered members of the group reside in New Jersey and at least one other state; and any plan approved for the mass marketing of insurance pursuant to N.J.A.C. 11:2–12 in which policyholders of the plan reside in New Jersey and at least one other state.

"Plan" means a plan of orderly withdrawal from insurance business in New Jersey.

"Portfolio reinsurance agreement" means a contract between insurers whereby one insurer transfers its entire liability for in-force policies or outstanding losses, or both, to another insurer regarding a described segment of insurance business.

"Rating system" means every schedule, class, classification, rule, guide, standard, manual, table or rating plan by whatever name described containing the rates, rules and forms used by any insurer or by any rating organization in determining or ascertaining a rate.

"Reinsurance agreement" means a contract between insurers whereby one insurer agrees to insure part or all of an insurance risk of an originating, or ceding, insurer.

"Residual market mechanism" means any program authorized or created by the New Jersey State Legislature which is designed to provide an insurance market for insureds who are unable to obtain insurance in the voluntary market.

"State" means the State of New Jersey.

"Withdraw" or "withdrawal" means the nonrenewal, cancellation, or termination of policies, or surrender of authority to transact the business of insurance in this State, or any insurer action that is equivalent to a withdrawal from the business of insurance in this State which may include, but is not limited to, the elimination of a rating system, termination of agency contracts, reduction in agency commissions, restrictions on agency solicitation or binding authority, insurer refusal of applications or declaration of a dividend to an affiliate, when such action or actions exceed those occurring in the ordinary course of business. Whether the above activities are equivalent to a withdrawal shall be determined by the Commissioner on a case-by-case basis.

"Withdraw" or "withdrawal" also means the transfer to another insurer of insurance business pursuant to an assumption agreement as defined herein or a portfolio reinsurance agreement as defined herein.

11:2–29.3 General provisions

(a) Any insurer that seeks to undertake any of the actions described as withdrawals in N.J.A.C. 11:2–29.2 shall provide the Commissioner with written notification so that he or she may determine whether the insurer must file a plan of orderly withdrawal pursuant to N.J.A.C. 11:2–29.4 or, if such plan is waived by the Commissioner under circumstances he or she considers appropriate, a reasonable substitute withdrawal procedure approved by the Commissioner.

(b) Any insurer that is required by the Commissioner to file a plan of orderly withdrawal pursuant to N.J.A.C. 11:2–29.4 shall submit to the Department an original and five copies of a proposed plan for prior approval thereof.

1. The Commissioner shall not begin his or her evaluation of the proposed plan until the applicant has complied with the requirements contained herein for its submission, including the submission of any additional information specifically required pursuant to N.J.A.C. 11:2–29.4(b), after which the Commissioner shall approve the plan within 120 days, subject to the terms and conditions which he or she may consider appropriate.

i. The Commissioner shall acknowledge to the applicant the receipt of any filing and request any additional information required for review pursuant to N.J.A.C. 11:2–29.4(b) within 30 days thereafter, the failure of which shall allow the applicant to treat the filing as complete.

ii. The Commissioner may extend the 120 day time frame for approval of the plan an additional 40 days for good cause and shall provide notice to the applicant of such extension.

2. An applicant shall not commence any action in furtherance of a withdrawal as defined herein prior to the Commissioner's approval thereof. For the purposes of this paragraph, commencing an action in furtherance of a withdrawal does not include the non-binding oral or written communication between an insurer/applicant and another insurer in negotiating a replacement of the insurer/applicant's insurance business by the other insurer, the negotiation of an agreement with a replacement carrier subject to approval of the Commissioner and conditioned on approval of the plan, or non-binding oral or written communications with any of the entities set forth at N.J.A.C. 11:2–29.4(a)11.

3. The authority of an applicant to conduct the business of insurance from which it seeks to withdraw, as well as any other authority which it is required to surrender pursuant to this subchapter shall, upon approval of the plan, continue in effect, but only in accordance with the plan as approved.

4. No withdrawal shall become effective until the applicant has complied with any and all conditions contained in the approved plan which relate to the effective date of withdrawal.

5. Unless the applicant specifically requests and is granted a waiver, the applicant shall make either or both of the following special deposits, as a condition of approval of the plan, in securities or the equivalent thereof in performance bonds as determined by the Commissioner, until such time as the applicant's liabilities as determined by the Commissioner no longer exist in this State:

i. A deposit established with and in the name of the Commissioner for the benefit of all of the applicant's New Jersey policyholders, claimants and creditors which shall be equal to an amount not to exceed 125 percent of the applicant's current and potential liabilities existing or that may exist in this State;

ii. A deposit established with and in the name of the Commissioner pursuant to a consent order signed by the applicant to guarantee compliance with the approved plan, a material breach of which may, upon notice to the insurer, result in an immediate forfeiture of the deposit in whole or in part. This deposit shall be in an amount established at the discretion of the Commissioner and may equal the greater of one million dollars or 10 percent of the applicant's average annual net direct premiums written within the last three years in the line(s) from which it seeks to withdraw.

6. The applicant may substitute, with the approval of the Commissioner, in place of the deposits required in (b)5i above, the following:

i. A proper guarantee from its immediate or ultimate parent;

ii. A letter of credit;

iii. A trust agreement; or

iv. Any other financial guarantee of the applicant's total liabilities.

7. For good cause shown, the Commissioner may waive the special deposits or substitutes required in (b)5 and 6 above upon a consideration of factors including, but not limited to, the uniqueness of the applicant's circumstances, its size, and its volume of business and whether the withdrawal is being effected pursuant to an assumption or portfolio reinsurance agreement.

(c) The Commissioner may require as a condition of approval of the plan the surrender of some or all certificates of authority, issued pursuant to Chapters 17 or 32 of Title 17 of the Revised Statutes, held by the applicant or by other companies within the same insurance holding company system as the applicant for amendment, termination, suspension, restriction or such other modification as the Commissioner considers appropriate. Upon specific request by the applicant for a waiver of any portion of these requirements the Commissioner may grant the waiver in whole or in part if the Commissioner finds that, based upon proofs presented, one or more of the following mitigating circumstances exist:

1. The withdrawal will not cause a market availability problem or an undue disruption in the marketplace;

2. The applicant will enter into an agreement with a proposed replacement carrier to assume the applicant's existing book of business conditioned, however, upon an approved plan;

3. The withdrawal will not adversely affect competition;

4. The withdrawal is due to specified problems affecting the solvency of the applicant;

5. The withdrawal is consistent with the insurer's overall plan of withdrawal in other jurisdictions as part of a corporate restructuring; or

6. The public interest is best served by such a waiver.

(d) If more than one insurer within the same holding company system seeks or is required by the Commissioner pursuant to this subchapter to withdraw from the business of insurance in this State, each withdrawing affiliate shall submit a separate plan to the Commissioner pursuant to this subchapter or, if such plan is waived pursuant to (a) above, a reasonable substitute withdrawal procedure approved by the Commissioner.

(e) An insurer that currently services a residual market mechanism and is subject to the withdrawal provisions contained in the plan of operation governing such mechanism is exempted from the requirements of this subchapter to the extent of the insurance business serviced by the insurer in such mechanism.

(f) The applicant and its affiliates shall be prohibited for a period of up to five years after the effective date of withdrawal from acquiring, directly or indirectly, a controlling interest in any insurer that is licensed to do business in this State without approval of the Commissioner.

11:2–29.4 Elements of proposed plan of orderly withdrawal

(a) A proposed plan of orderly withdrawal shall contain the following information supported by adequate proof of the validity thereof, if not specifically required herein:

1. The reasons the applicant seeks to withdraw, supported by a description and documentation of the applicant's financial condition for the last three years or such other period as the Commissioner considers appropriate, including the underlying accounting, actuarial and other relevant data or material relied upon in deciding to seek withdrawal;

2. The proposed commencement date of such withdrawal;

3. A description of the following:

i. All authority currently and previously held by the applicant in all jurisdictions (specifically listing states in which the applicant has withdrawn);

ii. The authority in New Jersey currently and previously held by its insurer affiliates, including dates of issuance, surrender, suspension or revocation; and

iii. The authority in other jurisdictions held by the applicant or its insurer affiliates that has recently been surrendered or is intended for surrender currently and in the future;

4. An organizational chart and narrative description of the relationships among the applicant and its insurer affiliates, if any, indicating at a minimum:

i. The business of insurance which each has authority to write in New Jersey;

ii. The management relationships;

iii. The financial relationships (for example, reinsurance agreements, pooling arrangements, common investments, etc.);

iv. The marketing relationships;

v. The agency relationships;

vi. The claims handling relationships; and

vii. Whether any of the applicant's insurer affiliates are also taking action or applying to withdraw from the business of insurance in this State (and if so, the details thereof);

5. A description, by line of insurance written in New Jersey, of the applicant's and its insurer affiliates' business (both property/casualty and life/health) during the last three years, including for each year the corresponding premium volume, number of current policyholders, number of exposures, approximate market share and the number of insurance producers and employees servicing the business. If employees of the applicant or any of its affiliates will be terminated in this State as a result of the applicant's withdrawal, a description of the method of termination, a description of the termination benefits, and any other financial or nonfinancial accommodations made on the employees' behalf shall be included;

6. The address of each of the applicant's offices in this State;

7. Copies of the proposed cancellation and nonrenewal notices, and termination notices, the applicant intends to send to its policyholders and insurance producers, respectively, as well as any other withdrawal-related correspondence, including the proposed dates of such notices or correspondence. Producer termination notices shall comply with the requirements contained in N.J.S.A. 17:22–6.14a;

8. In the case of a proposed withdrawal of life, health or annuity business to be effected through one or more assumption agreements, the proposed certificate(s) of assumption and letters of notification (where appropriate) to policyholders informing them of the transfer of their policies to another insurer. In the case of a proposed withdrawal of other than life, health or annuity business to be effected through one or more portfolio reinsurance agreements, the reinsurance agreement(s) and letters of notification (where appropriate) to policyholders informing them of the reinsurance of their risks with another insurer;

9. The name and address of each insurance producer, as well as the number of policies sold and premium volume produced by each producer, by line of insurance, for a 12 month period prior to the filing of the proposed plan;

10. A specimen copy of each current producer contract;

11. Copies of all correspondence and notices to be sent to the following entities or their statutory successors, as well as a description of all agreements (which need not be in final form) reached with such entities or their statutory successors as to the applicant's financial and reporting obligations to them, as applicable; if not applicable, an explanation why. The following list is not intended to be exhaustive. It is the responsibility of the applicant to furnish the information required under this paragraph for any other statutorily created or authorized entity to which it owes or may owe a financial or reporting obligation. The Commissioner may require the applicant to deposit with any of the below-listed entities (or their statutory successors) an amount sufficient to meet the applicant's obligations thereto.

i. The Unsatisfied Claim and Judgment Fund established pursuant to N.J.S.A. 39:6–61 et seq.;

ii. The New Jersey Property–Liability Insurance Guaranty Association established pursuant to N.J.S.A. 17:30A–1 et seq.;

iii. The New Jersey Automobile Insurance Risk Exchange established pursuant to N.J.S.A. 39:6A–21 through 22.1;

iv. The Mutual Workers Compensation Security Fund established pursuant to N.J.S.A. 34:15–112;

v. The Stock Workers Compensation Security Fund established pursuant to N.J.S.A. 34:15–105;

vi. The New Jersey Insurance Division of Fraud Prevention established pursuant to N.J.S.A. 17:33A–1 et seq.;

vii. The Commercial Automobile Insurance Procedure established pursuant to N.J.S.A. 17:29D–1;

viii. The New Jersey State Division of Taxation for premium taxes required by N.J.S.A. 54:18A–1 et seq. and 17:33B–49;

ix. The Surplus Lines Guaranty Association established pursuant to N.J.S.A. 17:22–6.70 et seq.;

x. The Medical Malpractice Reinsurance Association established pursuant to N.J.S.A. 17:30D–1 et seq.;

xi. The Market Transition Facility established pursuant to N.J.S.A. 17:33B–11;

xii. The New Jersey Automobile Full Insurance Underwriting Association for examination assessments provided by N.J.S.A. 17:30E–18.1;

xiii. The New Jersey Automobile Full Insurance Underwriting Association for residual market equalization charges and policy constants established pursuant to N.J.S.A. 17:30E–8 and 17:29A–37.1, respectively; and

xiv. The Department of Insurance for examination fees provided for by N.J.S.A. 17:23–1 et seq. and other statutory fees provided for by N.J.S.A. 17:33–1;

12. A statement, by line of insurance written in this State, of all of the applicant's current incurred liabilities and reserves, including those incurred but not reported, as developed and certified by a "qualified actuary" as defined in N.J.A.C. 11:1–21.1 for property and casualty lines and by a Fellow of the Society of Actuaries for life and health lines, as of a date not earlier than 90 days prior to the submission of the proposed plan and which shall include the following in the case of insurance other than life:

i. Copies of all work papers of the actuary supporting the actuarial opinions;

ii. Copies of all underlying statistics used by the actuary;

iii. If not included in (b)12ii above, development triangles, New Jersey only and countrywide for the following. Triangles shall be constructed as of December 31 for as many accident years and as many development years as necessary to display at least five mature accident years. For the purpose of this requirement, a mature accident year is defined as one for which paid losses equal at least 99 percent of incurred losses including IBNR. Such data shall be supplied both in hard copy and as their ASCII equivalent. Any narrative necessary for proper interpretation of the data supplied shall be provided.

(1) Paid losses;

(2) Incurred losses; and

(3) Claim counts:

(A) Reported; and

(B) Closed; and

iv. If the insurer does not have five mature accident years as required in (b)12iii above, then it shall display five accident years which are the closest to being mature, and if the insurer does not have five accident years of data, then it shall display the accident years it has.

13. A description of the manner in which the applicant has in the past three years handled and intends to handle claims, premium factor charges, premium billing, and policyholder service regarding policies held by New Jersey residents remaining in force after the plan has been approved. Provide a description of the applicant's staff and adjusters servicing these claims, including the

servicing location and the procedures for consumer contact;

14. A list of all the applicant's and its affiliates' deposits, if any, currently held pursuant to N.J.S.A. 17:20–1 et seq.;

15. A description of the kind and amount of all reinsurance assumed and ceded by the applicant, identifying each ceding and assuming insurer and describing the corresponding risks in each reinsurance agreement. An explanation of whether the proposed withdrawal will affect the surplus of another insurer as a result of the loss of credit received by that insurer on any of the applicant's assumed reinsurance, as well as a description of the procedures designed to minimize any marketplace disruption or hazardous financial condition that may occur as a result of the loss of credit, shall be included;

16. A description of all multi-state accounts under which insurance has been provided for risks located in New Jersey, as well as an explanation of the impact of withdrawal on such risks;

17. The proposed amount of the special deposits required under N.J.A.C. 11:2–29.3(b)5, which shall be maintained until such time as the applicant's liabilities and potential liabilities no longer exist in this State;

18. Written certification from a duly authorized officer of the applicant, signed under the pains and penalties of perjury, that the information submitted in the proposed plan is accurate and complete to the best of his or her belief and that for as long as insurance policies are in force or there are unpaid losses or expenses in this State:

i. The applicant shall fully honor all of its legal obligations in this State;

ii. The applicant shall continue to service, without discrimination, all outstanding policies, bonds and surety obligations, which includes processing all usual and customary endorsements requested by insureds during the term of such policies, subject to the applicant's normal underwriting standards;

iii. The applicant shall continue to submit annual statements and information required by the entities set forth in (a)11 above, upon request, for as long as the applicant has any unearned premium or any unpaid or incurred losses in this State;

iv. The applicant shall continue to operate in accordance with the laws and regulations of this State and remain subject to examination by the Department for as long as considered necessary by the Commissioner;

v. The applicant shall not accept any new business whatsoever in this State unless authorized or required by the Commissioner, including reinsurance and excess or surplus lines placements; and

vi. The applicant shall maintain its designation of the Commissioner as its agent for service of process; and

19. The plan shall include a method acceptable to the Commissioner to verify the applicant's compliance with its obligations under the plan as approved which may include, but is not limited to, quarterly financial and informational reports of the applicant's progress under the plan.

(b) The Commissioner may require any other information he or she considers relevant to the evaluation of the request to withdraw.

11:2–29.5 Replacement; non-renewal

(a) Notwithstanding the provisions of N.J.A.C. 11:3–8.3, if an applicant's request to withdraw involves private passenger automobile insurance and the applicant is required to submit a proposed plan, the applicant is subject to the following additional conditions which must be addressed in the proposed plan:

1. The applicant shall seek to place its business with a voluntary market replacement carrier or carriers acceptable to the Commissioner for a specified period of years after the Commissioner's approval of the plan or until all automobile insurance is replaced, whichever is sooner.

i. The period of time in which an applicant must seek to place its business with a replacement carrier will be determined by the Commissioner, but in no instance will it be less than one year or more than five years. If, at the end of the designated period, the applicant has not succeeded in placing all of its private passenger automobile insurance policies with a voluntary market carrier, the applicant shall begin an orderly process of nonrenewal at a rate designated by the Commissioner. In accordance with such process, the applicant shall provide two notices of nonrenewal to remaining policyholders. Unless the Commissioner finds that good cause exists for shortening the initial notice period, the first nonrenewal notice shall be provided at least one year prior to the next policy expiration date and its contents shall comply with the provisions of N.J.A.C. 11:3–8.3. The insurer shall issue a second notice of nonrenewal in compliance with the time and content requirements of N.J.A.C. 11:3–8.3.

ii. An insurer which acts as a replacement carrier for the private passenger automobile insurance business from which the applicant seeks to withdraw assumes all of the legal rights, duties and obligations associated with the participation of private passenger automobile insurers in the automobile insurance market in this State.

2. An applicant shall be required to accept the quotas established by N.J.S.A. 17:33B–11(c)5 unless the applicant specifically requests and the Commissioner agrees to a waiver of this requirement.

(b) The Commissioner shall not consider any replacement carrier or carriers acceptable for the purposes of (a) above unless the applicant certifies that it will take any action(s) necessary to ensure that such replacement carrier(s) will maintain a net premium-to-surplus ratio not to exceed 2.5 to one. Where the replacement carrier is an affiliate of the applicant, the applicant shall provide a guarantee from its ultimate parent that such parent will take any action necessary to ensure the requirements set forth in this subsection are met.

1. The duration of the guarantee requirement set forth in (b) above shall be for a period not less than one or more than five years, such period to be coterminous with the remaining portion of the withdrawal period determined by the Commissioner pursuant to (a)1i above.

2. If the replacement carrier(s) is not an affiliate of the applicant, the Commissioner may waive the requirement set forth in (b) above if the applicant demonstrates to the Commissioner that the financial capacity of replacement carrier(s) to service the business to be assumed is equal to or greater than that of the withdrawing carrier, and that the financial condition and methods of operation of the proposed replacement carrier(s) is not such that the assumption of the applicant's book of business would render the replacement carrier's condition or operations hazardous to the public or policyholders of this State.

(c) If an applicant's request to withdraw involves other than private passenger automobile insurance, the applicant may be subject to conditions addressed either in the approved plan or, if the plan is waived pursuant to N.J.A.C. 11:2–29.3(a), in a reasonable substitute withdrawal procedure approved by the Commissioner.

Amended by R.1995 d.577, effective November 6, 1995.
See: 27 N.J.R. 2533(a), 27 N.J.R. 4311(a).

11:2–29.6 Confidentiality of plan of orderly withdrawal

(a) All data or information contained in the plan is confidential and will not be disclosed by the Department to any person other than its employees and representatives, except the following items, but only upon written, specified request and upon notice to the insurer/applicant:

1. N.J.A.C. 11:2–29.4(a)3i—Description of current and prior authority to do business by jurisdiction;

2. N.J.A.C. 11:2–29.4(a)4—Organizational chart;

3. N.J.A.C. 11:2–29.4(a)4i—Lines of insurance written by each affiliate;

4. N.J.A.C. 11:2–29.4(a)4v—Agency relationships of affiliates by agent name, to the extent available through the Department's licensing system;

5. N.J.A.C. 11:2–29.4(a)5—Premium volume, number of current policyholders, market share and number of producers by line of business;

6. N.J.A.C. 11:2–29.4(a)6—Address of applicant's offices in this State;

7. N.J.A.C. 11:2–29.4(a)7—Policyholder nonrenewal and producer termination notices;

8. N.J.A.C. 11:2–29.4(a)9—Name and address of each insurance producer to the extent available through the Department's licensing system;

9. N.J.A.C. 11:2–29.4(a)11—Copies of all correspondence and notices sent to various entities, as approved, to which the applicant owes a financial obligation;

10. N.J.A.C. 11:2–29.4(a)12—Certified statement of New Jersey incurred liabilities and reserves;

11. N.J.A.C. 11:2–29.4(a)14—Deposits held by a custodian on behalf of the Commissioner; and

12. N.J.A.C. 11:2–29.4(a)17—Establishment of special deposits or equivalent performance bonds as approved.

11:2–29.7 Fines and penalties

Failure to comply with this subchapter may result in the imposition of sanctions by the Department including, but not limited to, sanctions pursuant to N.J.S.A. 17:33–2.

11:2–29.8 Severability

If any provision of this subchapter or its application to any person or circumstance is held invalid, such determination shall not affect other provisions or applications of this subchapter which can be given effect without the invalid provision or application, and to that end the provisions of this subchapter are separable.

SUBCHAPTER 30. (RESERVED)

SUBCHAPTER 31. MANNER OF DETERMINING PREMIUM FOR PERPETUAL HOMEOWNERS INSURANCE

Authority

N.J.S.A. 17:1–18.1, 17:1C–6(e), 17:23–1 et seq. and 54:18A–1 et seq.

Source and Effective Date

R.1991 d.139, effective March 18, 1991.
See: 22 N.J.R. 601(a), 23 N.J.R. 860(b).

11:2–31.1 Purpose

This subchapter sets forth the manner of determining premium for perpetual homeowners insurance for any applicable statutory fee, surcharge, tax or assessment.

11:2–31.2 Scope

The provisions of this subchapter apply to all insurers transacting the business of perpetual homeowners insurance in this State, including all perils insured thereunder.

11:2–31.3 Definitions

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

"Annual adjustments" means any adjustments in the perpetual deposit account during the calendar year, exclusive of dividends. Increases include any additions to the account, such as policy fees and premium assessments. Decreases include the return of perpetual deposits, in whole or in part, due to the termination of policies and any other decreases, exclusive of dividends.

"Commissioner" means Commissioner of the New Jersey Department of Insurance.

"Insurer" means an insurance company licensed to transact the business of perpetual homeowners insurance in this State.

"Net perpetual deposits" means the total perpetual deposits received by an insurer for perpetual homeowners insurance increased or decreased by annual adjustments.

"Perpetual deposit" means a payment by a policyholder for perpetual homeowners insurance.

"Perpetual homeowners insurance" means a homeowners policy and related endorsements, including all perils insured thereunder, which remains continuously in effect until cancelled, and is paid for with one lump sum deposit with no additional payment required, notwithstanding any subsequent fees or assessments.

11:2–31.4 Determination of premium

(a) For the purposes of any statutory fee, surcharge, tax or assessment based on premium and applicable to perpetual homeowners insurance, premium is:

1. The sum of the net perpetual deposits received for perpetual homeowners insurance from the inception of the policy through the calendar year immediately preceding the date that such applicable statutory fee, surcharge, tax or assessment is due, multiplied by:

2. The average annual interest rate on one-year U.S. Treasury bills for the calendar year in question.

(b) The premium base for any applicable statutory fee, surcharge, tax or assessment is calculated annually as set forth in (a) above less any so-called dividends returned or credited to policyholders during the calendar year in question.

11:2–31.5 Data filed; examination

(a) Each insurer shall include with the annual statement filed with the Commissioner, a list of the lines of business under which perpetual homeowners insurance is written, on form(s) prescribed by the Commissioner.

(b) All data submitted is examined by the Commissioner and he or she may make any further audit or investigation or reaudit as necessary. An insurer shall pay the reasonable expenses of any examination, pursuant to N.J.S.A. 17:23–4.

11:2–31.6 Penalties

Failure to comply with these provisions may result in the imposition of sanctions by the Department including, but not limited to, sanctions pursuant to N.J.S.A. 17:33–2.

SUBCHAPTER 32. CUSTODIAL DEPOSITS

Authority

N.J.S.A. 17:16A–1 et seq., 17:20–1 et seq., 17B:18–37 et seq., 17B:18–39.1, 17:46B–1 et seq. and 17:50–1 et seq.

Source and Effective Date

R.1991 d.14, effective January 7, 1991.
See: 22 N.J.R. 2640(a), 23 N.J.R. 105(a).

11:2–32.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the procedures for the holding by the Commissioner of any required deposits and to establish the fees to be charged the depositor for the services of the custodian of such deposits pursuant to P.L. 1989, c.264.

(b) This subchapter applies to all insurers required by the laws of this State to make a security deposit to be held for the benefit and security of all the policyholders of the company making such deposit. This subchapter also applies to any other entity required to make a deposit with the Commissioner in order to transact business in this State. This subchapter does not apply to any insurer under liquidation pursuant to N.J.S.A. 17:30C–1 et seq. or 17B:32–1 et seq., as applicable.

11:2–32.2 Definitions

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

"Bank" means a State or Federally chartered bank, savings bank, or savings and loan association which has trust powers and which has its principal office in New Jersey.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Custodian" means a bank which performs fiduciary functions in the maintenance of deposits.

"Deposit" means those deposits of securities required to be made by insurance companies prior to their authorization to transact business within any jurisdiction or required to be made by any other entity prior to being authorized by the Commissioner to transact business in this State.

"Federal Reserve book-entry system" means the computerized system sponsored by the United States Department of the Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and the agencies and instrumentalities, respectively, in Federal Reserve Banks through banks which are members of the Federal Reserve System or which otherwise have access to this computerized system.

11:2–32.3 Deposits with custodian; establishment of fees

(a) Whenever the Commissioner is required or authorized by a law of this or any other State or country to receive and hold a deposit, such deposit shall be made with the custodian on behalf of the Commissioner. The custodian is appointed by the Commissioner on the basis of bids submitted by banks to perform such fiduciary functions as the Commissioner deems necessary in the maintenance of deposits, pursuant to N.J.S.A. 17:20–1b and 17B:18–37b.

(b) If securities are deposited, such securities must be:

1. Bills, bonds and notes issued by the United States Treasury;

2. Debt obligations of the State of New Jersey, its authorities, counties and municipalities; or

3. Certificates of deposit of a State or Federally chartered bank, savings bank or savings and loan association with its principal office in New Jersey.

(c) All securities deposited shall be held by the custodian in physical form or, in the case of bills, bonds and notes issued by the United States Treasury, purchased for the depositor's account in the Federal Reserve book-entry system.

(d) The fees to be charged the depositor for the services of the custodian shall be established by the contract between the Commissioner and the custodian.

(e) All depositors shall pay the applicable fee to the custodian when due. All depositors shall also pay any applicable fees or penalties charged by the custodian for nonpayment in addition to any penalties which may be imposed by the Commissioner pursuant to law for violation of this subchapter.

11:2–32.4 Compliance dates

(a) All deposits made on or after January 7, 1991 shall conform to the requirements contained in this subchapter.

(b) To the extent a depositor has on deposit securities that do not conform with the types of securities specified herein, such depositor shall, by June 30, 1991 or upon the maturity of such non-conforming securities, whichever is sooner, make any substitution of securities necessary so that the securities deposited conform with the types of securities specified in this subchapter.

11:2–32.5 Penalties

Failure to comply with this subchapter may result in the imposition of penalties as provided by law.

SUBCHAPTER 33. WORKERS' COMPENSATION SELF–INSURANCE

Authority

N.J.S.A. 17:1C–6(e), 17:1–8, 17:1–8.1, and 34:15–77.

Source and Effective Date

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).

11:2–33.1 Purpose and scope

(a) This subchapter sets forth the filing requirements for an employer seeking to self-insure its workers' compensation liability pursuant to N.J.S.A. 34:15–77.

(b) This subchapter applies to all employers seeking to self-insure workers' compensation liability in this State.

11:2–33.2 Definitions

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

"Applicant" means an employer applying for an exemption from insuring its compensation liability.

"Certificate of Order Granting Exemption from Insuring Liability for Compensation" or "certificate" means the written order of the Commissioner that exempts the applicant from insuring its workers' compensation liability pursuant to N.J.S.A. 34:15–77.

"Certificate holder" means an employer who currently possesses a valid certificate.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Compensation liability" means loss or damage from liability as established by N.J.S.A. 34:15–1 et seq.

"Employer" is as defined at N.J.S.A. 34:15–36.

11:2–33.3 Exemption from insuring compensation liability; filing requirements

(a) Any employer which applies for an exemption from insuring all or part of its compensation liability shall submit the following to the Commissioner:

1. A copy of its most recent annual financial statement certified by an independent certified public accountant to present fairly, in accordance with generally accepted accounting principles, and statutory accounting principles where applicable, the financial condition of the applicant;

2. A copy of its Form 10K filing;

3. A brief description of the following, inclusive of all operations in New Jersey, for every separate applicant seeking an exemption:

i. The nature and location of the applicant's business operations;

ii. The applicant's number of employees; and

iii. The estimated average annual payroll; and

4. For corporate applicants domiciled in a state other than this State, a copy of the applicant's registration with the New Jersey Secretary of State.

(b) Upon the Commissioner's review and acceptance of the information submitted pursuant to (a) above, the applicant shall submit the following information to the Commissioner:

1. A completed application form in the format of Exhibit A in the Appendix incorporated herein by reference;

2. Evidence that excess insurance will be obtained in a form and amount acceptable to the Commissioner including the amount of liability that the applicant intends to retain;

3. A loss history on open and closed claims for the applicant's workers' compensation and employers' liability for the three years immediately preceding the date of the application; and

4. The application filing fee as set forth in N.J.A.C. 11:1–32.4(b)13.

(c) If the applicant is a corporation, the applicant may request that the Commissioner include the name of any subsidiary corporation under the control of that corporation in the certificate conditioned upon the applicant's compliance with the requirements of (a) and (b) above for each subsidiary corporation.

1. The Commissioner shall not include the name of any subsidiary in the certificate unless the ultimate parent corporation guarantees that it will discharge the subsidiary's liability as evidenced by filing an indemnity agreement in the format of Exhibit B in the Appendix incorporated herein by reference, or in such other form which is acceptable to the Commissioner. The applicant shall also file a certification of the resolution of the board of directors, in the format of Exhibit C in the Appendix incorporated herein by reference, or in such other form which is acceptable to the Commissioner.

2. If the name of the subsidiary is included in the certificate of the ultimate parent corporation and ownership of the ultimate parent or subsidiary corporation changes, the ultimate parent or subsidiary shall reapply for the certificate within 30 days of the ownership change. The Commissioner may revoke the existing certificate if the ultimate parent or subsidiary fails to reapply for the certificate as set forth above.

(d) An applicant with a substantial number of subsidiaries in New Jersey may request permission to file a consolidated application on behalf of itself and its subsidiaries which shall be in a form acceptable to the Commissioner. The applicant shall demonstrate that the relationship between the parent company and the subsidiaries is clearly evident to covered employees.

1. Upon granting any such request, the Commissioner shall require such information as he or she deems necessary to ensure that the applicant and its subsidiary corporations will satisfy the requirements for the issuance of a certificate pursuant to N.J.S.A. 34:15–77 and this subchapter, including, but not limited to, a listing of all subsidiary corporations to be included in the certificate(s).

2. If the application is approved pursuant to this subsection, the certificate holder shall notify the Commissioner of any additions or deletions to the list of subsidiaries covered under the certificate(s) within 15 days of such change. Coverage for a subsidiary under the parent corporation's certificate(s) shall not terminate until notice has been filed with the Commissioner.

3. The Commissioner may subsequently require an applicant or certificate holder permitted to file consolidated information pursuant to this subsection to file information for each subsidiary corporation based upon any changes in the relationship between the parent and its subsidiaries occurring after permission was granted.

(e) If the applicant is a subsidiary, and the subsidiary's ultimate parent does not apply for a certificate, the subsidiary shall obtain a guarantee from the ultimate parent that it will discharge the subsidiary's liability as evidenced by the filing of an indemnity agreement and certification of the resolution of the board of directors as set forth in (c) above.

(f) In addition to the filing fee set forth in (b)4 above, the applicant shall be assessed and shall pay upon demand the amount necessary to reimburse the Department for expenses incurred in obtaining a risk assessment report on the applicant from a rating agency as determined by the Commissioner.

(g) If an application is approved, the applicant shall submit a surety bond in a form and amount determined by the Commissioner, with a minimum penal sum of $500,000 and an executed contract of excess insurance in an amount acceptable to the Commissioner. Upon receipt of the required surety bond and executed contract of excess insurance, the Commissioner shall issue a "Certificate of Order Granting Exemption from Insuring Liability for Compensation" to the applicant.

(h) All certificates shall be valid from the date of issuance until June 30 immediately following and may be renewed thereafter, pursuant to N.J.A.C. 11:2–33.4, for a one-year period beginning July 1 and ending June 30 the following year.

(i) All information or notifications required by this subchapter or other information reasonably deemed necessary by the Commissioner or otherwise required by law shall be sent to:

New Jersey Department of Insurance
Division of Financial Examinations
Attention: Workers' Compensation Self–Insurance
20 West State Street
CN–325
Trenton, New Jersey 08625

11:2–33.4 Renewals

(a) Any certificate holder which applies for renewal shall submit the following so that it is received by the Commissioner not later than 60 days prior to the expiration of its current certificate:

1. A completed "Statement by Employer Exempted From Insuring Liability For Compensation" as set forth in Exhibit D in the Appendix incorporated herein by reference;

2. A supplementary statement of outstanding death or disability claims as set forth in Exhibit E in the Appendix incorporated herein by reference for the calendar year immediately preceding the expiration date of the certificate;

i. The certificate holder shall provide the name, address and telephone number of the person who actually completed the supplementary statement, and shall provide the location of the claim records utilized in the preparation of the statement.

3. A copy of the certificate of renewal of excess insurance;

4. A financial statement for the fiscal year immediately preceding the expiration date of the certificate which is certified by an independent certified public accountant to present fairly, in accordance with generally accepted accounting principles, and statutory accounting principles, where applicable, the financial condition of the certificate holder;

5. A certification that the certificate holder recognizes that it may be subject to examination by the Commissioner as required pursuant to (e) below;

6. The renewal fee as set forth in N.J.A.C. 11:1–32.4(b)13; and

7. Any other information that is materially different from the information provided in the original application or from the information provided in the last renewal period.

(b) In addition to the renewal fee set forth in (a)6 above, upon the initial renewal of its certificate the certificate holder shall be assessed and shall pay upon demand the amount necessary to reimburse the Department for expenses incurred in obtaining a risk assessment report on the certificate holder from a rating agency as determined by the Commissioner.

1. The requirement in (b) above shall not apply to any certificate holder that was required to submit a risk assessment report as part of the initial application pursuant to N.J.A.C. 11:2–33.3(f).

2. After the initial submission of the risk assessment report pursuant to N.J.A.C. 11:2–33.3(f) or 33.4(b), the Department may obtain a risk assessment report on the certificate holder and assess the certificate holder the costs of obtaining such report as set forth herein if the Commissioner determines that the certificate holder's financial condition may have deteriorated, or an event occurs which is reasonably likely to cause the certificate holder's financial condition to deteriorate as provided at (e) below.

(c) After the submission of the application for renewal, the Commissioner may require a surety bond, or an increase in the penal sum of an existing surety bond, in an amount determined by the Commissioner if he or she deems it necessary to ensure that the certificate holder satisfies the requirements for the issuance of a certificate set forth in N.J.S.A. 34:15–77 and this subchapter.

(d) Upon approval of the application for renewal, the Commissioner shall issue a new certificate.

(e) If the Commissioner determines that the certificate holder's financial condition may have deteriorated, or an event occurs which is reasonably likely to cause the certificate holder's financial condition to deteriorate, he or she may conduct such further examination of the certificate holder as he or she deems necessary to ensure that the certificate holder continues to satisfy the requirements for the issuance of a certificate set forth in N.J.S.A. 34:15–77 and this subchapter.

1. In determining whether to conduct such an examination pursuant to this section, the Commissioner shall consider the following factors, without limitation:

i. A major loss suffered by the certificate holder over the previous year or a trend of losses over several years;

ii. A significant decrease in the certificate holder's bond rating over the previous year or a trend of decreases over the past several years;

iii. A significant increase in claims payments by the certificate holder to employees; or

iv. Major environmental litigation or asbestosis litigation to which the certificate holder has or may become subject.

2. The examination may consist of an examination at the certificate holder's offices conducted by the Commissioner's designee; a review of such additional information as the Commissioner may request, including, but not limited to, a risk assessment report as set forth in (b) above, and a statement of opinion by a qualified actuary attesting to the adequacy of reserves for outstanding death or disability claims that meets the requirements of N.J.A.C. 11:1–21; or both.

3. The costs of any examinations shall be borne by the certificate holder.

Administrative Correction.
See: 25 N.J.R. 4179(a).

11:2–33.5 Confidentiality

The financial reports submitted pursuant to N.J.A.C. 11:2–33.3(a)1 and 33.4(a)4, and the supplementary statement submitted pursuant to N.J.A.C. 11:2–33.4(a)2, shall be confidential and shall not be subject to public inspection or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A–1 et seq. However, financial reports or statements which have been filed with the Securities and Exchange Commission or the New Jersey Bureau of Securities shall not be confidential pursuant to this section.

11:2–33.6 Cancellation of exemption

(a) A certificate holder may cancel its exemption from insuring compensation liability by notifying the Commissioner in writing by certified letter return receipt requested not later than 30 days prior to date such cancellation takes effect.

(b) Notwithstanding the cancellation of the exemption, the employer shall continue to file with the Commissioner a supplementary statement of outstanding death or disability claims as set forth in Exhibit E not later than June 1 of each year until such time as all open claims are resolved to final payment.

(c) If no surety bond is in effect at the time of the notification of cancellation, the Commissioner may require as a condition of cancellation the certificate holder to provide a surety bond, deposit or other security to ensure the discharge of its obligations under N.J.S.A. 34:15–1 et seq.

11:2–33.7 Failure to comply with subchapter; denial of exemption

Failure to submit the information required by this subchapter completely and accurately shall constitute grounds for and may result in the denial or refusal to renew an exemption from insuring workers' compensation liability.

11:2–33.8 Severability

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

APPENDIX

EXHIBIT A
(290)

Exemption No. .....

NOTE:–All Information Given in this Application is Confidential.

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE

EMPLOYER'S APPLICATION FOR THE PRIVILEGE OF PAYING COMPENSATION WITHOUT INSURANCE

(As provided by Title 34, Chapter 15, Article 77, of the "Revised Statutes")

To the Commissioner of Insurance of New Jersey:

The undersigned, an employer, subject to the provisions of Title 34, Chapter 15, of the "Revised Statutes" of New Jersey, hereby applies for the privilege of being exempt from insuring the payment of compensation, and submits the following facts under oath to the Commissioner of Insurance to enable him to determine if sufficient financial ability exists to render certain the payment of such compensation.

1. Name of applicant .....

2. P. O. address ..... (Number) (Street) (City or Town) (County) (State)

3. The applicant is ..... (State whether individual, co-partnership, limited partnership, corporation, receiver or trustee)

4. If a partnership: Date of formation of partnership ..... Date of commencement of business.....

Name of each partner	*Address*	*Amount of capital contributed*	*Individual's worth outside of interest in this business*
.....	.....	$.....	$.....

5. If a corporation: Date of incorporation .....Date of commencement of business .....

Incorporated under the laws of the State of ....Rates of dividends paid during each of the last five years? .....

List below the names and addresses of officers and directors and the par value of the stock owned by each.

Title	*Name*	*Address*	*Stock owned*
President			
Vice-President			
Secretary			
Treasurer			
Director			
Director			
Director			
Director			
Director			
Director			
Director			
Director			

Is the employer a subsidiary? ..... If so, give name and address of parent company?

.....

6. Safety, sanitation and welfare conditions:

Is your plant inspected otherwise than by State authority? .....

If so, by whom? .....

Have you a committee of safety whose duty it is to recommend safety devices and to secure compliance with statutes or general orders of the Department of Labor as to safety and sanitation? .....

Do you maintain a hospital in connection with your works? ..... If so, state description of its equipment and service .....

.....

7. Do you maintain any reinsurance against losses?..... If so, furnish copy of policy.

8. Have you set aside any special funds in trust specifically designated for the discharge of outstanding claims of long duration? ..... If any, give name of beneficiary, amount and place of deposit.

.....

9. Give complete description of the organization, personnel and other special arrangements or facilities for performing the duties of a self-insurer .....

.....

.....

10. FINANCIAL STATEMENT, AS OF THE LAST CLOSING DATE ....., 19.....

Assets	*Amount*	*Liabilities*	*Amount*
Cash on hand	$	Open accounts owing (not due)	$
Cash in ..... Bank		Open accounts owing (past due)	
Cash in ..... Bank		Notes payable	
Cash in ..... Bank		Owing to ..... Bank	
Stocks and Bonds owned (Schedule B)		Owing to other banks, bankers or brokers	
Merchandise in stock, at cost		Owing to other persons, relatives or friends	
(Insurance on same $.....)		Deposits and other trust funds	
Work in process or raw material in warehouse at cost		Goods held on consignment	
(Insurance on same $.....)		Liens on merchandise	
Bills receivable, Less than 12 mos. due		Chattel mortgages on	
Bills receivable, Over 12 mos. due		Bonded indebtedness	
Accounts, receivable, GOOD		Mortgages or deeds of trust on real estate (see Schedule C)	
Secured loans owned (Schedule A)		Unpaid workmen's compensation claims	
Machinery & fixtures (Cost $.....)		Other liabilities including reserves (specify):	
Animals & vehicles (Cost $.....)			
Real estate owned (Schedule C)			
If the employer is a partnership or a corporation, state the amount, if any, of bills and accounts owing from partners, officers, stockholders, directors or employees. (NOTE: The amount if any, should also be included among the accounts and bills receivable listed above.)			
..... $			
..... $			
..... $			
..... $			
Other assets (specify):		CONTINGENT LIABILITIES (Do not carry amounts out into column)	
		Upon bills receivable, not included in above statement, rediscounted ..... $	
		Accommodation paper or endorsements ..... $	
		Exchanged paper ..... $	
		Guarantees ..... $	
		Bonds ..... $	
		Capital stock outstanding	
		Surplus	
Total	$	Total	$

Are the above assets pledged as collateral? .....
If yes, explain .....

Are any of the above liabilities secured by collateral? .....
If yes, explain .....

Is foregoing statement based on actual inventory? ..... If so, date .....
Have the books been audited by a public accountant? ..... If so, when and by whom? .....

11. PROFIT AND LOSS STATEMENT AS OF THE LAST CLOSING DATE ....., 19.....

Losses	*Amount*	*Profits*	*Amount*
Expenses of operation	$	Surplus beginning of period	$
Taxes, rentals and interest paid		From operations	
Bad debts charged off		interest and discounts	
Depreciation charged off		investments	
Repairs or betterment charges		bad debts previously charged off	
Dividends paid or amounts otherwise withdrawn		All income other than from usual operations	
All other amounts withdrawn			
Surplus end of period			
Total	$	Total	$

What is the amount of net profits from operations during period? $ .....

12. Schedules referred to in above Financial Statement.

SCHEDULE A.—SECURED LOANS OWNED.

Description of Security	*Name of Maker*	*Address*	*Amount of Loan*
		Totals	$

SCHEDULE B.—STOCKS AND BONDS OWNED.

Description of Bonds or Stocks—(Give rate of interest and year of maturity of bonds, and number of shares of stock.)	*Par Value*	*Book Value*	*Market Value*
	$	$	$
Totals	$	$	$

SCHEDULE C.—REAL ESTATE OWNED.

Description and Location of Property	*Amount at Which Carried on Books*	*Amount of Liens on Property, if any*	*Estimated Actual Value of property*	*Fire Insurance Carried on property*
	$	$	$	$
Totals	$	$	$	$

13. Statement of Locations of Shops and other Workplaces, Number of Employees, Payrolls and Description of Operations in New Jersey.

This report covers the latest fiscal period of the Employer, extending from ..... to .....

Location of Factory, Office or other work place by town, city or other designation	*Estimated Average Number of Employees at Each Location*	*Division of Operations* (Payroll and number of employees are to be given on separate lines for each operation at each location.)	*Actual Payroll Expenditure for past Year*	*Rate (Do not fill in.)*	*Premium (do not fill in)*
		(a) Clerical office employees and draftsmen engaged exclusively in office duties. (b) Outside salesmen, collectors and messengers. (c) Drivers and helpers. (d) Chauffeurs and helpers. (e) General operations at plant of employer or elsewhere within the State of New Jersey. Note: Classify each separate operation as closely as possible in accordance with insurance rate manual in force.			

14. Total estimated average number of employees ....., and total payroll expenditure in the past year $ ..... for *all* operations wherever conducted.

15. The applicant agrees to discharge faithfully and promptly all payments and obligations which are now due or shall become due under the provisions of Title 34, Chapter 15, of the "Revised Statutes" of New Jersey; to furnish to the Commissioner of Insurance such further information as is from time to time requested as a condition to the privilege of going without insurance; and to advise the said Commissioner of Insurance immediately of any accident resulting fatally to two or more employees.

.....
(Signature of Applicant Employer)

By ....
(Name) (Title)

Dated at ....., ..., 19.....

AFFIDAVIT

(The person subscribing to the below affidavit should be the employer himself; or if the employer be a partnership, one of the partners; or if employer be a corporation, its president, vice-president, secretary or treasurer.)

STATE OF NEW JERSEY }
County of ..... } ss.

..... first being duly sworn on oath deposes and says that he is acquainted with the affairs of the above-mentioned applicant employer, to which representations and statements set forth in the foregoing application relate; that he has read said application, knows the contents thereof and that said representations and statements therein contained are true to the best of his knowledge and belief.

Subscribed and sworn to before me at ..... N. J.
this ..... day of ..... A. D. 19.....

.....

.....
(Official Title)

.....

EXHIBIT B

INDEMNITY AGREEMENT

This agreement is made on _____, 19___, in the City of _____, County of _____, State of _____,

The parties to the agreement are _____, of _____, City of _____, County of _____, State of _____, hereinafter called "indemnitor," and _____, of _____, City of _____, County of _____, State of _____, hereinafter called "indemnitee."

Since indemnitee is a subsidiary of indemnitor and is an employer subject to the provisions of N.J.S.A. 34:15–1 et seq. and, as such, has applied to the Commissioner of Insurance of New Jersey for exemption from insuring payment of workers' compensation liability in conformity with the provisions of said statutes and an assumption by indemnitor of the self-insurance obligations of indemnitee is essential to secure payment thereof pursuant to the provisions of N.J.A.C. 11:2–33, in consideration of the grant of exemption from insuring liability by the Commissioner of Insurance of New Jersey to indemnitee,

It is hereby agreed:

In the event (indemnitee) shall not pay or cause to be paid directly to claimants the benefits due or that may become due under N.J.S.A. 34:15–1 et seq., then (indemnitor) covenants and agrees that it will pay to all such claimants the benefits due, with the expressed knowledge and understanding that the execution and acceptance of this agreement is for the benefit of unknown and unnamed claimants of (indemnitee) and (indemnitor) does hereby recognize this agreement as a direct financial guarantee to said claimants.

PROVIDED HOWEVER, (indemnitor) shall have a right to cancel and terminate this agreement at any time upon giving the New Jersey Insurance Department at least thirty (30) days written notice of its desire to do so; provided such cancellation shall not affect its liability as to any benefits payable for claims occurring prior to the date of cancellation specified in such notice.

This agreement shall be effective as of _____, 19___.
Signed and sealed this _____ day of _____, 19___.

ON BEHALF OF INDEMNITOR
BY: _____
(signature and title)

ATTEST:

_____
(signature and title)

ON BEHALF OF INDEMNITEE
BY: _____
(signature and title)

ATTEST:

_____
(signature and title)

EXHIBIT C

CERTIFICATION OF RESOLUTION OF THE BOARD OF DIRECTORS OF _____

Whereas the _____ and _____ [titles of corporate officers] of this corporation propose to execute a general indemnity agreement in favor of _____, a subsidiary, by which this corporation agrees and undertakes to guarantee the payment of any sum of money for compensation, including disability benefits, which may be or become legally due from said subsidiary under the provisions of N.J.S.A. 34:15–1 et seq., and that this resolution will not be amended or abrogated without prior notice to the Commissioner of Insurance, State of New Jersey; and such agreement having been fully considered and approved by the directors present at this meeting;

Now, therefore, be it resolved that the _____ and _____ [titles of officers] are hereby expressly authorized to execute the general indemnity agreement in favor of _____ [subsidiary] by unanimous vote of the directors of this corporation.

I hereby certify that I am the _____ [secretary] of _____ [corporation], and that the above resolution is a true and accurate copy of a resolution unanimously adopted by the board of directors at a meeting duly called and held on _____, 19___, in the office of the corporation, at which a quorum of the directors was present.

Dated _____, 19___

_____
Signature and Title

[Corporate seal]

EXHIBIT D

(391) Exemption No.....

NOTE:—All information Given in this Statement is Confidential

STATE OF NEW JERSEY

DEPARTMENT OF INSURANCE

STATEMENT BY EMPLOYER EXEMPTED FROM INSURING LIABILITY FOR COMPENSATION

To the Commissioner of Insurance of New Jersey:

The undersigned employer, being the holder of a certificate of exemption from insuring liability for compensation, in accordance with Title 34, Chapter 15, Section 77 of the "Revised Statutes," desires to have such certificate continued in force and for that purpose submits the following verified statement:

1. Name of employer_____

2. P. O. address _____ (Number) (Street) (City or Town) (County) (State)

3. The applicant is_____ (State whether individual, co-partnership, limited partnership, corporation, receiver or trustee)

4. If a partnership: Date of formation of partnership_____Date of commencement of business_____

Name of each partner	Address	Amount of capital contributed	Individual's worth outside of interest in this business
		$	$

5. If a corporation: Date of incorporation_____Date of commencement of business_____
Incorporated under the laws of the State of_____ Rate of dividend paid during the past year?_____
List below the names and addresses of your officers and directors and the par value of the stock owned by each.

Title	Name	Address	Stock owned
President			
Vice-President			
Secretary			
Treasurer			
Director			
Director			
Director			
Director			
Director			
Director			
Director			
Director			
Director			

Is the employer a subsidiary?_____ If so, give name and address of parent company?

6. Safety, sanitation and welfare conditions:
Is your plant inspected otherwise than by State authority?_____
If so, by whom?_____
Have you a committee of safety whose duty it is to recommend safety devices and to secure compliance with statutes or general orders of the Department of Labor as to safety and sanitation?_____
Do you maintain a hospital in connection with your works?_____ If so, state description of its equipment and service_____

7. Do you maintain any reinsurance against losses?_____ If so, file copy of policy unless already on file_____

8. Have you set aside any special funds in trust specifically designated for the discharge of outstanding claims of long duration?_____ If any, give name of beneficiary, amount and place of deposit.

9. Give complete description of the organization, personnel and other special arrangements or facilities for performing the duties of a self-insurer_____

10. FINANCIAL STATEMENT, AS OF THE LAST CLOSING DATE ..... 19.....

ASSETS	AMOUNT	LIABILITIES	AMOUNT
Cash on hand	$	Open accounts owing (not due)	$
Cash in ____ Bank		Open accounts owing (past due)	
Cash in ____ Bank		Notes payable	
Cash in ____ Bank		Owing to ____ Bank	
Stocks and Bonds owned (Schedule B)		Owing to other banks, bankers or brokers	
Merchandise in stock, at cost		Owing to other persons, relatives or friends	
(Insurance on same $____)		Deposits and other trust funds	
Work in Process or raw material in warehouse at cost		Goods held on consignment	
(Insurance on same $____)		Liens on merchandise	
Bills receivable, { Less than 12 mos. due		Chattel mortgages on	
Bills receivable, { Over 12 mos. due		Bonded indebtedness	
Accounts receivable, COOD		Mortgages or deeds of trust on real estate (see Schedule C)	
Secured loans owned (Schedule A)		Unpaid workmen's compensation claims	
Machinery & fixtures (Cost $____)		Other liabilities including reserves (specify):	
Animals & vehicles (Cost $____)			
Real estate owned (Schedule C)			
If the employer is a partnership or a corporation, state the amount, if any, of bills and accounts owing from partners, officers, stockholders, directors or employees. (NOTE: The amount if any, should also be included among the accounts and bills receivable listed above.)			
____ $____		CONTINGENT LIABILITIES (Do not carry amounts out into colums)	
____ $____		Upon bills receivable, not included in above statement, rediscounted	
____ $____		____ $____	
____ $____		Accommodation paper or endorsements ____ $____	
Other assets (specify):		Exchanged paper ____ $____	
		Guarantees ____ $____	
		Bonds ____ $____	
		Capital stock outstanding	
		Surplus	
Total	$	Total	$

Are the above assets pledged as collateral? ____

If yes, explain ____

Are any of the above liabilities secured by collateral? ____

If yes, explain ____

Is foregoing statement based on actual inventory? ____ If so, date ____

Have the books been audited by a public accountant? ____ If so, when and by whom? ____

11. PROFIT AND LOSS STATEMENT AS OF THE LAST CLOSING DATE ____, 19____

Losses	Amount	Profits	Amount
	$	Surplus beginning of period	$
Expense of operation		From operations	
Taxes, rentals and interest paid		interest and discounts	
Bad debts charged off		investments	
Depreciation charged off		bad debts previously charged off	
Repair or betterment charges		All income other than from usual operations:	
Dividends paid or amounts otherwise withdrawn			
All other amounts withdrawn			
Surplus end of period			
Total	$	Total	$

What is the amount of net profits from operations during period? $____

12. Schedules referred to in above Financial Statement.

SCHEDULE A.—SECURED LOANS OWNED.

Description of Security	Name of Maker	Address	Amount of Loan
			$
		Total	$

SCHEDULE B.—STOCKS AND BONDS OWNED.

Description of Bonds and Stocks—(Give rate of interest and year of maturity of bonds, and number of shares of stock.)	Par Value	Book Value	Market Value
	$	$	$
Totals	$	$	$

SCHEDULE C.—REAL ESTATE OWNED.

Description and Location of Property	Amount at Which Carried on Books	Amount of Liens on Property, if any	Estimated Actual Value of Property	Fire Insurance Carried on Property
	$	$	$	$
Totals	$	$	$	$

13. Statement of Locations of Shops and other Work places, Number of Employees, Payrolls and Description of Operations in New Jersey.

This report covers the latest fiscal period of the Employer, extending from _____ to _____

Location of Factory, Office or other work place by town, city or other designation	Estimated Average Number of Employees at Each Location	Division of Operations (Payroll and number of employees are to be given on separate lines for each operation at each location.)	Actual Payroll Expenditure for past year	Rate (Do not fill in)	Premium (Do not fill in)
		(a) Clerical office employees and draftsmen engaged exclusively in office duties. (b) Outside salesmen, collectors and messengers. (c) Drivers and helpers. (d) Chauffeurs and helpers. (e) General operations at plant of employer or elsewhere within the State of New Jersey. Note: Classify each separate operation as closely as possible in accordance with insurance rate manual in force.			

14. Total estimated average number of employees _____, and total payroll expenditure in the past year $_____ for *all* operations wherever conducted.

15. **Loss Exhibit**

A. Total amount of compensation (indemnity only) PAID during past year ..... $.....

B. Total amount of medical, hospital and surgical expense for the past year including cost of supplies and equipment for employer's plant hospital (paid $.....) total incurred..... $.....

C. Outstanding Indemnity Reserve (total of reserve as per Col. 10 of supplementary statement) ..... $.....

D. Total incurred loss for past year [A. + B. + C. - C. (Prior Year)] ..... $.....

_____
(Signature of Employer)

By _____
(Name) (Title)

Dated at _____, _____ 19.....

AFFIDAVIT

(The person subscribing to the below affidavit should be the employer himself; or if the employer be a partnership, one of the partners; or if the employer be a corporation its president, vice-president, secretary or treasurer.)

STATE OF NEW JERSEY, }
_____County. } ss.

_____first being duly sworn on oath deposes and says that he is acquainted with the affairs of the above-mentioned employer, to which the foregoing statement and supplementary statement of outstanding disability claims accompanying the same relate, that he has read said statements, knows the contents thereof and that the same are true and completely answer the several questions to the best of his knowledge and belief.

Subscribed and sworn to before me at _____, this _____day of _____, A. D. 19____ } _____

_____

_____
(Official Title)

EXHIBIT E

(E91 A)

Supplementary Statement by.....(name of employer).....(address).....

Outstanding Death or Disability Claims, as of the last closing date.....19.....

Include all accidents occurring prior to above date which resulted in death or in disability exceeding seven days unless final payment has been made prior to said date in accordance with award or agreement approved by the Workmen's Compensation Bureau, or the right to recovery is barred by limitation of statute.

☞This statement is to be rendered in all cases. If there are no claims of the kind indicated write "none" in the column numbered 2.

Workmen's Compensation Bureau Case No. 1	Name of Injured or Deceased 2	Date of Accident 3	Weekly Wages at Time of Accident 4	Weekly Compensation 5	Nature of Injury 6	Number of Dependents and Ages of each (Fatal Cases Only) 7	Year of Birth (when Injury is Permanent) 8	Probable Future Duration in Weeks 9	Estimated Total Future Payments 10

Additional supply of this sheet, if required, will be furnished upon request.

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

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:22–6.57, 6.58, 6.59, 6.61, 6.64, 6.65, 6.73, 6.75(2), 6.76, and 54:49–3 and 4.

Source and Effective Date

R.1993 d.582, effective November 15, 1993.
See: 25 N.J.R. 1826(a), 25 N.J.R. 5194(a).

11:2–34.1 Purpose and scope

(a) This subchapter sets forth the method by which the surplus lines premium receipts tax imposed pursuant to N.J.S.A. 17:22–6.59 and 6.64 and the New Jersey Surplus Lines Insurance Guaranty Fund assessment imposed pursuant to N.J.S.A. 17:22–6.75 is computed on the portion of the premium which is properly allocable to the risks or exposures located within this State.

(b) This subchapter applies to all surplus lines agents and insureds required to forward premium receipts tax to the Commissioner pursuant to N.J.S.A. 17:22–6.59 and 6.64, and assessments to the New Jersey Surplus Lines Insurance Guaranty Fund pursuant to N.J.S.A. 17:22–6.75a(2).

11:2–34.2 Definitions

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

"Allocation Schedule" means the schedule in the Appendix to this subchapter incorporated by reference which sets forth the criteria for tax allocation to New Jersey of a portion of the premium of multi-state risks.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Guaranty fund" means the New Jersey Surplus Lines Insurance Guaranty Fund created by N.J.S.A. 17:22–6.73.

"Located in New Jersey" or "in New Jersey" means a physical presence in or headquartered in the State of New Jersey.

"Surplus lines agent" means an individual licensed pursuant to N.J.S.A. 17:22A–1 et seq. and N.J.A.C. 11:17–2.2 to place insurance coverages with unauthorized insurers.

"Surplus lines insurer" means an unauthorized insurer which is eligible for placement of insurance coverage pursuant to N.J.S.A. 17:22–6.42, 6.43 and 6.45.

"Unauthorized insurer" means an insurer that is not duly authorized to transact business in this State by a current certificate of authority issued pursuant to N.J.S.A. 17:17–1 et seq. for domestic insurance companies and N.J.S.A. 17:32–1 et seq. for foreign companies, and any other laws of this State.

11:2–34.3 Allocation of premium tax and surcharge

(a) Each surplus lines agent shall on or before the end of the month next following each year calendar quarter file with the Commissioner a verified report in duplicate of all surplus lines insurance transacted, or not transacted, during such calendar quarter as set forth in N.J.S.A. 17:22–6.58. The surplus lines agent shall collect from the insured and forward to the Commissioner the appropriate amount of tax collected for each quarterly period as set forth in N.J.S.A. 17:22–6.59 which shall be allocated as set forth in this subchapter when a surplus lines policy covers risks or exposures only partially located within this State.

(b) Premiums charged by eligible surplus lines insurers in this State are subject to a surcharge of up to four percent calculated in accordance with N.J.S.A. 17:22–6.75(2). The surplus lines agent shall collect from the insured and forward to the Fund the amount of the surcharge on a quarterly payment basis.

(c) The surplus lines agent or insured shall determine the premium and surcharge properly allocable to risks or exposures located in this State by using the method of allocation according to the Allocation Schedule set forth in the Appendix to this subchapter, which is hereby incorporated by reference, which pertains to the classification describing the coverage.

(d) If the Allocation Schedule does not identify a classification appropriate to the property or risk located in this State, the surplus lines agent or insured shall use an alternative equitable method of allocation for the property or risk.

(e) If a policy covers more than one classification:

1. For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed using the Allocation Schedule for the corresponding portion of the premiums.

2. For any portion of the coverage not identified by a classification on the Allocation Schedule, the tax shall be computed as set forth in (d) above.

3. For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation that pertains to the classification on the Allocation Schedule describing the predominant coverage.

(f) If, in the opinion of the Commissioner, the information provided by the surplus lines agent or insured is insufficient to support its method of allocation, or if the Commissioner determines that the method used is incorrect, the Commissioner shall determine an equitable and appropriate method of allocation as follows:

1. If the Allocation Schedule identifies a classification appropriate to the coverage, the Commissioner shall use the method of allocation as set forth in (c) above.

2. If the Allocation Schedule does not identify the classification appropriate to the coverage, the Commissioner, in determining an alternate method of allocation, shall give significant weight to documented evidence of the underwriting exposure basis and any other criteria used by the insurer to determine the policy premium. The Commissioner may also consider other available information to the extent he or she finds the information sufficient and relevant, including, but not limited to, the following:

i. The percentage of the insured's physical assets in this State;

ii. The percentage of the insured's employee payroll in this State;

iii. The percentage of the insured's sales in this State; and

iv. The amount of premium tax paid to another jurisdiction.

(g) The listing of any coverage of insurance in the Allocation Schedule shall not mean that such coverage has been deemed by the Commissioner as eligible for export. No coverage shall be eligible for export unless the conditions set forth in N.J.S.A. 17:22–6.43 are satisfied.

11:2–34.4 Duty to file allocation form

(a) The surplus lines agent shall file a copy of the work sheets which show the method of allocation when it employs an alternative method of allocation to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22–6.57 and 6.58 and all renewals, until such time as a different method is approved and filed.

(b) The insured or self-insured shall file a copy of the allocation form when it employs an alternative method of allocation to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22–6.64 and 6.65, and all renewals, until such time the alternative method is approved and filed.

11:2–34.5 Duty to keep records

(a) The surplus lines agent shall maintain records concerning the method used to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22–6.57 and 6.58, including those records as indicated in the allocation schedule, and all renewals, for a period not less than three years.

(b) The insured or self insured shall maintain records concerning the method used to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22–6.64 and 6.65, including those records as indicated in the allocation schedule, and all renewals, for a period not less than three years.

(c) These records shall be available for review by the Department at all times and copies shall be provided to the Surplus Lines Examining Office of the Department, upon request, at any time during the period of retention.

11:2–34.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as provided by law including, but not limited to, N.J.S.A. 17:22–6.61, 6.64 and 6.76.

APPENDIX

SURPLUS LINES PREMIUM TAX AND ALLOCATION SCHEDULE

Criteria for Tax Allocation of Multi–State Risks

Classification	Allocated to New Jersey by
PROPERTY INSURANCE	
Real Property (including buildings and other permanent additions)	Insured value of structures and other property in New Jersey
Personal Property (including inland marine)	Insured value of property permanently or principally situated in New Jersey
Business Interruption, Time Element or similar time valued coverages	Insured time valued elements in New Jersey
Farmowners, Homeowners and Businessowners (BOP)	Insured value of structures and other property in New Jersey
Aircraft	Insured value of aircraft principally hangared in New Jersey
Motor Vehicle	Insured value of motor vehicles principally garaged in New Jersey
Kidnap and Ransom	Number of insured employees principally employed in New Jersey
Ocean Marine	None to New Jersey
FIDELITY AND SURETY	
Fidelity, Forgery and other Indemnity Bonds	Number of insured employees in New Jersey
Bankers Blanket Bonds	Number of insured employees in New Jersey
Performance Bonds	Total bond value of contracts in New Jersey
Other Surety Bonds	Total bond value of contracts in New Jersey
CREDIT INSURANCE	
Credit Insurance	Value of insured debt in New Jersey
RESIDUAL VALUE INSURANCE	
Residual Value Insurance	Allocate to value of underlying property
LIABILITY INSURANCE	
Manufacturers and Contractors	Payroll in New Jersey
Premises Operations	Square footage of premises in New Jersey

Classification	Allocated to New Jersey by
Owners and Contractors Protective	Cost of contract in New Jersey
Products	Number of units manufactured in New Jersey
Completed Operations	Receipts in New Jersey
Child Care	Number of children in New Jersey
Contractual	If "stand alone" policy, value of sales in New Jersey
Recreational	Amount of gate receipts in New Jersey
Environmental Impairment	Number of units of exposure in New Jersey
Asbestos Abatement	Payroll in New Jersey
Employee/Member Benefit Program	Number of employees/members in New Jersey
Special Events	Number of events in New Jersey
Professional Liability	Number of named insureds in New Jersey
Errors and Omissions	Revenues generated in New Jersey
Directors and Officers:	
For-profit organization	Revenues generated in New Jersey
	Number of employees
Non-for-profit organization	Headquartered in New Jersey
Hospital, Nursing Home and Adult Home	Number of beds in New Jersey plus one additional bed for each 100 outpatient visits at locations in New Jersey
Liquor Liability	Receipts from sales of alcoholic beverages in New Jersey
Railroad Protective	Miles of track in New Jersey
Aircraft	Number of aircraft principally hangared in New Jersey
Motor Vehicle	Number of motor vehicles principally garaged in New Jersey
Umbrella	Classification of predominant coverage; except if underlying coverages are divisible, then use underlying classifications
Excess Liability	If directly over primary, use underlying classifications. If over umbrella, use method for "umbrella" coverage
Comprehensive General Liability	Composite Rated Exposure based allocated to New Jersey

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

Authority

N.J.S.A. 17:1–8.1, 17:1C–(6)(e), 17:33B–1 et seq.

Source and Effective Date

R.1991 d.519, effective October 21, 1991.
See: 23 N.J.R. 660(a), 23 N.J.R. 3166(a).

11:2–35.1 Purpose and scope

(a) The purpose of this subchapter is to establish the informational and procedural requirements for insurer requests for exemption, abatement, deferral, suspension of or excuse from an insurer's obligation, as the case may be, under the Fair Automobile Insurance Reform Act of 1990, N.J.S.A. 17:33B–1 et seq.

(b) This subchapter applies to all insurers licensed to transact the business of property/casualty insurance in this State and all insurers licensed to transact and writing the business of private passenger automobile insurance in this State, as the case may be.

Amended by R.1993 d.24, effective January 4, 1993.
See: 24 N.J.R. 3212(a), 25 N.J.R. 138(a).
Provision for excuse from obligation added.

11:2–35.2 Definitions

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

"Applicant" means the insurer seeking an exemption, abatement, deferral, suspension of or excuse from its obligations pursuant to the FAIR Act.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"FAIR Act" means the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8 (N.J.S.A. 17:33B–1 et seq.).

"Insurer" means any person, corporation, association, partnership, company or interinsurance exchange authorized or admitted by the laws of this State to transact the business of insurance in this State.

"Relief" means an exemption, abatement, deferral, suspension of or excuse from the obligations imposed pursuant to the FAIR Act.

"Unsafe or unsound financial condition" is as defined in N.J.S.A. 17:33B–19, 17:33B–20, 17:33B–23, 17:33B–24, 17:33B–27, 17:33B–28, 17:33B–52, 17:33B–53, 17:33B–55 and 17:33B–56, as applicable. For purposes of relief from obligations imposed pursuant to N.J.S.A. 17:30E–14g, 17:33B–9c, and 17:33B–11c(5), "unsafe or unsound financial condition" shall have the same meaning as in N.J.S.A. 17:33B–19 and 17:33B–20, and the same procedures therein shall be followed depending on whether the relief sought is immediate or discretionary.

Amended by R.1993 d.24, effective January 4, 1993.
See: 24 N.J.R. 3212(a), 25 N.J.R. 138(a).
"Excuse" added to "Applicant" and "Relief" definition; "unsafe or unsound" clarified further.

11:2–35.3 Application procedures and filing format

(a) Any insurer seeking immediate relief from any FAIR Act obligation pursuant to N.J.S.A. 17:30E–14g, 17:33B–9c, 17:33B–11c(5), 17:33B–19, 17:33B–23, 17:33B–27, 17:33B–52 or 17:33B–55 shall submit a request for such relief no more than 45 days and not less than 15 days prior to the due date for payment or fulfillment of such obligation.

(b) Any insurer seeking discretionary relief from any FAIR Act obligation pursuant to N.J.S.A. 17:30E–14g, 17:33B–9c, 17:33B–11c(5), 17:33B–20, 17:33B–24, 17:33B–28, 17:33B–53 or 17:33B–56 shall submit a request for such relief no later than the due date of such obligation.

(c) All requests outlined in this subchapter shall be accompanied by a statement averring a need for immediate or discretionary relief from such obligation, as the case may be, including supporting documentation, as set forth in N.J.A.C. 11:2–35.4 and shall specify the statutory basis for such relief. A single filing may request relief from any number of FAIR Act obligations.

(d) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:2–25.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(e) All insurers requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (d) above.

(f) A request which is untimely, which is not submitted in the proper format, or which does not contain all of the information required by N.J.A.C. 11:2–35.4 or this section, may be rejected on such grounds by the Commissioner.

(g) If a request fails to contain all of the information required by N.J.A.C. 11:2–35.4 or this section, the Department shall notify the insurer that its request for relief is deficient and is denied for inadequate documentation. The notice shall also set forth the information required to cure the deficiency. The insurer shall submit the additional information within 30 days of receipt of the Department's notice of deficiency. Failure to submit within 30 days the information necessary to cure the deficiency may result in the insurer's request being rejected as untimely.

Amended by R.1993 d.24, effective January 4, 1993.
See: 24 N.J.R. 3212(a), 25 N.J.R. 138(a).
N.J.S.A. citations added, in reference to FAIR Act exemptions.

11:2–35.4 Informational filing requirements

(a) When requesting immediate or discretionary relief pursuant to the FAIR Act, an insurer shall provide with its request the following information in a clear, concise and complete manner.

1. A cover letter stating:

i. The name of the applicant;

ii. The form and specific amount/percentage of relief which the insurer is requesting and a statement of facts relied upon as the basis under which relief is sought; and

iii. A name, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;

2. Exhibits for the latest preceding calendar quarter ending at least 45 days prior to the date of the request, and, unless otherwise indicated, on a statutory accounting basis that show:

i. Balance sheet;

ii. Profit and loss statement, containing information as set forth in the statutory annual statement page 4, Underwriting and Investment Income Exhibit, Statement of Income; and

iii. Cash flow page;

3. Exhibits by each line of business written in New Jersey that show:

i. Profit and loss statements containing information as set forth in (a)2ii above by line of business for three calendar years prior to the date of filing;

ii. Profit and loss statements containing information as set forth in (a)2ii above by line of business from the period beginning January 1 in the year of filing to date of the filing as reported in the NAIC quarterly statement filed immediately preceding the date of the filing; and

iii. A detailed description of the method of allocation of expenses by line of business;

4. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the company unless relief is granted as requested;

5. The most recent financial examination report conducted by the state of domicile;

6. A statement that summarizes any pending New Jersey rate filing requests, including any New Jersey flex rate filings projected to be made on or after July 1 of the year in which relief was requested. The Department of Insurance filing number, the amount of the rate request, and the requested effective date of the change shall be included;

7. A statement addressing whether the company is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;

8. If the company is a member of a holding company system, the following shall be provided:

i. A list of all members of the holding company system;

ii. A list of all intercompany transactions for the period noted in (a)3i and ii above;

iii. A balance sheet and profit and loss statement for the ultimate parent company on a consolidated basis for the periods noted in (a)3i and ii above; and

iv. A balance sheet and profit and loss statement for the ultimate parent company on an unconsolidated basis for the periods noted in (a)3i and ii above;

9. A certification of reserves for unearned premiums, losses and loss adjustment expense, such certification to be attested to by a qualified actuary as defined in N.J.A.C. 11:1–21.1;

10. A report signed by the certifying actuary referred to in (a)9 above, which includes in summary form, if necessary, all data utilized by him or her, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

i. All data shall be presented as hard copy and on 5¼ inch floppy diskettes as Lotus 1–2–3 worksheet files or the equivalent thereof with page breaks omitted (submitting, in total, one copy of the diskettes for each filing). The data shall include, at a minimum, relevant loss and loss expense triangles both on paid and incurred bases for sufficient numbers of accident years and maturities such that, on a paid basis, at least five accident years are developed to within 90 percent of ultimate. If only a lesser amount of data is available, state the reason for this deficiency.

ii. In the event that paid or incurred loss developments have been distorted by changes in the rate of settlements, in the relative adequacy of reserving, in the mix of business, or in other relevant factors, such distortions shall be fully explained in the narrative. To include the impact of these distortions, appropriate adjusted triangles shall also be supplied plus corresponding triangles of reported, paid and outstanding claim counts.

iii. Annual earned premiums shall be shown as the first column of each triangle;

11. For insurers seeking discretionary relief and asserting that it would experience an adverse change in its rating by A.M. Best and Company, Dun and Bradstreet, Moody's or Standard and Poor's, a statement from a representative of the appropriate rating agency that the insurer will experience an adverse change in its rating through fulfillment of the obligation from which relief is sought; and

12. Any other information the Commissioner may deem relevant to the consideration of the request.

(b) If the applicant is a member of a pooling operation among affiliates, all information requested in items (a)2 and 3 above shall be provided on a pre-pooled and post-pooled basis. The applicant shall indicate the names of other members in the pool that are also filing for exemption, abatement, deferral or suspension of, or excuse from an obligation, as the case may be, under the FAIR Act.

(c) An insurer asserting that the Department's review of its request be evaluated on a particular basis (that is, pre-pooled, post-pooled, consolidated or unconsolidated) shall submit a written statement which sets forth the reasons for which it believes evaluation on a particular basis is appropriate to that insurer, and the reasons for which evaluation on other bases would be inappropriate.

Amended by R.1993 d.24, effective January 4, 1993.
See: 24 N.J.R. 3212(a), 25 N.J.R. 138(a).
Exhibits further specified at (a)3; deleted (a)4; text at (b) clarified.

11:2–35.5 Relief

(a) When the Commissioner determines that fulfillment of a FAIR Act obligation or obligations set forth at N.J.A.C. 11:2–35.3(a) or (b) will result in the insurer being or becoming in an unsafe or unsound financial condition, or that an insurer is currently in an unsafe or unsound financial condition, the Commissioner shall order relief from the obligation(s) as set forth in (b) and (c) below.

(b) Except as provided at (c) below, the Commissioner shall order that insurer's duty to fulfill the applicable FAIR Act obligation be suspended or excused pending quarterly review of the insurer's financial condition.

(c) Where the Commissioner has granted an insurer relief from payment of assessments or surtaxes pursuant to N.J.S.A. 17:30A–8a(9) or 17:33B–49, as applicable, the Commissioner shall order that the insurer's obligation be exempted, abated or deferred, as follows:

1. Except as provided at (c)2 below, the Commissioner shall in all cases order that the insurer's obligation be deferred pending a quarterly review of the insurer's financial condition. The deferral shall be deemed to be an exemption two years from the date the obligation was originally due, unless the Commissioner, prior to that date, determines that the insurer's financial condition has improved such that payment of the obligation, or a portion thereof, will not result in the insurer's financial condition being or becoming unsafe or unsound. If an insurer is required to pay a portion of its obligation prior to the expiration of the two-year period, the remainder shall be deferred, and shall be deemed exempt at the expiration of the two-year period in the same manner as provided in this paragraph for deferred obligations.

2. The Commissioner shall order that the insurer's obligation be exempted, and thus no obligation thereafter shall be deemed to exist for the particular obligation for which the exemption was granted, if the insurer is in liquidation pursuant to N.J.S.A. 17:30C–8, or similar statute of the insurer's state of domicile, at the time the request is made. The Commissioner shall also grant an exemption if the insurer is in rehabilitation or conservation pursuant to N.J.S.A. 17:30C–6 or 17:30C–11, or

similar statute of the insurer's state of domicile. The Commissioner shall also grant an exemption if payment of the obligation would result in the insurer being in a hazardous financial condition as determined in accordance with N.J.A.C. 11:2–27. An exemption granted under this paragraph to an insurer shall be for the entire obligation and no obligation thereafter shall exist for the particular obligation for which the exemption was granted; provided that the determination whether to grant an exemption from a future obligation shall be considered at the time such obligation becomes due based on the insurer's financial condition at that time.

3. The Commissioner shall order that the insurer's obligation to pay the full amount of the assessment or surtax be abated if he or she determines that payment of some amount will not result in the insurer's financial condition being or becoming unsafe or unsound. The amount which is not abated shall be deferred in the same manner provided by (c)1 above.

New Rule, R.1993 d.24, effective January 4, 1993.
See: 24 N.J.R. 3212(a), 25 N.J.R. 138(a).

11:2–35.6 Hearings

(a) If the Commissioner denies an insurer's request for relief made pursuant to this subchapter, or if the insurer objects to the form of relief granted, the insurer may request a hearing on the Commissioner's determination within seven days from the date of such receipt of determination as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting a hearing; and

iv. A concise statement describing the basis for which the insurer believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the insurer and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

i. If the Commissioner finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Commissioner shall notify the applicant in writing as to the final disposition of the matter.

ii. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) Receipt of a timely request for a hearing in the form set forth in (a)1 above shall stay the effect of a denial of relief until the Commissioner's final disposition of the matter made pursuant to this section.

New Rule, R.1993 d.24, effective January 4, 1993.
See: 24 N.J.R. 3212(a), 25 N.J.R. 138(a).

SUBCHAPTER 36. RISK RETENTION GROUPS AND PURCHASING GROUPS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and P.L. 1993, c.240.

Source and Effective Date

R.1993 d.558, effective October 15, 1993.
See: 25 N.J.R. 4298(a), 25 N.J.R. 5197(a).

Subchapter Historical Note

Subchapter 36, Risk Retention Groups and Purchasing Groups, was adopted as emergency new rules R.1993 d.449, effective August 16, 1993 (to expire October 15, 1993). See: 25 N.J.R. 4298(a). The provisions of R.1993 d.449 were readopted as R.1993 d.558. See: Source and Effective Date.

11:2–36.1 Purpose and scope

(a) The purpose of this subchapter is to regulate in this State the formation and/or operation of:

1. Foreign or alien risk retention groups; and

2. Purchasing groups formed in the United States pursuant to 15 U.S.C. § 3901 et seq.

(b) This subchapter applies to:

1. All foreign or alien risk retention groups and their legal representatives, who are doing or intend to do business in this State; and

2. All purchasing groups with members located in this State and their legal representatives, who are doing or intend to do business in this State.

11:2–36.2 Definitions

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

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Doing business in this State" means solicitation in this State, having group members in this State, or having an office in this State.

"Domicile" means, with respect to a purchasing group: for a corporation, the state in which the purchasing group is incorporated; for an unincorporated entity, the state of its principal place of business.

"Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance and any other arrangement for shifting and distributing risk which is determined to be insurance pursuant to the laws of the State.

"Liability" means legal liability for damages, including the cost 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 such other persons resulting from or arising out of: any profit or non-profit business, trade, product, services, including professional services, premises, or operations; or any activity of any state or local government or any agency or political subdivision thereof, but 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. § 51 et seq.

"Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of the risk retention group, including: information sufficient to verify that its members are engaged in business or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; 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; historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available; pro forma financial statements and projections; appropriate opinions by a qualified actuary, including the determination of minimum premium or participation levels and capitalization required to commence operations and to prevent a hazardous financial condition, which shall be in the format and otherwise satisfy all requirements established by the Commissioner for loss reserve actuarial opinions required to be submitted by licensed property and casualty insurers in this State; identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements; identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

"Purchasing group" means any group which has as one of its purposes the purchase of liability insurance on a group basis; purchases such insurance only for its group members and only to cover their similar or related liability exposure; is composed of members whose business 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; and is domiciled in this or any other state.

"Risk retention group" means any corporation or other limited liability association: which is organized for the primary purpose of, and whose primary activity consists of, assuming and spreading all, or any portion, of the liability exposure of its group members; which is chartered and licensed as a liability insurance company and is authorized to engage in the business of insurance under the laws of any state, or prior to 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, certified to the commissioner of insurance, or other appropriate official, of at least one state that it satisfied the capitalization requirements of that state, except that any such group shall be 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 defined in the Federal "Product Liability Risk Retention Act of 1981," Pub.L. 97–45 (15 U.S.C. § 3901 et seq.), before October 27, 1986; which does not exclude any person from membership in the group solely to provide for members of that group a competitive advantage over such a person; which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group, or has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and its owners are the only persons who comprise the membership of the risk retention group and who are provided insurance by such group; whose 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; whose activities do not include the provision of insurance, other than liability insurance for assuming and spreading all or any portion of the liability of its group members, and reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any member of any other group, which is engaged in businesses or activities so that this group or member meets the requirement that 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 for membership in the risk retention group which provides the reinsurance; and the name of which includes the phrase "risk retention group."

11:2–36.3 Risk retention group registration requirements

(a) No risk retention group shall do business in this State as a risk retention group until it has complied with the requirements of this subchapter and received Notice of Registration from the Department.

(b) Any risk retention group which is chartered and licensed under the laws of any other state and which wishes to do business in this State shall submit to the Department:

1. A copy of its certificate of authority or license authorizing it to transact business as an insurance company, certified by the state of domicile;

2. A statement identifying the state(s) in which the risk retention group is chartered and licensed as a liability insurance company, the date of its charter and admission as a licensed insurer and its principal place of business, and any other information, including information regarding its membership. Additionally, the statement shall include the following:

i. The identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;

ii. The amount and nature of initial capitalization;

iii. The coverages to be afforded; and

iv. The states in which the group intends to operate;

3. A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to the state or states in which the risk retention is chartered and licensed in accordance with P.L. 1993, c.240;

4. A statement of registration (as set forth in Appendix A and incorporated herein by reference) and a Notice of Appointment (as set forth in Appendix B and incorporated herein by reference), which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process; and

5. Payment of the $100.00 registration filing fee which shall accompany the statement of registration, in accordance with N.J.A.C. 11:1–32.

(c) Any risk retention group currently registered with the Department prior to August 16, 1993 shall submit a statement of registration (as set forth in Appendix A) and a Notice of Appointment (as set forth in Appendix B). The registration must be filed no later than November 8, 1993. The risk retention group shall notify the Department of any change in the information in the statement of registration within 30 days of any change.

(d) Each foreign and alien risk retention group which has received a certificate of registration from the Department to do business in this State shall submit to the Department:

1. On or before March 1, or as prescribed by the state of domicile, a statement of financial condition for the preceding calendar year ended December 31. The statement shall be on a form as prescribed by the state of domicile;

2. On or before June 1, a statement of opinion on loss or loss adjustment expense reserves made by a member of the American Academy of Actuaries, or a qualified loss reserve specialist;

3. By June 30, a report of financial condition, certified by an independent public accountant;

4. Within 30 days after filing in its state of domicile, a copy of each examination of the risk retention group as certified by the chartering state's commissioner or public official conducting the examination;

5. Upon request of the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group;

6. Such information as may be required to verify its continuing qualification as a risk retention group under N.J.A.C. 11:2–36.2, including, but not limited to, a certification of an officer that the group is composed of members whose business or activities are similar or related with respect to liability; and

7. Payment of the $100.00 Annual Statement filing fee in accordance with N.J.A.C. 11:1–32.

(e) Failure by any currently registered risk retention group either to file a statement of registration, to complete all information requested pursuant to this subchapter or to update changes in the statement of registration may result in suspension or forfeiture of the risk retention group's registration status with the Department.

(f) Any person wishing to establish a risk retention group chartered and licensed to write only liability insurance in this State shall, in addition to meeting the requirements pursuant to N.J.S.A. 17:17–1 et seq., submit to the Department a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days of any such change. The group shall not offer any additional kinds of liability insurance in this State, or in any other state, until a revision of such plan or study is approved by the Commissioner. Additionally, the risk retention group shall adhere to the requirements of P.L. 1993, c.240 and (b)1 through 5 above.

(g) Each risk retention group, its agents and representatives shall comply with the Unfair Claims Settlement Practices Act of this State, N.J.S.A. 17:29B–1 et seq., and any other State law regarding deceptive, false or fraudulent acts or practices.

(h) Each risk retention group must submit to an examination 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. The risk retention group shall pay the reasonable expenses of such an examination upon presentation by the Commissioner of a detailed account of the expenses.

(i) Each risk retention group shall comply with any lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the Commissioner if there has been a finding of financial impairment after an examination pursuant to this section.

(j) Each risk retention group shall comply with any injunction issued by a court of competent jurisdiction upon a petition by the Commissioner alleging that the group is in a hazardous financial condition or is financially impaired.

Amended by R.1993 d.558, effective November 15, 1993.
See: 25 N.J.R. 4298(a), 25 N.J.R. 5197(a).

11:2–36.4 Additional risk retention groups requirements

(a) Any risk retention group which is registered in this State and chartered and licensed under the laws of any other state and which wishes to do business in this State, in addition to the requirements of N.J.A.C. 11:2–36.3, shall distribute its annual statement of operations to its members.

11:2–36.5 Notice and registration requirements of purchasing groups

(a) No purchasing group shall do business in this State as a purchasing group until it has complied with the requirements of this subchapter and received notification from the Department that it has been registered to do business in this State.

(b) Any group of persons with similar exposure to risk may form a purchasing group for the purpose of purchasing liability insurance.

1. Any purchasing group with members located in this State shall submit to the Department a statement of registration (as set forth in Appendix C and incorporated herein by reference) and a Notice of Appointment (as set forth in Appendix D and incorporated herein by reference) which shall be accompanied by a registration fee in accordance with N.J.A.C. 11:1–32.

2. Each purchasing group registered pursuant to this section shall submit to the Department from time to time, as it may require, reports relative to the group's operations.

3. Each purchasing group with members in this State registered pursuant to this subsection is subject to audits or examination as the Commissioner may deem necessary.

(c) Any purchasing group which was doing business in this State prior to August 16, 1993 shall submit to the Department a statement of registration (as set forth in Appendix C) and a Notice of Appointment (as set forth in Appendix D). The statement of registration must be filed no later than November 8, 1993. The purchasing group shall notify the Commissioner of any change in the information in the statement of registration within 30 days of any change.

(d) Failure of any currently registered purchasing group either to file a statement of registration, to complete all information requested pursuant to this subchapter or to update changes in the statement of registration, may result in suspension or forfeiture of the purchasing group's registration status with the Department.

11:2–36.6 Fines and penalties

(a) Each risk retention group, whether chartered in this State or otherwise, is subject to the same fines and penalties to which insurers licensed in this State are subject for any violation of this subchapter or any other applicable law.

(b) Failure of a risk retention group or purchasing group doing business in this State to comply with the provisions of this section may, after notice and a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, result in the revocation or suspension of its registration in this State.

APPENDIX A

STATEMENT OF REGISTRATION

STATE OF NEW JERSEY

APPLICATION FOR REGISTRATION AS A RISK RETENTION GROUP

(All information should be typed)

1. List the corporate name of the Risk Retention Group.

_____

(Name *must* include the phrase "Risk Retention Group")

2. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of _____, and is authorized to engage in the following lines of insurance under the laws of its chartering State:

_____

_____

_____

3. Ownership of the Risk Retention Group consists of one of the following (check one):

☐ the owners of the Group are the only persons who comprise the membership of the Group and who are provided insurance by the Group;

☐ the sole owner of the Group is _____

_____

_____

(Give name and address of organization)

an organization whose members only comprise the membership of the Group, and whose owners are only persons who comprise the membership of the Group and who are provided insurance by the Group.

4. Give a general description of business or activities engaged in by Group members:

_____

_____

_____

5. List the name, address, fax number and telephone number of each officer of the Risk Retention Group and the key officer or staff person (*Not* an employee of the group's management company) responsible for overseeing "hands on management" of the group. (Attach additional pages if necessary.)

_____

_____

_____

_____

6. A. List the home office address of the Risk Retention Group:

_____

_____

_____

B. List the mailing address of the Risk Retention Group:

_____

_____

_____

7. List the name, address and telephone number of the company responsible for management of the insurance operations of this risk retention group. (If none, answer none.)

_____

_____

_____

8. List the name, address and telephone number of the principal agent or broker responsible for marketing the group's insurance policies, pursuant to N.J.S.A. 17:22A–1 et seq.

Name:_____

Address:_____

Phone Number:_____

Producer ID Reference Number:_____

9. The items described below should be attached to the registration form:
   A. If not previously submitted, registration fee in the amount of $100.00 made payable to the "State of New Jersey General Treasury."
   B. Completed and signed Service of Process.
   C. A listing of the individual(s) who organized the group and the individuals who are providing administrative services or otherwise influence or control the activities of the group.

As President or Chief Executive Officer of the _____, I hereby certify that the information contained in this registration is true and correct and in conformance with 15 USC 3901 et seq., N.J.S.A. 17:___ and N.J.A.C. 11:___. Further, I certify that:

The Risk Retention Group is composed of members who are engaged in the following described business or activities, which are similar or related with respect to the liability to which such members are exposed by virtue of related, similar, or common business, trade, product, services, premises or operations.

The primary activity of this Risk Retention Group consists of assuming and spreading all, or any portion, of the liability exposure of its members.

The Risk Retention Group is organized for the primary purpose of conducting the activity described above.

The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

The activities of the Risk Retention Group do not include the provision of insurance other than:

(a) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and

(b) Reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities which qualify such other Risk Retention Group (or member) under item (6) above for membership in this Group.

In addition all required documents as set forth in 15 USC 3901 et seq., N.J.S.A. 17:___ and N.J.A.C. 11:___ are being included in this filing.

_____

President or Chief Executive Officer

_____

Secretary

Sworn before me this _____ day of _____, 19____.

_____

Notary Public, State of:
My Commission Expires:

(Revised 7/93)

Amended by R.1993 d.558, effective November 15, 1993.
See: 25 N.J.R. 4298(a), 25 N.J.R. 5197(a).

APPENDIX B

NOTICE OF APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE

STATE OF _____

DEPARTMENT OF INSURANCE

The _____, a Risk Retention Group (called the Group) duly organized under the laws of the State of _____, appoints the Insurance Commissioner of the State of _____, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Insurance Commissioner and his or her successors, full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This constitutes full compliance with Section 2(a)(1)(D) of the Liability Risk Retention Act of 1986.

The Group designates [_____] whose address is [_____] as the person to whom process against the Group served upon the Commissioner [Director, Superintendent] shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed at the City of _____, State of _____, this _____ day of _____, 19___.

Attest:

_____ _____

Secretary (Name of Risk Retention Group)

By

_____

President

APPENDIX C

STATE OF NEW JERSEY
APPLICATION FOR REGISTRATION AS A PURCHASING GROUP

(All information should be typed)

1. List the exact name of the Purchasing Group.

2. Indicate the form of organization or incorporation and date.

3. The Purchasing Group is domiciled in the State of:

4. List any other names under which the Purchasing Group is or may be doing business in this State or any other State if different from above.

5A. List the complete physical address of the Purchasing Group.

5B. List the mailing address of the Purchasing Group.

6A. List the name, title, address, fax number, and telephone number of the principal officer of the purchasing group who has knowledge of its insurance program, including membership criteria, coverages, and key personnel of the group's administrator and insurance carrier.

6B. List the name, title, address, fax number, and telephone number of the firm that acts as the administrator of the purchasing group and the name of the principal account executive responsible for the group's insurance program. (If none, answer none.)

7. List the names, addresses and occupation of the principal officers and directors of the Purchasing Group. Attach additional pages if necessary.

Principal Officers	Principal Directors

8. Give a general description of the business or activities engaged in by purchasing group members:

9. List the lines and classification of liability insurance Purchasing Group will purchase:

10. What are the limits of liability including per occurrence, aggregate per participant and group aggregate.

11. Deductible and self-insurance retentions
(a) Which are the responsibility of the individual participant?

(b) Which are the responsibility of the purchasing group and how funded?

12. List the insurance carriers from whom the Purchasing Group will purchase liability insurance described in item (9) above. Give full name of company, state of domicile and NAIC#:

13. Purchasing groups procuring insurance through companies licensed in New Jersey or registered Risk Retention Groups must use an insurance producer pursuant to N.J.S.A. 17:22A-1 et seq. Please identify the producer(s) representing the purchasing group:
Name_____
Address_____
Phone No._____
Producer License Reference Number: _____

14. Purchasing groups procuring insurance from New Jersey eligible surplus lines companies must place it through a licensed New Jersey insurance producer with surplus lines authority pursuant to N.J.S.A. 17:22–6.40 et seq. and 17:22A–1. Please identify the producer(s) representing the purchasing group:
Name_____
Address_____
Phone No._____
Producer License Reference Number: _____
15. List who will adjust the claims?
Name_____
Address_____
Phone No._____
Producer License Reference Number: _____
16. Has any person transacting business on behalf of this Purchasing Group ever:
(A) been arrested, indicted and convicted of a felony or is a felony charge currently pending against any such person? _____
(B) had denied any application for a professional, vocational or business license? _____
(C) had suspended or revoked any such license? _____
(D) had withdrawn or surrendered any such application or license to avoid potential disciplinary action against licensee? _____
If the answer to any part of this question is yes, attach a supplementary statement explaining in full each such occurrence.
The items described below should be attached to the registration form:
(a) If not previously submitted, registration fee in the amount of $100.00 made payable to the "State of New Jersey—General Treasury."
(b) Completed and signed Service of Process.
(c) A listing of the individual(s) who organized the Purchasing Group and the individuals who are providing administrative services or otherwise influence or control the activities of the group.
(d) A listing of current members.
- The Purchasing Group is composed of members whose business 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.
- The Purchasing Group purchases such liability insurance only for its members and only to cover their similar or related liability exposure, as described in item (8) above.
- The policy and promotional material the purchasing group will use has been forwarded along with the registration.

In addition, all required documents are set forth in 15 USC 3901 et seq., N.J.S.A. 17:___ and N.J.A.C. 11:___ are being included in this filing.

_____
President or Chief Executive Officer

_____
Secretary

Sworn before me this _____ day of _____, 19____.

_____
Notary Public, State of:
My Commission Expires:

(Revised 7/93)

APPENDIX D

NOTICE TO APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE

STATE OF NEW JERSEY

The _____, a Purchasing Group (called the Group) duly organized under the laws of the State of _____, appoints the Insurance Commissioner of the State of _____, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Insurance Commissioner and his or her successors full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This constitutes full compliance with Section 2(a)(1)(D) of the Liability Risk Retention Act of 1986.

The Group designates [_____] whose address is [_____] as the person to whom process against the Group served upon the Commissioner [Director, Superintendent] shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed in the City of _____, State of _____, this _____ day of _____, 19____.

Attest:

_____
Secretary

_____
(Name of Risk Retention Group)

By

_____
President

Amended by R.1993 d.558, effective November 15, 1993.
See: 25 N.J.R. 4298(a), 25 N.J.R. 5197(a).

SUBCHAPTER 37. PRODUCER–CONTROLLED INSURERS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and P.L. 1993, c.239.

Source and Effective Date

R.1993 d.559, effective October 15, 1993.
See: 25 N.J.R. 4304(a), 25 N.J.R. 5202(a).

Subchapter Historical Note

Subchapter 37, Producer–Controlled Insurers, was adopted as emergency new rules R.1993 d.450, effective August 16, 1993 (to expire October 15, 1993). See: 25 N.J.R. 4304(a). The provisions of R.1993 d.450 were readopted as R.1993 d.559. See: Source and Effective Date.

11:2–37.1 Purpose

The purpose of this subchapter is to implement P.L. 1993, c.239 to enable the Department to regulate transactions involving insurers which are controlled by insurance producers.

11:2–37.2 Scope

This subchapter shall apply to all licensed property and casualty insurers domiciled in this State or domiciled in a state that is not an accredited state having in effect a law substantially similar to P.L. 1993, c.239. This subchapter shall not apply to captive insurers.

11:2–37.3 Definitions

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

"Accredited state" means a state in which the insurance department or other regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the NAIC.

"Captive insurer" means an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Control" or "controlled" has the same meaning as defined at N.J.S.A. 17:27A–1c.

"Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

"Controlling producer" means a producer who, directly or indirectly, controls an insurer.

"Department" means the New Jersey Department of Insurance.

"Licensed insurer" or "insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17–1.

"FNAIC" means National Association of Insurance Commissioners.

"Producer" means any person engaged in the business of an insurance agent, insurance broker or insurance consultant as defined at N.J.S.A. 17:22A–2.

"Producer-controlled" means controlled, directly or indirectly, by a producer.

11:2–37.4 Filing of Producer–Controlled Insurer Information Report

All licensed property and casualty insurers domiciled in this State or domiciled in another state that is not an NAIC accredited state having in effect a law substantially similar to P.L. 1993, c.239, shall file an annual Producer–Controlled Insurer Information Report on a form (incorporated herein by reference as Appendix A) approved by the Commissioner. The Report shall be completed and filed with the Commissioner on or before April 1 for the calendar year immediately preceding.

11:2–37.5 Contents of the Producer–Controlled Insurer Information Report

(a) A Producer–Controlled Insurer Information Report form (Appendix A) shall be completed annually by each licensed property and casualty insurer to whom this subchapter applies and shall include the following information:

1. The name and address of the reporting insurer and any controlling producer. (A separate form should be completed and filed for each controlling producer.);

2. A certification by insurers that are not producer-controlled that they are not issuing any property and casualty insurance coverages that are or may be reportable pursuant to the provisions of P.L. 1993, c.239 or this subchapter;

3. A certification by producer-controlled insurers containing the following information:

i. The amount of the insurer's admitted assets as of September 30 of the preceding calendar year, gross premiums written during the calendar year and the percentage that gross premiums written represent of admitted assets;

ii. The amount of net premiums written during the preceding calendar year, commissions paid to the controlling producer during the calendar year and the

percentage that commissions paid to the controlling producer represent of the net premiums written;

iii. Comparable amounts and percentage paid to noncontrolling producers for placement of the same kinds of insurance;

iv. An opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling producer, which loss reserve opinion shall satisfy all requirements established by N.J.A.C. 11:1–21 for loss reserve opinions required to be submitted by licensed property and casualty insurers in this State; and

v. A statement indicating whether or not the insurer's controlling producer or producers have been notified of the requirements of P.L. 1993, c.239 and these rules.

11:2–37.6 Confidentiality of documents

All documents submitted to the Commissioner pursuant to this subchapter are confidential and not public documents as defined in the Public Records Act, N.J.S.A. 47:1A–1 et seq.

11:2–37.7 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as provided by law.

APPENDIX A

PRODUCER–CONTROLLED INSURER INFORMATION REPORT FORM

Calendar Year Ending December 31, _____

Instructions: All licensed property and casualty insurers domiciled in New Jersey, or domiciled in another state that is not a NAIC "accredited state" having in effect a law substantially similar to P.L. 1993, c.239, are required to complete annually either Section I or Section II of this form. Section I certifies that the requirements of New Jersey Law have been reviewed and there is no controlling producer information to be reported. Section II should be completed for each producer who "controls" a reporting insurer. Completed reporting forms are due annually, on or before April 1 of each year.

SECTION I

To be completed by Insurers that are *not* Producer–Controlled

I certify that _____
(Name of Insurer)

_____
(Address of Insurer)

is not issuing any property and casualty insurance coverages that are or may be reportable pursuant to the provisions of P.L. 1993, c. 239 and N.J.A.C. 11:2–37.1 et seq.

_____ _____
Date Authorized signature

_____
Title

SECTION II

To be completed by Producer–Controlled Insurers
(A separate Report Form should be completed and filed for each controlling producer.)
Calendar Year Ending December 31, _____

Name of Reporting Insurer: _____
Address: _____
Name of Controlling Producer: _____
Address: _____

1. Insurer's admitted assets as of September 30 of calendar year pursuant to P.L. 1993, c. 239, § 3a: $_____
2. Gross premiums written, calendar year: $_____
3. Percentage that gross premiums written represent of admitted assets: _____%
4. Net premiums written, calendar year: $_____
5. Amount of commissions paid to controlling producer, calendar year: $_____
6. Percentage that commissions paid represent of net premiums written: _____%
7. Comparable amounts and percentage paid to non-controlling producers for placement of the same kinds of insurance:
   Net premiums written: $_____
   Commissions paid: $_____
   Percentage: _____%
8. Attach the information required by P.L.1993, c. 239, § 3e: An opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling producer.
9. We have notified our controlling producer(s) of the requirements of P.L. 1993, c. 239 and N.J.A.C. 11:2–37.1 et seq.

I certify that the above information is accurate and complete.

_____ _____
Date Authorized signature

_____
Title

SUBCHAPTER 38. INCREASE IN PROPERTY AND CASUALTY CAPITAL AND SURPLUS REQUIREMENTS

Authority

N.J.S.A. 17:1C–6(e), 17:17–1 et seq. and 17:50–5.

Source and Effective Date

R.1993 d.560, effective October 15, 1993.
See: 25 N.J.R. 4306(a), 25 N.J.R. 5204(a).

Subchapter Historical Note

Subchapter 38, Increase in Property and Casualty Capital and Surplus Requirements, was adopted as emergency new rules R.1993 d.451, effective August 16, 1993 (to expire October 15, 1993). See: 25 N.J.R. 4306(a). The provisions of R.1993 d.451 were readopted as R.1993 d.560. See: Source and Effective Date.

11:2–38.1 Purpose and scope

(a) The purpose of this subchapter is to provide procedures whereby property and casualty insurers may request a temporary waiver from the minimum capital and surplus requirements set forth in P.L. 1993, c.234, sections 2 and 3. This subchapter also provides procedures whereby the Commissioner may, pursuant to P.L. 1993, c.234, section 6, subsequently require an increase in these statutory minimum requirements.

(b) This subchapter shall apply to all insurers, including reciprocal insurance exchanges, authorized, admitted or eligible to transact the business of property and casualty insurance in this State.

11:2–38.2 Definitions

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

"Capital" means par value per share multiplied by the number of issued shares, or in the case of no-par shares, the total stated value.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Insurer" means any stock or mutual insurance corporation, including a reciprocal insurance exchange, authorized, admitted or eligible to transact the business of property and casualty insurance in this State pursuant to N.J.S.A. 17:17–1 et seq.

"Surplus" means the net worth of an insurer as reported in its annual statement. For a stock insurer, surplus means net worth less minimum capital. For a mutual insurer, surplus means its net worth.

11:2–38.3 Requests for temporary waiver of capital and surplus requirements

(a) An insurer transacting business in this State as of August 9, 1993 may request a two-year temporary waiver from the minimum capital and surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3, by making application in writing to the Commissioner on or before October 8, 1993. The waiver request shall be forwarded to:

New Jersey Department of Insurance
Financial Exams, Capital and Surplus Waivers
20 W. State Street
CN 325
Trenton, NJ 08625

(b) The Commissioner shall approve a temporary waiver requested pursuant to (a) above provided the insurer complies with the requirements set forth in (c) through (f).

(c) With the exception of (c)7 and (i) below, within 120 days of making application to the Commissioner for a temporary waiver of the statutory minimum capital and surplus requirements, the insurer shall additionally submit to the Department at the same address as set forth in (a) above, a proposed financial plan, which shall include the following:

1. The insurer's current capital and/or surplus as reflected in the last filed quarterly statement;

2. The reason(s) for the insurer's inability to meet the minimum capital and/or surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3;

3. The insurer's proposed method and time frame for meeting the statutory minimum capital and/or surplus requirements, including the source(s) and amount(s) of additional funding;

4. A five-year projection, beginning December 31 of the following year and for the subsequent four years, of the following certified by a qualified actuary and accompanied by a narrative explaining the sources of anticipated premium and all assumptions made in developing the entire projection:

i. Assets, liabilities and surplus and other funds in the format of the Assets page and the Liabilities and Surplus and Other Funds page in the Annual Statement representing the insurer's five successive year-ends;

ii. Underwriting and investment income in the format of the Underwriting and Investment Exhibit, Statement of Income in the Annual Statement for each of the five years;

iii. The following information by line of business for each of the five years (the line of business classifications shall be those set forth in the Underwriting and Investment Exhibit, Part Two in the Annual Statement):

(1) Premiums earned;

(2) Losses incurred;

(3) Loss expenses incurred; and

(4) Ratios of the sum of the losses and loss expenses to premium earned;

(5) Net premiums written; and

iv. The projected values required in the Underwriting and Investment Exhibit, Part Four—Expenses in the Annual Statement; and

5. Any other information requested by the Commissioner which is relevant to the evaluation of a specific temporary waiver request.

6. In the case of a request for an extension pursuant to (g) below of a two-year waiver granted under (b) above, the insurer's proposed financial plan shall additionally include a report of the insurer's progress in meeting the minimum capital and/or surplus requirements.

7. Certain insurers transacting business in this State as of August 9, 1993 may, instead of filing the financial plan pursuant to (c)1 through 6 above, file a limited financial plan with the Department as follows:

i. Insurers intending to meet the statutory minimum capital and surplus requirements by deleting unused lines of business from its certificate of authority shall file within 120 days of making application to the Commissioner for a temporary waiver of the requirements, a limited financial plan which shall include a concise, accurate description of the specific course of action the insurer will follow to comply with the statutory capital and surplus requirements. These insurers may request in writing from the Commissioner a waiver from filing an orderly plan of withdrawal pursuant to N.J.A.C. 11:2–29.

ii. Insurers intending to meet the statutory minimum capital and surplus requirements by completing certain corporate and/or accounting adjustments to either capital stock or surplus accounts, shall file within 120 days of making application to the Commissioner for a temporary waiver of the requirements, a limited financial plan which shall include a concise, accurate description of the specific course of action the insurer will follow to comply with the statutory capital and surplus requirements.

(d) Upon receipt of the insurer's financial plan in (c) above, the Department shall provide the insurer with written notice of its approval of, or of any deficiencies in, the financial plan's proposed method for meeting the minimum capital and/or surplus requirements.

(e) Within 60 days of receipt of the Department's notice in (d) above informing the insurer of the deficiencies in its proposed financial plan, the insurer shall resubmit a revised financial plan correcting all deficiencies to the Department at the address set forth in (a) above.

(f) All data or information contained in the plan under (c) above is confidential and will not be disclosed by the Department to any person other than its employees and representatives.

(g) An insurer may request an extension of a two-year waiver granted by the Commissioner under (b) above not to exceed the five-year statutory compliance period set forth in P.L. 1993, c.234, sections 2 and 3 by submitting to the Department at least 90 days prior to the expiration of the two-year waiver, the items set forth in (c) above. The Department shall evaluate the insurer's extension request by following the procedures set forth in (d) through (f) above.

(h) If an insurer fails to request a temporary waiver of the minimum capital and/or surplus requirements pursuant to the procedures set forth in this section, the Department shall conclude that the insurer has met the minimum capital and/or surplus requirements. If, in fact, the insurer is unable to meet the minimum statutory capital and/or surplus requirements, the insurer shall be subject to suspension or revocation of its authority to do business in this State pursuant to P.L. 1993, c.234, section 9.

(i) An insurer filing for a temporary waiver of the statutory capital and surplus requirements pursuant to (a) through (f) above, but which meets the requirements prior to expiration of the 120–day period for filing a financial plan with the Department, shall not be required to file a financial plan with the Department pursuant to N.J.A.C. 11:2–38.3(c). The insurer shall be required to file with the Department, within 120 days of applying for a waiver, a certification signed by the insurer's Chief Executive Officer, stating that the insurer has met the statutory capital and surplus requirements. The Commissioner may request that the insurer submit additional documentation to support the certification, if necessary.

Amended by R.1993 d.560, effective November 15, 1993.
See: 25 N.J.R. 4306(a), 25 N.J.R. 5204(a).

11:2–38.4 Procedures for increasing capital and surplus requirements

(a) If, upon consideration of the risks and factors set forth in P.L. 1993, c.234, sections 6 and 7, the Commissioner determines that an increase in an insurer's minimum capital and/or surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3 is required to provide adequate protection against risks affecting the insurer's financial condition that are not adequately or fully covered by its reserves or other assets, the Commissioner shall notify the insurer as follows:

1. The Commissioner shall issue an order to insurer, which shall include the following:

i. The minimum amount of capital and surplus required;

ii. The amount by which the insurer's capital or surplus is deficient; and

iii. Notice that the insurer shall either submit a plan to the Commissioner for meeting its applicable capital and surplus requirements pursuant to (b) below or request a hearing pursuant to N.J.A.C. 11:2–38.5.

(b) With the exception of requesting a hearing pursuant to N.J.A.C. 11:2–38.5, the insurer shall respond to the Commissioner's order issued under (a) above within seven days from the date of receipt of such order as follows:

1. The insurer's response to the Commissioner's order shall be in writing and shall include:

i. A waiver of the insurer's right to a departmental hearing on the Commissioner's determination; and

ii. Notice that the insurer shall submit a proposed plan to the Commissioner within 60 days from Commissioner's receipt of insurer's response in (b) above for meeting the applicable increased capital or surplus requirements.

2. The insurer's plan for meeting the applicable capital and surplus requirements shall be in writing and shall include:

i. The insurer's proposed method and time frames for meeting the increased minimum capital and/or surplus requirements, including the source(s) and amount(s) of additional funding; and

ii. A five-year projection, beginning December 31 of the following year and for the subsequent four years, certified by a qualified actuary as defined at N.J.A.C. 11:1–21 and accompanied by a narrative explaining the sources of anticipated premium and all assumptions made in developing the entire projection.

3. The insurer's five-year projection shall include:

i. Assets, liabilities and surplus and other funds in the format of the Assets page and the Liabilities and Surplus and Other Funds page in the Annual Statement representing the insurer's five successive year-ends;

ii. Underwriting and investment income in the format of the Underwriting and Investment Exhibit, Statement of Income in the Annual Statement for each of the five years;

iii. The following information by line of business for each of the five years (the line of business classifications shall be those set forth in the Underwriting and Investment Exhibit, Part Two in the Annual Statement):

(1) Premiums earned;

(2) Losses incurred;

(3) Loss expenses incurred;

(4) Ratios of the sum of the losses and loss expenses to premium earned; and

(5) Net premiums written; and

iv. The projected values required in the Underwriting and Investment Exhibit, Part Four—Expenses in the Annual Statement; and

4. Any other information requested by the Commissioner which is relevant to the evaluation of the insurer's plan to comply with increased capital and surplus requirements.

(c) The Department shall, upon receipt of the insurer's proposed plan in accordance with N.J.A.C. 11:2–38.4(b), provide the insurer with written notice of its approval of, or any deficiencies in, the proposed plan.

11:2–38.5 Hearing requirements and procedures

(a) If an insurer is subject to an order issued by the Commissioner pursuant to N.J.A.C. 11:2–38.4(a), and the insurer objects to the actions ordered to be taken as set forth therein, the insurer may request a hearing on the Commissioner's determination within seven days from the date of receipt of such order as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the insurer should not be required to increase its capital and surplus consistent with the Commissioner's order.

(b) Pursuant to P.L. 1993, c.234, section 6, a hearing relating to the increase of capital or surplus shall be a formal departmental hearing before the Commissioner or his designee, on a record, and all matters pertaining to a hearing or to an increase of capital or surplus shall be confidential and not subject to subpoena or public inspection, except as otherwise provided by N.J.S.A. 17:17–1 et seq.

(c) The Department shall initiate the departmental hearing within 20 days from the date of the insurer's receipt of the Commissioner's notice in N.J.A.C. 11:2–38.4(a) above.

(d) An Order issued by the Department pursuant to N.J.A.C. 11:2–38.4(a) above shall be stayed pending the outcome of the hearing.

(e) The Department shall issue a written hearing decision within 30 days of the hearing, which shall include the Department's findings and a determination whether the Order issued in N.J.A.C. 11:2–38.4(a) above shall be affirmed, modified or rescinded.

11:2–38.6 Fines and penalties

(a) Failure to comply with this subchapter may result in an insurer's suspension or revocation of authority to do business in the State of New Jersey.

SUBCHAPTER 39. INCREASE IN CAPITAL AND SURPLUS REQUIREMENTS FOR LIFE AND HEALTH INSURERS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B–32–31 et seq.; P.L. 1993, c.235 and c.245.

Source and Effective Date

R.1993 d.561, effective October 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

Subchapter Historical Note

Subchapter 39, Increase in Capital and Surplus Requirements for Life and Health Insurers, was adopted as emergency new rules R.1993 d.452, effective August 16, 1993 (to expire October 15, 1993). See: 25 N.J.R. 4309(a). The provisions of R.1993 d.452 were readopted as R.1993 d.561. See: Source and Effective Date.

11:2–39.1 Purpose and scope

The purpose of this subchapter is to provide a framework for the establishment of uniform risk-based capital and surplus requirements for all insurers authorized to write life, health and annuity business specified in N.J.S.A. 17B:17–3, 4 and 5, and to implement the provisions of P.L. 1993, c.235 (enacted August 9, 1993), which provide new minimum capital and surplus requirements and authorize the Commissioner to increase these requirements for individual insurers based upon the insurer's business risks.

11:2–39.2 Definitions

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

"Adjusted RBC Report" means an RBC Report which has been adjusted by the Commissioner in accordance with N.J.A.C. 11:2–39.3(d).

"Corrective order" means an order issued by the Commissioner in accordance with N.J.A.C. 11:2–39.5(b).

"NAIC" means the National Association of Insurance Commissioners.

"NAIC RBC Instructions" means the form of the Life Risk–Based Capital Report and instructions for completing such form adopted by the NAIC, as such form and instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"NAIC RBC Report" means the Life Risk–Based Capital Report prepared pursuant to the NAIC RBC Instructions.

"Negative trend" means a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the NAIC RBC Instructions.

"RBC" means Risk–Based Capital.

"RBC Instructions" means the NAIC RBC Instructions as supplemented by the Commissioner.

"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, with respect to any insurer, the product of 1.5 and its Authorized Control Level RBC;

3. "Authorized Control Level RBC" means, with respect to any insurer, the number determined under the risk-based capital formula in accordance with the RBC Instructions; and

4. "Mandatory Control Level RBC" means, with respect to any insurer, the product of .70 and its Authorized Control Level RBC.

"RBC Plan" means a comprehensive financial plan containing the elements specified at N.J.A.C. 11:2–39.4(b). 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."

"RBC Report" means the NAIC RBC Report as supplemented pursuant to the RBC Instructions.

"Required capital" is zero for any mutual insurer, and for any stock insurer means:

1. $1,000,000 for either or both kinds of business specified in N.J.S.A. 17B:17–3 and 5;

2. $700,000 for the kind of business specified in N.J.S.A. 17B:17–4; and

3. $1,530,000 for all three kinds of business specified in N.J.S.A. 17B:17–3, 4 and 5.

"Required surplus" means, for any insurer, such amount of statutory surplus as would cause the insurer's total adjusted capital to equal its Mandatory Control Level RBC, but in no event less than:

1. For either or both kinds of business specified in N.J.S.A. 17B:17–3 and 5, $4,000,000;

2. For the kind of business specified in N.J.S.A. 17B:17–4, $2,800,000 for a stock insurer or $3,000,000 for a mutual insurer; and

3. For all three kinds of business specified in N.J.S.A. 17B:17–3, 4 and 5, $6,120,000 for a stock insurer or $6,300,000 for a mutual insurer.

"Total adjusted capital" means an insurer's statutory capital and surplus increased or decreased by such other items, if any, as the RBC Instructions may provide.

Amended by R.1993 d.561, effective November 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

11:2–39.3 RBC reports

(a) Every domestic insurer authorized to write life insurance, health insurance or annuity business in this State shall, on or before each March 15 (the "filing date"), prepare and submit to the Commissioner an RBC Report as of the preceding December 31. The RBC Report shall be sent or delivered to:

New Jersey Department of Insurance
Financial Examinations, RBC Reports
20 West State Street
CN 325
Trenton, New Jersey 08625

(b) If at any time the Commissioner believes that the financial condition of an insurer authorized to write life insurance, health insurance or annuity business in this State may have materially changed, the Commissioner may request in writing an updated RBC Report from the insurer. In such event, the insurer shall, on or before the 45th day following such request (the "filing date"), prepare and submit to the Commissioner at the address in (a) above an RBC Report as of the last day of the calendar month coincident with or last preceding the date of the request.

(c) Every domestic insurer shall also file its NAIC RBC Report with the NAIC in accordance with the NAIC RBC Instructions. In addition, if the insurer has been notified in writing by the insurance department of any state in which the insurer is authorized to do business, the insurer shall file its NAIC RBC Report with such state by the filing date or, if later, within 15 days from receipt of notice to file.

(d) If an insurer files an RBC Report which 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.

(e) The calculation of an insurer's required surplus as set forth in an RBC Report filed and accepted by the Commissioner pursuant to (a) or (b) above, or as adjusted by the Commissioner pursuant to (d) above, shall be deemed to be a redetermination of the insurer's minimum statutory capital and surplus requirement pursuant to P.L. 1993, c.235, § 4.

1. If an insurer disagrees with the minimum capital and surplus as determined above, it may request a hearing as provided at N.J.A.C. 11:2–39.9.

2. An insurer requesting a hearing shall do so upon filing an RBC Report, or within 20 days of receipt of notice from the Commissioner of an adjustment.

3. Failure to request a hearing shall be deemed to be a waiver of the right to a hearing on the redetermined minimum capital and surplus requirement for the insurer.

11:2–39.4 Company action level event

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

1. The filing of an RBC Report by an insurer which indicates that:

i. The insurer's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC; or

ii. The insurer has total adjusted capital which 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 (a)1i or ii above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2–39.9; or

3. If the insurer, under N.J.A.C. 11:2–39.9, challenges an Adjusted RBC Report that indicates the event in (a)1i or ii above, 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, a domestic insurer shall within 45 days prepare and submit to the Commissioner an RBC Plan which shall:

1. Identify the conditions in the insurer which contribute to the company action level event;

2. Set forth corrective actions which the insurer intends to take that are reasonably 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 and/or surplus. (The projections of both new and renewal business shall 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; and

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) Within 60 days after the submission by a domestic insurer of an RBC Plan or a Revised RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether such Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines that the Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the Plan satisfactory, in the judgment of the Commissioner. The Commissioner may, at his or her discretion, subject to the insurer's right to a hearing under N.J.A.C. 11:2–39.9, specify in the notification that the notification constitutes a regulatory action level event. 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:

1. Within 45 days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under N.J.A.C. 11:2–39.9, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Every domestic insurer that flies 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:

1. Such state has a confidentiality provision substantially similar to N.J.A.C. 11:2–39.10(a); and

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:

i. Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

ii. The date on which the RBC Plan or Revised RBC Plan is filed under (b) or (c) above.

Amended by R.1993 d.561, effective November 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

11:2–39.5 Regulatory action level event

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

1. The filing of an RBC Report by an insurer which indicates that the sum of its capital and statutory surplus is at least 110 percent but less than 125 percent of the sum of its required capital and required surplus;

2. The filing of an RBC Report by an insurer which 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;

3. The notification by the Commissioner to an insurer of an Adjusted RBC Report that indicates the event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2–39.9;

4. If the insurer, under N.J.A.C. 11:2–39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 or 2 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

5. The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

6. The failure of the insurer to comply with the filing deadlines set forth at N.J.A.C. 11:2–39.4(b) and (c);

7. Notification by the Commissioner to the insurer that:

i. An RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

ii. Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under N.J.A.C. 11:2–39.9;

8. If the insurer, under N.J.A.C. 11:2–39.9, challenges a determination by the Commissioner pursuant to (a)7 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

9. 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 N.J.A.C. 11:2–39.9; or

10. If the insurer, under N.J.A.C. 11:2–39.9, challenges a determination by the Commissioner pursuant to (a)9 above, 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 for a domestic insurer, and may for a foreign insurer pursuant to N.J.A.C. 11:2–39.12:

1. Require the insurer to prepare and, within 45 days, 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; and

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.

(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 and 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 affiliated or controlling party as directed by the Commissioner.

Amended by R.1993 d.561, effective November 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

11:2–39.6 Authorized control level event

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

1. The filing of an RBC Report by an insurer which indicates that the sum of its capital and statutory surplus equals or exceeds by less than 10 percent the sum of its required capital and required surplus;

2. The filing of an RBC Report by an insurer which 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;

3. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2–39.9;

4. If the insurer, under N.J.A.C. 11:2–39.9, challenges an Adjusted RBC Report that indicates an event in (a)1 or 2 above, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

5. The failure of the insurer to comply with the filing deadline set forth at N.J.A.C. 11:2–39.5(b)1, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured such failure within 10 days after the deadline;

6. 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 N.J.A.C. 11:2–39.9; or

7. If the insurer has challenged a corrective order under N.J.A.C. 11:2–39.9 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:

1. Take such actions as are required under N.J.A.C. 11:2–39.5 regarding an insurer with respect to which a regulatory action level event has occurred; or

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 pursuant to N.J.S.A. 17B:32–31 et seq. In the event the Commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the Commissioner to take action under the said Act, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in the said Act.

11:2–39.7 Mandatory control level event

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

1. The filing of an RBC Report which indicates that the sum of the insurer's capital and statutory surplus is less than the sum of its required capital and required surplus;

2. The filing of an RBC Report which indicates that the insurer's total adjusted capital is less than its Mandatory Control Level RBC;

3. Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2–39.9; or

4. If the insurer, under N.J.A.C. 11:2–39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 or 2 above, 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 mandatory control level event as set forth in (a)2, 3 or 4 above, the Commissioner shall take actions necessary to cause a domestic insurer to be placed under regulatory control pursuant to N.J.S.A. 17B:32–31 et seq. In that event, the mandatory control level event shall be deemed sufficient grounds for the Commissioner to take action under the said Act, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in the said Act. In the event the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under provisions of the said Act. 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. In the event of a mandatory control level event as set forth in (a)1 above, the Commissioner may take such action as provided in this subsection.

11:2–39.8 Filings of RBC Plans

A filing of an RBC Plan pursuant to N.J.A.C. 11:2–39.4(b), 5(b) or 15(a)2 shall be accompanied by a nonrefundable filing fee of $500.00 and shall be sent or delivered to:

New Jersey Department of Insurance
Financial Examinations, Capital and Surplus Waivers
20 West State Street
CN 325
Trenton, New Jersey 08625

11:2–39.9 Hearings

(a) An insurer shall have the right to a departmental hearing, on a record, at which the insurer may challenge any determination or action by the Commissioner.

(b) The insurer shall notify the Commissioner of its request for a hearing within five days upon:

1. Notification to the insurer by the Commissioner of an Adjusted RBC Report; or

2. Notification to the insurer by the Commissioner that:

i. The insurer's RBC Plan or Revised RBC Plan is unsatisfactory; and

ii. Such notification constitutes a regulatory action level event with respect to such insurer; or

3. 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 or regulatory action level event with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

4. Notification to the insurer by the Commissioner of a corrective order with respect to the insurer; or

5. Increased requirements pursuant to P.L. 1993, c.235, § 4.

(c) 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 20 days after the date of the Commissioner's notice to the insurer granting the hearing.

(d) All matters pertaining to a hearing or to an increase of capital or surplus pursuant to these rules shall be confidential and not subject to subpoena or public inspection, except to the extent that the Commissioner finds release of information necessary to protect the public.

(e) Failure to request a hearing upon filing of an RBC Report or failure to request a hearing within 20 days of notice of an Adjusted RBC Report shall be deemed a waiver of an insurer's right to a hearing pursuant to P.L. 1993, c.235, § 4.

Amended by R.1993 d.561, effective November 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

11:2–39.10 Confidentiality and prohibition on announcements

(a) All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or reports of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the Commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which 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 and/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 subchapter or any other provision of the insurance laws of this State.

(b) The comparison of an insurer's total adjusted capital to any of its RBC Levels is a regulatory tool which 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 the provisions of this subchapter, 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 insurer's 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.

11:2–39.11 Supplemental provisions

The provisions of this subchapter 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 including, but not limited to, N.J.S.A. 17B:32–31 et seq. and N.J.A.C. 11:2–27.

11:2–39.12 Foreign insurers

(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 the filing date or within 15 days after the request is received by the foreign insurer.

(b) Any foreign insurer admitted to transact business in this State shall promptly submit to the Commissioner a copy of any RBC Plan or Revised RBC Plan that is filed with the insurance commissioner of any other state.

(c) In the event of a company action level event or regulatory action level event with respect to any foreign insurer, 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 a manner substantially similar to that specified under N.J.A.C. 11:2–39.4, 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 business in this State.

(d) In the event of an authorized control level event or 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 pursuant to N.J.S.A. 17B:32–31 et seq. with respect to the liquidation of property of foreign insurers found in this State, and the occurrence of the authorized control level event or mandatory control level event shall be considered adequate grounds for the application.

Amended by R.1993 d.561, effective November 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

11:2–39.13 Severability clause

If any provision of this subchapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this subchapter which can be given effect without the invalid provision or application, and to that end the provisions of this subchapter are severable.

11:2–39.14 Notices

All notices by the Commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail to the insurer's mailing address as provided pursuant to N.J.A.C. 11:1–25 or, in the case of any other transmission, shall be effective upon the insurer's receipt of such notice.

11:2–39.15 Phase–in provision

(a) An insurer subject to this subchapter may request a temporary waiver of the minimum capital and surplus requirements set forth in P.L. 1993, c.235 as follows:

1. The insurer must make application in writing to the Commissioner by October 15, 1993. The waiver request shall be forwarded to:

New Jersey Department of Insurance
Financial Examinations, Capital and Surplus Waivers
20 West State Street
CN 325
Trenton, New Jersey 08625

2. Filing the waiver request shall constitute a regulatory action level event. The insurer shall prepare and file an RBC Plan with the Commissioner at the same address as set forth above, but the time for filing the RBC Plan shall be extended to 120 days. After such review, examination and analysis as is deemed necessary, the Commissioner shall issue a corrective order which may include an appropriate limited waiver of the minimum capital and

surplus requirements. In no event shall the corrective order temporarily waive the applicable capital and surplus requirements for a period of more than five years.

3. If the insurer is responding to the corrective order in a manner satisfactory to the Commissioner, then the filing of an RBC Report shall not constitute an authorized control level event or a mandatory control level event.

4. Solely for the purpose of this subsection, an insurer's RBC Plan may be limited to a certification that its capital and surplus meet the minimum requirements set forth in P.L. 1993, c.235 as of December 31, 1993. Such certification shall be signed by the insurer's Chief Executive Officer and shall have the effect of terminating the regulatory action level event. The Commissioner may request that the insurer submit additional documentation to support the certification, if necessary.

(b) For RBC Reports required to be filed with respect to 1993, the following requirements shall apply in lieu of the provisions of N.J.A.C. 11:2–39.5, 39.6 and 39.7:

1. In the event of a regulatory action level event under N.J.A.C. 11:2–39.5(a)1, 2 or 3, the Commissioner shall take the actions required under N.J.A.C. 11:2–39.4.

2. In the event of a regulatory action level event under N.J.A.C. 11:2–39.5(a)4, 5, 6, 7 or 9 or an authorized control level event, the Commissioner shall take the actions required under N.J.A.C. 11:2–39.5 with respect to the insurer.

3. In the event of a mandatory control level event with respect to an insurer, the Commissioner shall take the actions required under N.J.A.C. 11:2–39.6 with respect to the insurer.

(c) Until August 16, 1996, all insurers shall be deemed to have applied for, and been granted, a waiver from the requirement of P.L. 1993, c.235 § 2 to maintain their minimum capital and surplus in cash and short term assets. This waiver shall not be construed to prevent the Commissioner from taking any other action authorized by law with regard to an insurer's financial condition including, but not limited to, action pursuant to N.J.S.A. 17B:32–31 et seq.; P.L. 1993, c.245; and N.J.A.C. 11:2–27.

Amended by R.1993 d.561, effective November 15, 1993.
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).

SUBCHAPTER 40. LIFE, HEALTH AND ANNUITY REINSURANCE AGREEMENTS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6, 17:23–1 et seq., 17:44A–24, 17:45–1 et seq., 17B–18–62 et seq., 17B–21–1 et seq. and P.L. 1993, c.243.

Source and Effective Date

R.1993 d.562, effective October 15, 1993.
See: 25 N.J.R. 4314(a), 25 N.J.R. 5212(a).

Subchapter Historical Note

Subchapter 40, Life, Health and Annuity Reinsurance Agreements, was adopted as emergency new rules R.1993 d.453, effective August 16, 1993 (to expire October 15, 1993). See: 25 N.J.R. 4314(a). The provisions of R.1993 d.453 were readopted as R.1993 d.562. See: Source and Effective Date.

11:2–40.1 Purpose and scope

(a) The purpose of this subchapter is to provide standards for reinsurance agreements pursuant to which a ceding insurer may reduce a liability or establish an asset on any financial statements filed with the Department.

(b) This subchapter shall apply to the following:

1. All domestic insurers authorized to transact life insurance, accident and health insurance or annuity business in this State;

2. All foreign and alien insurers authorized to transact life insurance, accident and health insurance or annuity business in this State which otherwise are not subject to rules in their state of domicile that are substantially similar to those contained herein;

3. All reinsurers authorized to effect life, accident and health or annuity reinsurance agreements in this State; and

4. All reinsurance agreements entered into by an entity subject to this subchapter, except as N.J.A.C. 11:2–40.5 may apply.

(c) This subchapter shall not apply with respect to assumption reinsurance agreements. N.J.A.C. 11:2–40.4(a)1, 4, 6 and 7 shall not apply to catastrophe, stop-loss or other nonproportional reinsurance. N.J.A.C. 11:2–40.4(a)4, 6 and 7 shall not apply to term reinsurance.

Amended by R.1993 d.562, effective November 15, 1993.
See: 25 N.J.R. 4314(a), 25 N.J.R. 5212(a).

11:2–40.2 Definitions

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

"Actuary" means a Member of the American Academy of Actuaries or a Fellow of the Society of Actuaries or a Fellow of the Casualty Actuarial Society who is qualified by training and experience, pursuant to the standards promulgated by the Actuarial Standards Board, to provide the opinions required in this subchapter.

"Assumption reinsurance" means reinsurance whereby the reinsurer assumes from the ceding insurer all risks, obligations, duties and rights arising under a policy; following assumption, a policy is treated by all persons as if the reinsurer were the insurer which had issued the policy.

"Authorized" means that an insurer has a certificate of authority issued by the Commissioner to act as an insurer in this State pursuant to Title 17 or 17B of the New Jersey Statutes.

"Catastrophe reinsurance" means reinsurance of the risk that the aggregate number or dollar amount of claims incurred under a set of policies as a result of a single event or occurrence, such as an accident or a storm, will exceed a defined threshold number or amount.

"Ceding insurer" means an insurer which procures indemnification for itself from another insurer with respect to all or part of an insurance risk associated with one or more policies issued by the former insurer, should losses be sustained.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Domestic" means an entity formed under the laws of this State.

"Insurer" means any person or entity transacting the business of life, accident or health insurance, or annuities.

"LTC" means long-term care insurance.

"Policy" means any life insurance, health insurance or annuity policy or contract, as defined pursuant to N.J.S.A. 17B:17–3, 4 and 5, which is not reinsurance.

"Reinsurance" means a contractual arrangement whereby an insurer, for some consideration, agrees to indemnify a ceding insurer for all or part of a loss which the ceding insurer may incur under one or more policies that the ceding insurer has or will issue. This term is intended to include facultative reinsurance, automatic reinsurance agreements, reinsurance agreements of pools and associations, and such other similar reinsurance arrangements by whatever name or device.

"Reinsurance credit" means the amount of a liability reduction or the asset established as permitted by this subchapter.

"Reinsurer" means an insurer which agrees to provide reinsurance.

"Renewable term reinsurance" means term reinsurance which is renewable, automatically or at the option of the ceding insurer, for successive terms at rates not exceeding those guaranteed in the reinsurance agreement.

"Significant risk" means an element of risk associated with a policy such that the actual experience of an insurer related to such element will have a direct and material effect on the profit or loss realized by the insurer as a consequence of having issued or assumed such policy.

"Stop-loss reinsurance" means reinsurance of the risk that the aggregate number or dollar amount of claims incurred under a set of policies during a specified period will exceed a defined threshold number or amount.

"Term reinsurance" means reinsurance of the risk that a mortality or morbidity claim on an insured life will be incurred during a specified term, such as one year.

11:2–40.3 Reinsurance agreements

(a) No ceding insurer subject to this subchapter shall enter into any new reinsurance agreement, nor amend any existing reinsurance agreement so as to increase its reinsurance credit, which shall reduce any liability or establish any asset in any financial statement filed with the Department except pursuant to the following requirements:

1. The reinsurance agreement or amendment shall be filed with the Commissioner no later than 30 days after its execution. In addition, no domestic insurer shall enter into any reinsurance agreement for which the Commissioner has been granted statutory prior approval authority involving a substantial transfer of risk without the prior approval of the Commissioner. For purposes of this subsection, a transfer of risk associated with a reinsurance agreement is considered to be substantial if a material number or percentage of policies are affected by the agreement, or if there is a material change in the reserve liabilities on the policies affected by the agreement. Such agreements shall be submitted to:

Valuation and Statement Bureau
Life and Health Actuarial Services
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625–0325

2. This filing shall include a written opinion of an actuary representing the reinsurer which describes the ceding insurer's significant risks under the policies reinsured and specifies the extent (if any) to which these significant risks are transferred to the reinsurer.

3. Each reinsurance agreement filed with the Department shall be accompanied by documentation detailing the financial impact of the agreement. This documentation shall include information as to reserves transferred under the agreement and details as to payment and expense charges to and from each party to the agreement.

(b) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the last day of the period covered by the financial statement, filed with the Commissioner pursuant to (a) above and meets the following standards:

1. In the case of a letter of intent, the letter of intent shall stipulate that the reinsurance agreement is subject to approval by the Commissioner where the Commissioner has been granted statutory prior approval authority, and that no reserve credits shall be taken by the insurer until the Commissioner has approved the agreement.

2. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, and before the filing of the first financial statement in which a credit is to be taken, in order for credit to be granted for the reinsurance ceded.

3. The reinsurance agreement or amendment shall stipulate that coverage thereunder shall terminate if it is not approved by the Commissioner where the Commissioner has been granted statutory prior approval authority and that, in any financial statement filed before the Commissioner has approved it, the ceding insurer shall take no reinsurance credit therefor, other than for any net cash refund available in the event that the agreement is not approved.

4. The reinsurance agreement shall stipulate that the written agreement, including any written amendments thereto, as filed with the Commissioner constitutes the entire agreement between the parties with respect to the risks being reinsured thereunder. The reinsurance agreement shall further stipulate that to the extent the original agreement required prior approval by the Commissioner, any change or modification of its terms shall be null and void unless made by written amendment signed by both parties and filed with the Commissioner for approval along with any necessary revisions to the actuarial opinion required by (a)2 above. There shall be no additional terms or conditions, either written or oral, and the parties to the reinsurance agreement shall not enter into any understandings or supplemental agreements with respect to the reinsurance, other than those set forth in the written agreement filed with the Commissioner.

5. The reinsurer shall not require, and the ceding insurer shall not make, any representations or warranties about the future experience under the policies being reinsured, nor any other representations or warranties which are not reasonably related to the policies being reinsured.

Amended by R.1993 d.562, effective November 15, 1993.
See: 25 N.J.R. 4314(a), 25 N.J.R. 5212(a).

11:2–40.4 Agreements or conditions precluding reduction of liability or inclusion as an asset

(a) Except as N.J.A.C. 11:2–40.5 applies, no insurer shall reduce any liability or establish any asset in any financial statement filed with the Department for any reinsurance ceded if by the terms of the reinsurance agreement, any of the following conditions exist, in substance or effect:

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

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

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

4. The ceding insurer is required, at specific points in time scheduled in the agreement, to terminate or automatically recapture all or part of the reinsurance ceded;

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

6. The treaty does not transfer all of the significant risk inherent in the business being reinsured. Exhibit 1 entitled "Significant Risks" appearing in the Appendix to this subchapter identifies the risks considered to be significant for the various products or types of business set forth in the table. For products not specifically included, the risks determined to be significant shall be consistent with this table;

7. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in (a)8 below) either transfer the underlying assets to the reinsurer, maintain such assets in a separate trust or escrow account, or otherwise establish a mechanism by contractual arrangement satisfactory to the Commissioner whereby the underlying assets are legally segregated;

8. Notwithstanding the requirements of (a)7 above, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of such assets: Health Insurance—LTC/LTD; Traditional Non–Par Permanent; Traditional Par Permanent; Adjustable Premium Permanent; Indeterminate Premium Permanent; and Universal Life Fixed Premium (no dump-in premiums allowed). The formula for determining the reserve interest rate adjustment should reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reflected in the financial statement. The formula set forth as Exhibit 2 in the Appendix to this subchapter is an example of an acceptable formula;

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

10. The ceding insurer is required to make representations or warranties which are not reasonably related to the business being reinsured;

11. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured;

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

(b) Notwithstanding (a) above, in financial statements filed with the Department a ceding insurer subject to this subchapter may, with the prior approval of the Commissioner, take such reinsurance credit as the Commissioner may deem consistent with the fair presentation of the insurer's financial condition under statutory accounting principles (as permitted or prescribed by Title 17B of the New Jersey revised statutes and rules and regulations promulgated thereunder), including actuarial interpretations and standards adopted by the Department.

11:2–40.5 Exceptions to agreements or conditions precluding reduction of liability or inclusion as an asset

(a) Agreements entered into on or after August 16, 1993 which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days from their date of execution.

(b) Any increase in surplus net of Federal income tax resulting from arrangements described in (a) above shall be identified separately on the insurer's financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance Ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

(c) Insurers subject to this subchapter shall reduce to zero by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to August 16, 1993 which, under the provisions of this subchapter would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding August 16, 1993.

11:2–40.6 Additional standards

(a) The ceding insurer's actuary signing the financial statement actuarial opinion with respect to the valuation of reserves shall consider this subchapter and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Department. The actuary shall maintain adequate documentation and be prepared upon request by the Department to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this subchapter.

(b) Compliance with N.J.A.C. 11:2–40.4 shall not abrogate the requirement that reserve credits shall be based upon actual liability assumed by a reinsurer to reimburse a ceding insurer for benefits that the ceding insurer is obligated to pay under its direct policies and that gave rise to a required statutory reserve amount. An agreement meeting the technical requirements of N.J.A.C. 11:2–40.4, but failing to comply with the objective of this rule, shall not provide a basis for the taking of reserve credits by a ceding insurer.

(c) The ceding insurer shall maintain data used to determine reinsurance credits at its place of business for review by the Department upon request. Such data and documentation shall demonstrate compliance by the ceding insurer with this subchapter, and shall include, but not be limited to:

1. A comparison of the renewal expense allowances with the ceding insurer's anticipated expenses; and

2. A comparison of the guaranteed reserve adjustment interest rates to the maximum allowable statutory valuation rates in accordance with N.J.S.A. 17B:19–8.

Amended by R.1993 d.562, effective November 15, 1993.
See: 25 N.J.R. 4314(a), 25 N.J.R. 5212(a).

11:2–40.7 Penalties

Failure to comply with the terms of this subchapter may result in the denial of any credit taken for the reinsurance agreement, as well as the assessment of any and all penalties available pursuant to law. These penalties may be assessed against any and all parties to a reinsurance agreement that fails to comply with the terms of this subchapter.

11:2–40.8 Severability

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

APPENDIX

EXHIBIT 1

Products/Types of Business	Risk Categories** a	b	c	d	e	f
Health Insurance—other than LTC/LTD*	+	O	+	O	O	O
Health Insurance—LTC/LTD*	+	O	+	+	+	O
Immediate Annuities	O	+	O	+	+	O
Single Premium Deferred Annuities	O	O	+	+	+	+
Flexible Premium Deferred Annuities	O	O	+	+	+	+
Guaranteed Interest Contracts	O	O	O	+	+	+
Other Annuity Deposit Business	O	O	+	+	+	+
Single Premium Whole Life	O	+	+	+	+	+
Traditional Non-Par Permanent	O	+	+	+	+	+
Traditional Non-Par Term	O	+	+	O	O	O
Traditional Par Permanent	O	+	+	+	+	+
Traditional Par Term	O	+	+	O	O	O
Adjustable Premium Permanent	O	+	+	+	+	+
Indeterminate Premium Permanent	O	+	+	+	+	+
Universal Life Flexible Premium	O	+	+	+	+	+
Universal Life Fixed Premium	O	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	O	+	+	+	+	+

+ = Significant/O = Insignificant
*LTC = Long Term Care Insurance
LTD = Long Term Disability Insurance
**Risk categories
a. Morbidity
b. Mortality
c. Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.
d. Credit Quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.
e. Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.
f. Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

EXHIBIT 2

Formula for Determining Reserve Interest Rate Adjustment

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

Where: I is the net investment income

CG is capital gains less capital losses

X is the current year cash and invested assets plus investment income due and accrued less borrowed money

Y is the same as X but for the prior year

All data is as reported in the Annual Statement.

Amended by R.1993 d.562, effective November 15, 1993. See: 25 N.J.R. 4314(a), 25 N.J.R. 5212(a).

SUBCHAPTER 41. WINDSTORM MARKET ASSISTANCE PROGRAM

Authority

N.J.S.A. 17:1C-6(e), 17:22-6.14a1, 17:29A-14, and 17:29D-1.

Source and Effective Date

R.1995 d.53, effective January 17, 1995.
See: 26 N.J.R. 4304(a), 27 N.J.R. 364(a).

11:2–41.1 Purpose and scope

(a) The purpose of this subchapter is to establish a program to ensure that eligible property owners in the coastal areas of the State are able to obtain homeowners' insurance through voluntary market outlets by:

1. Creating an Informal Referral Program ("IRP") by which information is provided to consumers and producers about insurers which are actively writing homeowners' insurance in the coastal areas of the State; and

2. Establishing the framework for a Formal Assistance Program ("FAP") among voluntary market insurers for qualified applicants unable to secure homeowners' coverage through normal market channels or the informal referral program and for the equitable distribution of such risks to insurers that choose to accept risks.

(b) The provisions of this subchapter shall apply to all property and casualty insurers admitted to write homeowners' insurance in this State.

11:2–41.2 Definitions

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

"Coastal area" shall be those areas of the State identified by postal zip code as set forth in Appendix A to this subchapter which is incorporated herein by this reference.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Homeowners' insurance" means the type of personal lines insurance provided against loss to real and personal property as defined in the standard fire policy and extended coverage endorsement thereon, a dwelling policy, the homeowner's multiple peril policy, insurance against the perils of vandalism, malicious mischief, burglary, or theft, or liability insurance, or any combination thereof, delivered or issued for delivery in this State. These policies include, but are not limited to, coverages written under six basic forms as follows:

1. Form 1—Basic, which covers: The dwelling, other structures, and personal property against fire, lightning, the extended coverage perils, vandalism, malicious mischief, theft, and glass breakage. Loss of use and additional coverages listed below are also included in this and each of the homeowners forms.

2. Form 2—Broad, which covers: The perils listed in Form 1 above plus falling objects; weight of ice, snow or sleet; accidental discharge from a plumbing, heating, air conditioning or sprinkler system or household appliance; tearing, cracking, burning, or bulging of a steam or hot water heating system; freezing of a plumbing, heating, air conditioning or sprinkler system or a household appliance; damage from artificially generated electricity; and volcanic eruption.

3. Form 3—Special, which covers: The dwelling and other structures on an open perils basis. Coverage on personal property applies with respect to the broad named perils insured under Form 2 above, plus the peril of damage by glass or safety glazing material which is part of a building, storm door or storm window.

4. Form 4—Tenants and Renters, which primarily covers: Tenants of a rented premises and provides only personal property coverage (no coverage on dwellings or on other structures) plus a limited amount of coverage on building additions and alterations made by the insured.

5. Form 6—Condominium: This form is designed especially for residential condominium unit owners.

6. Form 8—Modified coverage: This form is designed for homes not considered eligible for replacement cost coverage.

"Insurer" means any person or persons, corporation, association, partnership, company, or other legal entity admitted to transact the business of homeowners' insurance in this State except any residual market mechanism created by or pursuant to statute.

"Qualified applicant" means an applicant for homeowners' insurance whose property is located in the defined coastal area and who has applied for insurance to at least three admitted voluntary market insurers and has been denied coverage.

"Windstorm Market Assistance Program" or "Windstorm MAP" means the program created at N.J.A.C. 11:2–41.3.

11:2–41.3 Creation of the Windstorm MAP

(a) There is hereby created in the State of New Jersey a plan for the administration and apportionment of homeowners' insurance for qualified applicants to be known as the New Jersey Windstorm Market Assistance Program.

(b) The Windstorm MAP shall be administered by a governing committee appointed pursuant to this subchapter and a plan of operation approved by the Commissioner.

(c) The administrative offices of the Windstorm MAP shall be located within the State of New Jersey.

(d) All insurers admitted to transact and transacting the business of homeowners' insurance shall be members of the Windstorm MAP.

(e) The Independent Insurance Agents of New Jersey, Professional Insurance Agents of New Jersey and Insurance Brokers Association of New Jersey shall also be participants of the Windstorm MAP.

11:2–41.4 Governing committee

(a) The Windstorm MAP shall be administered by a governing committee of nine voting members.

1. Five members shall be salaried employees of insurers which are members of the Windstorm MAP. No more than one member shall be employed by the same insurer.

2. Three members shall be licensed producers.

3. One member shall be a public representative appointed by the Commissioner who is knowledgeable about homeowners' insurance matters but who is not employed by, or otherwise affiliated with, insurers, insurance producers, or other entities of the insurance industry.

4. The Commissioner, or his or her designated representative, shall be an ex-officio, non-voting member of the governing committee.

(b) The following insurer trade organizations shall each nominate two members to represent insurers:

1. Alliance of American Insurers;

2. American Insurance Association;

3. National Association of Independent Insurers; and

4. New Jersey Association of Mutual Insurance Companies.

(c) The Commissioner shall appoint one member from insurers which are not members of the organizations identified in (b) above. After a Plan of Operation is adopted, such insurers shall nominate two members in accordance with a fair method set forth in the plan of operation.

(d) The following organizations shall each nominate two members:

1. Independent Insurance Agents of New Jersey;

2. Insurance Brokers' Association of New Jersey; and

3. Professional Insurance Agents of New Jersey.

(e) With regard to the nomination of members set forth in (b), (c) and (d) above, in the event the Commissioner fails to appoint either of the nominees, the organization shall nominate another representative.

(f) The initial governing committee appointed pursuant to this subchapter shall serve for staggered terms of one or two years or until successors are appointed. Thereafter, all members of the governing committee shall serve for one year or until a successor is appointed. Each member may designate an alternate.

(g) All meetings of the governing committee shall be conducted in accordance with this subchapter and the plan of operation.

(h) The governing committee shall have the power and duty to:

1. Develop and submit to the Commissioner for approval a plan of operation;

2. Investigate complaints and hear appeals from members or participants about any matter pertaining to the proper administration of the Windstorm MAP;

3. Provide for the establishment of subcommittees, to which may be delegated specific tasks and the authority to act on behalf of the governing committee; and

4. Perform such other functions as may be necessary and proper in accordance with this subchapter and the approved plan of operation.

11:2–41.5 Plan of operation

(a) The plan of operation shall provide for the prompt and efficient administration of the IRP established by the Department, and for the provision of homeowners' insurance to qualified applicants under the FAP. The plan of operation shall provide for the following:

1. The internal organization and proceedings of the governing committee;

2. The coverages to be offered through the Windstorm MAP to qualified applicants;

3. Procedures to distribute on an equitable basis risks qualified for coverage based on the voluntary commitment of insurers to accept risks;

4. Procedures by which insurers may voluntarily agree to participate and to provide coverage through the Windstorm MAP;

5. Procedures to apply for coverage, including disqualifying characteristics;

6. Procedures for handling complaints and appeals to the governing committee;

7. Procedures for the operation of the informal referral program;

8. Procedures for the payment of commissions, where practicable, to licensed insurance producers that recognize the importance of maintaining producer/consumer relationships; and

9. Such other provisions as are deemed necessary by the governing committee for the operation of the Windstorm MAP.

(b) The governing committee shall, within 30 days of the adoption of these rules, submit to the Commissioner, for his or her review and approval, a proposed plan of operation. After approval of the plan, the governing committee may thereafter propose an amendment to the plan of operation at any time for review and approval by the Commissioner. If approved, the Commissioner shall certify approval to the governing committee.

1. If the Commissioner disapproves all or any part of the plan of operation or any amendment, he or she shall return same to the governing committee with a statement that sets forth the reasons for his or her disapproval and may include other recommendations he or she may wish to make.

2. If the governing committee does not submit a plan of operation by February 16, 1995, or a new plan which is acceptable to the Commissioner within 30 days after the disapproval of a proposed plan, the Commissioner may promulgate a plan of operation and certify same to the governing committee, until such time as the governing committee submits its own plan of operation which is acceptable to the Commissioner.

3. The Commissioner may review the plan of operation at any time and may suggest amendments to the governing committee.

11:2–41.6 Informal Referral Program ("IRP")

(a) The IRP shall provide for the distribution to the public of information about insurers offering coverage to qualified applicants that meet current underwriting guidelines.

(b) The governing committee shall provide in the plan of operation for administration of the IRP, which shall include provision for maintaining necessary records in order to confirm the applicant's qualification for the FAP pursuant to N.J.A.C. 11:2–41.7(a)2.

(c) The Windstorm MAP may revise the IRP as necessary to provide maximum assistance to property owners seeking homeowners' insurance in the coastal area; however, only the Department may gather underwriting information from homeowner insurers the Department determines is needed for use in the IRP.

11:2–41.7 Formal Assistance Program ("FAP") application process

(a) Any person applying for homeowners' insurance through the FAP shall demonstrate that he or she is a qualified applicant.

(b) The FAP shall arrange for coverage to qualified applicants to the extent that the Windstorm MAP has capacity to provide such coverage based upon the participation of insurers.

(c) The governing committee shall establish procedures in the plan of operation with respect to documentation to be provided by the applicant or the producer showing (where applicable) the reasons for termination of previous insurance coverage, including, but not limited to:

1. Previous insurance company name and policy number;

2. Reasons for termination and effective date of termination; and

3. Claim history for the preceding three years.

(d) Those insurers that have agreed to consider risks through the FAP shall provide homeowners' insurance coverage to qualified applicants in accordance with each insurers' voluntary commitment to participate and to provide coverage.

11:2–41.8 Right to petition for appeal to the Commissioner

(a) A member or participant may petition for appeal to the Commissioner from an adverse decision of the governing committee by filing a request in writing within 20 days of the date of receipt of the written decision of the governing committee.

1. The written request to appeal shall set forth the facts upon which it is based and include a copy of the written decision of the governing committee.

2. The Commissioner shall notify the petitioner and the governing committee within 30 days whether the request to appeal shall be granted.

3. Notice from the Commissioner that an appeal has been granted shall also provide a statement about whether the action of the governing committee has been stayed pending the disposition of the appeal.

(b) An appeal to the Commissioner granted pursuant to this rule shall be conducted on the record before the governing committee in accordance with applicable provisions of the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:2–41.9 Reports

Member insurers shall, no less frequently than quarterly, submit reports relative to the amount of homeowners' insurance in force and new business written in a format which shall be prescribed by Order of the Commissioner.

11:2–41.10 Windstorm deductibles

Member insurers that demonstrate pursuant to the provisions of this subchapter proportionate Statewide and coastal area market shares, may file for approval, pursuant to N.J.S.A. 17:29A–1 et seq., amendments to their filed rating systems in order to offer optional and/or mandatory windstorm deductibles. In determining whether to approve such filings, the Commissioner shall consider the insurer's demonstrated participation in the homeowners' insurance market and whether approval of the filing will contribute to improve availability and affordability of homeowners' insurance in the coastal areas.

APPENDIX A

COASTAL REGION ZIP CODES

07002	07715	07753	08202	08405	08750
07008	07716	07755	08203	08406	08751
07036	07717	07756	08204	08411	08752
07064	07718	07757	08212	08721	08753
07077	07719	07758	08223	08723	08754
07201	07720	07760	08226	08724	08755
07202	07721	07762	08230	08730	08756
07206	07723	07764	08243	08731	08757
07302	07730	08005	08247	08732	08758
07304	07732	08006	08248	08734	08832
07305	07734	08008	08260	08735	08861
07306	07735	08050	08400	08736	08862
07709	07737	08087	08401	08738	08878
07711	07740	08092	08402	08739	08879
07712	07748		08403	08740	
07713	07750		08404	08742	