

**CHAPTER 2  
INSURANCE GROUP**

**Authority**

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

**Source and Effective Date**

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

**Executive Order No. 66(1978) Expiration Date**

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

**Chapter Historical Note**

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

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

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

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

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

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

1985 Revisions: Subchapter 10, Casualty Insurers, Personal Lines Insurance, was repealed by R.1985 d.71, effective February 19, 1985.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

1989 Revisions: Subchapter 1, Educational Requirements for Licensing, and Subchapter 19 were repealed by R.1989 d.192, effective April 3, 1989.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

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

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

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

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

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

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

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

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#### APPENDIX A

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

##### 11:2-1.1 Purpose

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

##### 11:2-1.2 Scope

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

##### 11:2-1.3 Definitions

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

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

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

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

"IRIS" means the NAIC Insurance Regulatory Information System.

"NAIC" means National Association of Insurance Commissioners.

##### 11:2-1.4 General eligibility requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The applicant shall satisfy the following seasoning requirements:

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

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

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

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

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

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

(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. The written notifications required under this subsection shall not continue to apply to that aspect of a claim for which the claimant has become represented by an attorney, as evidenced by a letter of representation.

(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).

Amended by R.1996 d.497, effective October 21, 1996.

See: 28 N.J.R. 3703(a), 28 N.J.R. 4585(a).

Public Notice: Petition for Rulemaking.

See: 28 N.J.R. 5509(a).

Public Notice: Action on Petition for Rulemaking.

See: 29 N.J.R. 264(c).

### 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.

**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 a NAIC accredited state having in effect a law substantially similar to N.J.S.A. 17:22D-1 et seq., 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.

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

**11:2-37.5 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 N.J.S.A. 17:22D-1 et seq. 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 N.J.S.A. 17:22D-1 et seq. and these rules.

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

**11:2-37.6 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 N.J.S.A. 17:22D-1 et seq., 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 N.J.S.A. 17:22D-1 et seq. 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 N.J.S.A. 17:22D-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 noncontrolling producers for placement of the same kinds of insurance:
Net premiums written: \$ \_\_\_\_\_
Commissions paid: \$ \_\_\_\_\_
Percentage: \_\_\_\_\_%
8. Attach the information required by N.J.S.A. 17:22D-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 N.J.S.A. 17:22D-1 et seq. 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

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

SUBCHAPTER 38. INCREASE IN PROPERTY AND CASUALTY CAPITAL AND SURPLUS REQUIREMENTS

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 N.J.S.A. 17:17-6 and 17:17-7. This subchapter also provides procedures whereby the Commissioner may, pursuant to N.J.S.A. 17:17-16, 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.

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

### 11:2-38.2 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 N.J.S.A. 17:17-6 and 17:17-7, 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 West 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 N.J.S.A. 17:17-6 and 17:17-7;

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 N.J.S.A. 17:17-6 and 17:17-7 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 N.J.S.A. 17:17-19.

(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).

Amended by R.1996 d.3, effective January 2, 1996.

See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

#### 11:2-38.4 Procedures for increasing capital and surplus requirements

(a) If, upon consideration of the risks and factors set forth in N.J.S.A. 17:17-16 and 17:17-17, the Commissioner determines that an increase in an insurer's minimum capital and/or surplus requirements set forth at N.J.S.A. 17:17-6 and 17:17-7 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.

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

#### **11:2-38.5 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 N.J.S.A. 17:17-16, 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.

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

#### **11:2-38.6 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**

#### **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 N.J.S.A. 17B:18-67 et seq. (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.

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

### 11:2-39.2 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.

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

### 11:2-39.3 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 N.J.S.A. 17B:18-70.

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.

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

#### 11:2-39.4 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 files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

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 insurer's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

2. The notification by the Commissioner to an insurer of an Adjusted RBC Report that indicates the event in (a)1 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9;

3. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

4. The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

5. 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);

6. 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;

7. If the insurer, under N.J.A.C. 11:2-39.9, challenges a determination by the Commissioner pursuant to (a)6 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

8. Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event in accordance with its RBC Plan or Revised RBC Plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under N.J.A.C. 11:2-39.9; or

9. If the insurer, under N.J.A.C. 11:2-39.9, challenges a determination by the Commissioner pursuant to (a)8 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).

Amended by R.1996 d.3, effective January 2, 1996.

See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

#### 11:2-39.6 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 insurer's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but not less than its Authorized Control Level RBC;

2. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in (a)1 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9;

3. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates an event in (a)1 above, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

4. The failure of the insurer to 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;

5. 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

6. 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.

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

#### 11:2-39.7 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 insurer's total adjusted capital is less than its Mandatory Control Level RBC;

2. Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in (a)1 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)1 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) 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 under the 90-day period.

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

#### 11:2-39.8 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 N.J.S.A. 17B:18-70.

(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 N.J.S.A. 17B:18-70.

Amended by R.1993 d.561, effective November 15, 1993.  
See: 25 N.J.R. 4309(a), 25 N.J.R. 5208(a).  
Amended by R.1996 d.3, effective January 2, 1996.  
See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

#### **11:2-39.10 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 N.J.S.A. 17B:18-67 et seq. 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 N.J.S.A. 17B:18-67 et seq. 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 N.J.S.A. 17B:18-68 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.; N.J.S.A. 17:51A-1 et seq.; 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).  
Amended by R.1996 d.3, effective January 2, 1996.  
See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

## SUBCHAPTER 40. LIFE, HEALTH AND ANNUITY REINSURANCE AGREEMENTS

### 11:2-40.1 Purpose and scope

(a) The purpose of this subchapter is to provide standards for reinsurance agreements pursuant to which a ced-

ing 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 or group term reinsurance. 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 other 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).

Amended by R.1996 d.3, effective January 2, 1996.

See: 27 N.J.R. 3278(b), 28 N.J.R. 152(b).

In (c) added group term reinsurance and inserted "other" preceding "term insurance".

### 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.