

**CHAPTER 25****OFFICE OF THE INSURANCE  
CLAIMS OMBUDSMAN****Authority**

N.J.S.A. 17:1-8.1, 17:1-15e and 17:29E-1 et seq.

**Source and Effective Date**

R.2001 d.376, effective October 15, 2001.  
See: 33 N.J.R. 982(a), 33 N.J.R. 3680(a).

**Chapter Expiration Date**

Chapter 25, Office of the Insurance Claims Ombudsman, expires on October 15, 2006.

**Chapter Historical Note**

Chapter 25, Office of the Insurance Claims Ombudsman, was adopted as R.2001 d.376, effective October 15, 2001. See: Source and Effective Date.

**CHAPTER TABLE OF CONTENTS****SUBCHAPTER 1. GENERAL POWERS AND DUTIES**

- 11:25-1.1 Purpose and scope
- 11:25-1.2 Definitions
- 11:25-1.3 General provisions; disputed claims
- 11:25-1.4 Consultants and experts
- 11:25-1.5 Trade and marketing practices; investigations, hearings and complaints
- 11:25-1.6 Registry of closed claims and confidentiality of information
- 11:25-1.7 Publication of information

**SUBCHAPTER 2. INTERNAL APPEALS PROCEDURE**

- 11:25-2.1 Purpose and scope
- 11:25-2.2 Definitions
- 11:25-2.3 Complaint and internal appeals system—general requirements
- 11:25-2.4 Composition of internal appeals panel
- 11:25-2.5 Notice to insureds and maintenance of data
- 11:25-2.6 Reporting
- 11:25-2.7 Penalties

**APPENDIX****SUBCHAPTER 1. GENERAL POWERS AND  
DUTIES****11:25-1.1 Purpose and scope**

(a) The purpose of this subchapter is to establish procedures for the Insurance Claims Ombudsman to exercise his or her statutory authority to:

1. Investigate consumer complaints involving policies of insurance, including the payment of claims;

2. Monitor the implementation of N.J.S.A. 17:23A-1 et seq. (policyholder's personal information disclosure practices of regulated insurers);

3. Monitor the implementation of N.J.S.A. 17:29B-1 et seq. and 17B:30-1 et seq. (consumer complaints regarding unfair methods of competition; unfair, deceptive and discriminatory acts or practices by insurers);

4. Monitor the implementation of N.J.S.A. 17:35C-1 et seq. (Medicare supplement health insurance policies; regulation of contract provisions and required disclosure to consumers);

5. Investigate alleged violations of N.J.S.A. 17:35C-11 (use of false, misleading, or fraudulent statements and advertising to sell Medicare supplement insurance to consumers);

6. Respond to consumer inquiries, including, but not limited to, those regarding policy terms and availability of coverage;

7. Ensure that accurate and understandable buyers' guides and rate comparisons are published and disseminated to consumers where required by law, except those with respect to health insurance coverages provided pursuant to N.J.S.A. 17B:27A-2 et seq. and 17B:27A-17 et seq.;

8. Review the conduct of arbitrators appointed in accordance with the terms of a policy of insurance to arbitrate disputes, except those arbitration proceedings arising out of policies issued pursuant to N.J.S.A. 39:6A-1 et seq. or already subject to the provisions of N.J.A.C. 11:22-1;

9. Investigate such other improper patterns or practices as are deemed necessary and appropriate to the Office of Insurance Claims Ombudsman; and

10. Review disputes that are appealed by consumers after an internal appeals procedure (N.J.A.C. 11:25-2) is conducted by life, property and casualty insurers.

(b) This subchapter shall apply to all claims filed under a policy of insurance issued in accordance with N.J.S.A. 17:17-1, 39:6A-1 et seq., or any policy of life or health insurance issued in accordance with Title 17 or Title 17B of the New Jersey Statutes, except any dispute which may be or has been filed or adjudicated pursuant to N.J.S.A. 39:6A-5.1 and 39:6A-5.2 (PIP Alternate Dispute Resolution) shall not be subject to the Ombudsman's review.

**11:25-1.2 Definitions**

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

"Claim" means any claim filed under a policy of insurance issued pursuant to N.J.S.A. 39:6A-1 et seq., or any policy of life or health insurance issued pursuant to Title 17 or Title 17B of the New Jersey Statutes.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Disputed insurance claim" means any offer of settlement made by any insurer which is, in whole or in part, rejected or refused by the claimant.

"Insurance" means any contract of direct insurance written pursuant to N.J.S.A. 39:6A-1 et seq., or any policy of life or health insurance issued pursuant to Title 17 or Title 17B of the New Jersey Statutes.

"Ombudsman" or "Insurance Claims Ombudsman" means the Office of Insurance Claims Ombudsman within the New Jersey Department of Banking and Insurance established in accordance with N.J.S.A. 17:29E-1.

### 11:25-1.3 General provisions; disputed claims

(a) Upon the request of a consumer, the Ombudsman may conduct a review of any disputed insurance claim settlement where there is reasonable cause to believe that an insurer has failed or refused to settle a claim in accordance with the provisions of the policy or has engaged in any practice that may constitute a violation of N.J.S.A. 17:23A-1 et seq., 17:29B-1 et seq., 17:35C-1 et seq., 17B:30-1 et seq., or 17:35C-11; or

(b) Consumers seeking review in accordance with (a) above shall file a complaint with the Ombudsman in any form, which indicates that the complainant is seeking review of a disputed claim. All complaints shall be sent to:

The Office of Insurance Claims Ombudsman  
20 West State Street  
PO Box 329  
Trenton, NJ 08625-0329  
Telephone: (800) 446-7467  
Telefax: (609) 292-2431  
E-mail: [ombudsman@dobi.state.nj.us](mailto:ombudsman@dobi.state.nj.us)

1. All complaints received by the Ombudsman shall be entered into the data tracking system of the Office of Enforcement and Consumer Protection. The Ombudsman shall retain complaints for further action, or refer them to the Office of Enforcement and Consumer Protection for disposition. The Office of Enforcement and Consumer Protection may likewise refer matters to the Ombudsman.

2. If the Ombudsman needs further information on any complaint, the office shall notify the complainant of the additional information needed before any further action may be taken.

3. A copy of the filed complaint shall be sent promptly to the respondent together with a transmittal letter that advises the respondent that an answer to the complaint must be filed no more than 15 days after the date of receipt of the transmittal letter.

4. The respondent may raise a general denial to the complainant's allegations and may also raise such other legal, contractual or equitable defenses, which explain or justify the actions of the respondent.

5. Thereafter, the complainant shall be advised of the respondent's contentions and given an opportunity to rebut within seven days of receipt of the notice.

6. When deemed appropriate, the Ombudsman may extend all time limits mentioned in this subsection.

(c) At the discretion of the Ombudsman, an investigation and hearing may be conducted in person and under oath.

1. In the conduct of an investigation, the Ombudsman may, in his or her sole discretion:

i. Investigate whether the insurer's actions, determinations and proceedings with respect to the claim were in accordance with the law and the policy;

ii. Make any necessary and appropriate inquiries of the insurer or any other interested person to obtain such information as the Ombudsman deems necessary to the investigation;

iii. Hold a hearing on the disputed claim;

iv. Inspect any books and records that relate to the claim; and

v. Issue subpoenas to compel the attendance of any person at a specific time and place, as well as require the production of any documents, books, records, papers, objects and other evidence deemed necessary and relevant to the claim under investigation.

2. The Ombudsman may elect not to investigate a complaint if it is determined that:

i. The complaint is trivial, frivolous, vexatious or not made in good faith;

ii. The complaint has been too long delayed to justify further investigation;

iii. The resources available, considering the established priorities, are insufficient for an adequate investigation;

iv. The matter complained of is not within the investigatory authority of the Ombudsman; or

v. The subject is already under investigation by the Department or the Office of Insurance Fraud Prosecutor.