

**CHAPTER 3
AUTOMOBILE INSURANCE**

Authority

N.J.S.A. 17:1C-6(e) and 17:1-8.1.

Source and Effective Date

R.2001 d.44, effective January 4, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 3, Automobile Insurance, expires on July 3, 2006. See: 37 N.J.R. 4162(a).

Chapter Historical Note

Chapter 3, New Jersey Automobile Insurance Plan, was adopted as R.1972 d.20, effective January 31, 1972. See: 3 N.J.R. 223(d), 4 N.J.R. 49(d).

Subchapter 7, Automobile Repair Reform Act, was adopted as R.1972 d.244, effective December 4, 1972. See: 4 N.J.R. 270(a), 5 N.J.R. 13(c).

Subchapter 10, Auto Physical Damage Claims, was adopted as R.1976 d.46 and R.1976 d.47, effective May 1, 1976. See: 8 N.J.R. 38(b), 8 N.J.R. 136(b).

Pursuant to Executive Order No. 66(1978), Subchapter 8, Nonrenewal of Automobile Insurance Policies, was readopted as R.1983 d.190, effective June 6, 1983. See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).

Subchapter 12, Automobile Rate Filers: Flattening of Premium Taxes and Assessments Made for the Unsatisfied Claim and Judgment Fund, was adopted as R.1983 d.424, effective October 3, 1983. See: 15 N.J.R. 1170(a), 15 N.J.R. 1666(a).

Subchapter 13, Automobile Rate Filers: Deductibles for Private Passenger Automobile Collision and Comprehensive Coverage, was adopted as R.1983 d.467, effective October 17, 1983. See: 15 N.J.R. 1342(a), 15 N.J.R. 1769(b).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Insurance Identification Card, was readopted as R.1983 d.648, effective December 29, 1983. See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Public Notice: Automobile Insurance Written Notice/Buyer's Guide Coverage Selection Form. See: 16 N.J.R. 254(d).

Subchapter 15, Standards for Written Notice: Buyer's Guide and Coverage Selection Form, was adopted as R.1984 d.114, effective April 2, 1984. See: 15 N.J.R. 2142(a), 16 N.J.R. 733(a).

Subchapter 14, Personal Injury Protection Options, was adopted as R.1984 d.116, effective April 2, 1984. See: 15 N.J.R. 2139(a), 16 N.J.R. 730(b).

The Executive Order No. 66(1978) expiration date of Subchapter 7, Automobile Repair Reform Act, was extended by gubernatorial directive from August 17, 1984 to November 15, 1984, and was further extended by gubernatorial directive from November 15, 1984 to February 13, 1985. See: 17 N.J.R. 43(a).

Pursuant to Executive Order No. 66(1978), Subchapter 7, Automobile Repair Reform Act, was readopted as R.1985 d., effective February 13, 1985. See: 17 N.J.R. 43(a), 17 N.J.R. 707(b).

Subchapter 17, Rating Organizations, was adopted as R.1985 d.609, effective October 6, 1985. See: 16 N.J.R. 2936(a), 17 N.J.R. 2905(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1985 d.654, effective January 6, 1986, operative May 6, 1986. See: 16 N.J.R. 3286(a), 17 N.J.R. 89(b).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as R.1986 d.111, effective April 7, 1986. See: 17 N.J.R. 2597(a), 18 N.J.R. 692(a).

Subchapter 17, Rating Organizations, was repealed and Subchapter 17, Rating Organizations, was adopted as new rules by R.1986 d.419, effective October 6, 1986. See: 18 N.J.R. 1171(b), 18 N.J.R. 2045(a).

Subchapter 22, Coverage Option Survey: Personal Injury Protection and Tort Threshold Options, was adopted as R.1986 d.463, effective November 17, 1986. See: 18 N.J.R. 1344(b), 18 N.J.R. 2329(a).

Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, was adopted as R.1987 d.527, effective December 21, 1987. See: 19 N.J.R. 1880(a), 19 N.J.R. 2403(b).

Public Notice: Rescission of Circular Letter #75. See: 19 N.J.R. 570(e).

Subchapter 26, Accident Claims, Subchapter 27, Unsatisfied Claim and Judgment Fund Board, and Subchapter 28, Unsatisfied Claim and Judgment Fund's Reimbursement of Excess Medical Expense Benefits Paid by Insurers, were adopted as R.1989 d.268, effective May 15, 1989. See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was repealed and Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as new rules by R.1989 d.277, effective May 15, 1989. See: 21 N.J.R. 667(b), 21 N.J.R. 1335(a), 21 N.J.R. 1517(b).

Subchapter 24, Policy Constants, and Subchapter 25, Residual Market Equalization Charges (RMECs), were adopted as R.1989 d.278, effective May 15, 1989. See: 20 N.J.R. 3104(a), 21 N.J.R. 1358(b).

Subchapter 20A, Standard Limiting Effect of Negative Excess Investment Income in the Computation of Excess Profits, was adopted as R.1989 d.306, effective June 5, 1989. See: 21 N.J.R. 842(a), 21 N.J.R. 1517(c).

Subchapter 17, Rating Organizations, was repealed by R.1989 d.328, effective June 19, 1989. See: 21 N.J.R. 973(a), 21 N.J.R. 1708(a).

Subchapter 30, Motor Vehicle Self-Insurance, was adopted as R.1989 d.584, effective November 20, 1989. See: 21 N.J.R. 2876(a), 21 N.J.R. 3666(b).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was adopted as R.1990 d.108, effective February 5, 1990. See: 21 N.J.R. 3726(a), 22 N.J.R. 425(a).

Subchapter 18, Private Passenger Automobile Insurance: Rate Filing Review Procedures, was adopted as R.1990 d.109, effective February 5, 1990. See: 21 N.J.R. 3422(b), 22 N.J.R. 421(a).

Subchapter 16, Rate Filing Requirements: Voluntary Market Private Passenger Automobile Insurance, was adopted as R.1990 d.116, effective February 5, 1990. See: 21 N.J.R. 2182(a), 22 N.J.R. 399(a).

Subchapter 1, Provisions and Operations, was repealed and Subchapter 1, Commercial Automobile Insurance Plan, was adopted as new rules by R.1990 d.118, effective February 5, 1990. See: 21 N.J.R. 3613(a), 22 N.J.R. 392(b).

Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, was adopted as R.1990 d.161, effective March 19, 1990. See: 21 N.J.R. 3719(a), 22 N.J.R. 963(a).

Subchapter 34, Eligible Persons Qualifications and Automobile Insurance Eligibility Points Schedule, was adopted as emergency new rules by R.1990 d.620, effective November 26, 1990, operative April 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3847(a). The provisions of R.1990 d.620 were readopted as R.1991 d.93, effective

January 25, 1991, operative April 1, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3847(a), 23 N.J.R. 572(a)

Subchapter 36, Automobile Physical Damage Insurance Inspection Procedures, was adopted as emergency new rules by R.1990 d.622, effective November 26, 1990, operative March 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3861(a). The provisions of R.1990 d.622 were readopted as R.1991 d.95, effective January 25, 1991, operative October 1, 1992, with changes effective February 19, 1991. See: 22 N.J.R. 3861(a), 23 N.J.R. 579(a), 23 N.J.R. 1132(c).

Subchapter 38, Towing and Storage Fee Schedule, was adopted as emergency new rules by R.1990 d.623, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3874(a). The provisions of R.1990 d.623 were readopted as R.1991 d.97, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3874(a), 23 N.J.R. 592(a).

Subchapter 29, Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage, was adopted as emergency new rules by R.1990 d.624, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3809(a). The provisions of R.1990 d.624 were readopted as R.1991 d.96, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3809(a), 23 N.J.R. 536(a).

Subchapter 37, Order of Benefit Determination Between Automobile Personal Injury Protection and Health Insurance, was adopted as emergency new rules by R.1990 d.625, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3777(a). The provisions of R.1990 d.625 were readopted as R.1991 d.90, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, was adopted as emergency new rules by R.1990 d.627, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3856(a). The provisions of R.1990 d.627 were readopted as R.1991 d.94, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3856(a), 23 N.J.R. 577(a).

Subchapter 19, Standard/Non-Standard Rating Plans, was adopted as emergency new rules by R.1990 d.628, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3804(a). The provisions of R.1990 d.628 were readopted as R.1991 d.92, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3804(a), 23 N.J.R. 532(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1991 d.45, effective January 4, 1991, and Subchapters 2 through 5, concerning the Automobile Insurance Plan (AIP), were repealed by R.1991 d.45, effective February 4, 1991. See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Subchapter 24, Policy Constants, was repealed by R.1991 d.216, effective April 15, 1991. See: 22 N.J.R. 3441(a), 23 N.J.R. 1132(a).

Subchapter 25, Residual Market Equalization Charges (RMECs), was repealed by R.1991 d.217, effective April 15, 1991. See: 22 N.J.R. 3442(a), 23 N.J.R. 1132(b).

Subchapter 39, Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti-Theft, Vehicle Recovery and Safety Features, was adopted as R.1991 d.363, effective July 15, 1991, operative September 1, 1991. See: 23 N.J.R. 384(a), 23 N.J.R. 2144(a).

Subchapter 33, Appeals from Denial of Automobile Insurance, was adopted as R.1992 d.192, effective April 30, 1992. See: 24 N.J.R. 546(a), 24 N.J.R. 1510(a).

Subchapter 40, Insurers Required to Provide Automobile Insurance Coverage to Eligible Persons, was adopted as R.1992 d.207, effective May 4, 1992. See: 23 N.J.R. 3736(a), 24 N.J.R. 336(a), 24 N.J.R. 1796(b).

Subchapter 2, New Jersey Personal Automobile Insurance Plan, was adopted as new rules by R.1992 d.370, effective September 21, 1992. See: 24 N.J.R. 331(a), 24 N.J.R. 3400(a).

Subchapter 3, Limited Assignment Distribution Servicing Carriers, was adopted as new rules by R.1992 d.371, effective September 21, 1992. See: 24 N.J.R. 519(a), 24 N.J.R. 3414(a).

Subchapter 42, Producer Assignment Program, was adopted as emergency new rules by R.1992 d.381, effective September 4, 1992, to expire November 3, 1992. See: 24 N.J.R. 3421(a). The provisions of R.1992 d.381 were readopted as R.1992 d.482, effective November 2, 1992, with changes effective December 7, 1992. See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).

Subchapter 44, Special Rules for Effecting Coverage for Private Passenger Automobile Insurance, was adopted as emergency new rules by R.1993 d.135, effective March 1, 1993, operative March 8, 1993, to expire April 30, 1993. See: 25 N.J.R. 1290(a). The provisions of R.1993 d.135 were readopted as R.1993 d.238, effective April 30, 1993. See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

Subchapter 2B, Market Transition Facility of New Jersey Suspension of Claims, was adopted as emergency new rules by R.1994 d.164, effective March 1, 1994, to expire April 30, 1994. See: 26 N.J.R. 1393(a). The provisions of R.1994 d.164 were readopted as R.1994 d.261, effective April 29, 1994. See: 26 N.J.R. 1393(a), 26 N.J.R. 2288(a).

Subchapter 32, Certification of Compliance: Mandatory Liability Coverages, was adopted as R.1994 d.477, effective September 19, 1994. See: 26 N.J.R. 1939(a), 26 N.J.R. 3866(a).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was repealed by R.1995 d.171, effective March 20, 1995. See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

Subchapter 45, Insurers Required to Provide Survey Information, was adopted as R.1995 d.235, effective May 1, 1995. See: 27 N.J.R. 289(a), 27 N.J.R. 1803(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1996 d.58, effective January 4, 1996, and Subchapter 2A, New Jersey Automobile Full Insurance Underwriting Association Claims Payment Deferral, Subchapter 3, Limited Assignment Distribution Servicing Carriers, and Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, were repealed by R.1996 d.58, effective February 5, 1996. See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Subchapter 20A, Standard Limited Effect of Negative Excess Investment Income in the Computation of Excess Profits, was repealed by R.1996 d.312, effective July 15, 1996. See: 28 N.J.R. 1616(a), 28 N.J.R. 3627(b).

Subchapter 25, Private Passenger Automobile Insurance: Notification by Treating Health Care Providers, was adopted as new rules by R.1997 d.14, effective January 6, 1997. See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).

Subchapter 24, Defensive Driving Rate Reductions, was adopted as new rules by R.1997 d.522, effective December 15, 1997. See: 28 N.J.R. 4854(a), 29 N.J.R. 5305(a).

Subchapter 28A, Unsatisfied Claim and Judgment Fund Assessments, was adopted as R.1997 d.535, effective December 15, 1997. See: 29 N.J.R. 4246(a), 29 N.J.R. 5309(a).

Subchapter 19A, Tier Rating Plans and Underwriting Rules, was adopted as R.1998 d.129, effective March 2, 1998. See: 29 N.J.R. 5253(a), 30 N.J.R. 839(a).

Subchapter 46, Automobile Insurance Urban Enterprise Zone Program, was adopted as R.1998 d.290, effective June 1, 1998. See: 30 N.J.R. 773(a), 30 N.J.R. 2010(a).

Subchapter 3, Basic Automobile Insurance Policy, was adopted as new rules by R.1998 d.592, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3209(a), 30 N.J.R. 4398(a).

Subchapter 5, Personal Injury Protection Dispute Resolution, was adopted as new rules by R.1998 d.593, effective December 21, 1998. See: 30 N.J.R. 3359(a), 30 N.J.R. 4437(a).

AUTOMOBILE INSURANCE

Subchapter 4, Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests, was adopted as new rules by R.1998 d.597, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3211(a), 30 N.J.R. 3748(a), 30 N.J.R. 4401(a).

Subchapter 38, Towing and Storage Fee Schedule, was repealed by R.1999 d.1, effective January 4, 1999. See: 30 N.J.R. 2813(a), 31 N.J.R. 54(c).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.2001 d.44, effective January 4, 2001, and Subchapter 2B, Market Transition Facility of New Jersey Payment Prioritization and Claims Payment Deferral, Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, Subchapter 19, Standard/Nonstandard Rating Plans, and Subchapter 42, Producer Assignment Program, were repealed by R.2001 d.44, effective February 5, 2001. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. COMMERCIAL AUTOMOBILE INSURANCE PLAN

- 11:3-1.1 Purpose and scope
- 11:3-1.2 Definitions
- 11:3-1.3 Creation of the plan
- 11:3-1.4 Governing committee
- 11:3-1.5 Participation
- 11:3-1.6 Plan of operation
- 11:3-1.7 Coverage
- 11:3-1.8 Qualification
- 11:3-1.9 Rates and policy forms
- 11:3-1.10 Right to petition for appeal to the Commissioner

SUBCHAPTER 2. NEW JERSEY PERSONAL AUTOMOBILE INSURANCE PLAN

- 11:3-2.1 Purpose and scope
- 11:3-2.2 Definitions
- 11:3-2.3 Creation of the plan
- 11:3-2.4 Exemptions
- 11:3-2.5 Governing committee
- 11:3-2.6 Plan of operation
- 11:3-2.7 Coverage
- 11:3-2.8 Eligibility
- 11:3-2.9 Rates and policy forms
- 11:3-2.10 Installment payment option
- 11:3-2.11 Determination and fulfillment of quotas
- 11:3-2.12 Right to petition for appeal to the Commissioner
- 11:3-2.13 Voluntary rating tier (VRT)
- 11:3-2.14 Penalties

SUBCHAPTER 2A. SPECIAL AUTOMOBILE INSURANCE POLICY

- 11:3-2A.1 Purpose and scope
- 11:3-2A.2 Definitions
- 11:3-2A.3 General provisions
- 11:3-2A.4 Eligibility for special automobile insurance policy
- 11:3-2A.5 Coverages
- 11:3-2A.6 Election of special automobile insurance policy

SUBCHAPTER 2B. (RESERVED)

SUBCHAPTER 3. BASIC AUTOMOBILE INSURANCE POLICY

- 11:3-3.1 Purpose and scope
- 11:3-3.2 Definitions
- 11:3-3.3 General provisions
- 11:3-3.4 Coverages; mandatory and optional
- 11:3-3.5 Election of basic automobile insurance policy coverage and reporting
- 11:3-3.6 Filing requirements

SUBCHAPTER 3A. REPORTING REQUIREMENTS AND FILING DEADLINES

- 11:3-3A.1 Purpose and scope
- 11:3-3A.2 Definitions
- 11:3-3A.3 Report requirements
- 11:3-3A.4 Penalties

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

- 11:3-4.1 Scope and purpose
- 11:3-4.2 Definitions
- 11:3-4.3 Personal injury protection benefits applicable to basic and standard policies
- 11:3-4.4 Deductibles and co-pays
- 11:3-4.5 Diagnostic tests
- 11:3-4.6 Medical protocols
- 11:3-4.7 Decision point review plans
- 11:3-4.8 Voluntary networks
- 11:3-4.9 Assignment of benefits; public information
- 11:3-4.10 (Reserved)

APPENDIX TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATHS

EXHIBIT 1 GLOSSARY OF TERMS

EXHIBIT 2 TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATH OVERVIEW

EXHIBIT 3 CARE PATH 1

EXHIBIT 4 CARE PATH 2

EXHIBIT 5 CARE PATH 3

EXHIBIT 6 CARE PATH 4

EXHIBIT 7 CARE PATH 5

EXHIBIT 8 CARE PATH 6

EXHIBIT 9 TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATH DIAGNOSIS CODING

EXHIBIT 10 ADDENDUM TO CARE PATHS

EXHIBIT 11 DECISION POINT REVIEW/PRE-CERTIFICATION IMPLEMENTATION REPORT

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

- 11:3-5.1 Purpose and scope
- 11:3-5.2 Definitions
- 11:3-5.3 Designation of the administrator
- 11:3-5.4 Dispute resolution organizations
- 11:3-5.5 Dispute resolution professionals
- 11:3-5.6 Conduct of PIP dispute resolution proceedings
- 11:3-5.7 Recordkeeping
- 11:3-5.8 Medical review organizations
- 11:3-5.9 Standards for medical review organizations
- 11:3-5.10 Medical review organization certification process
- 11:3-5.11 Fees
- 11:3-5.12 Prohibition of conflicts of interest

SUBCHAPTER 6. INSURANCE IDENTIFICATION CARDS

- 11:3-6.1 Scope
- 11:3-6.2 Permanent identification cards
- 11:3-6.3 Temporary identification card
- 11:3-6.4 General provisions
- 11:3-6.5 (Reserved)

SUBCHAPTER 7. AUTOMOBILE REPARATION REFORM ACT

- 11:3-7.1 Purpose
- 11:3-7.2 General requirements applicable to additional personal injury protection benefits
- 11:3-7.3 Personal injury protection policy forms or endorsements
- 11:3-7.4 Minimum schedule of additional personal injury protection coverage benefits
- 11:3-7.5 Notice Requirement
- 11:3-7.6 Cancellation of automobile coverage for nonpayment of premium

SUBCHAPTER 8. RENEWAL AND NONRENEWAL OF AUTOMOBILE INSURANCE POLICIES

- 11:3-8.1 Scope
- 11:3-8.2 Definitions
- 11:3-8.3 General provisions
- 11:3-8.4 Standards of nonrenewal —ineligible persons
- 11:3-8.5 Other nonrenewals—standards
- 11:3-8.6 Limitations on nonrenewal
- 11:3-8.7 Suspension of nonrenewals
- 11:3-8.8 Records
- 11:3-8.9 Separability
- 11:3-8.10 Penalties

APPENDIX**EXHIBIT A NEW JERSEY AUTO CONSUMERS' RIGHTS Q&A****EXHIBIT B (RESERVED)****EXHIBIT C (RESERVED)****SUBCHAPTER 9. RATING INFORMATION: AUTOMOBILE INSURANCE ON PRIVATE PASSENGER CARS**

- 11:3-9.1 Rating information; private passenger cars; automobile insurance
- 11:3-9.2 (Reserved)

SUBCHAPTER 10. AUTO PHYSICAL DAMAGE CLAIMS

- 11:3-10.1 Scope
- 11:3-10.2 Definitions
- 11:3-10.3 Adjustment of partial losses
- 11:3-10.4 Adjustment of total losses
- 11:3-10.5 Unreasonable delay
- 11:3-10.6 Loss of use
- 11:3-10.7 Subrogation agreements
- 11:3-10.8 Repair estimates
- 11:3-10.9 Referral of insured to the at-fault party
- 11:3-10.10 Examinations by the New Jersey Department of Banking and Insurance

SUBCHAPTER 11. MOPED INSURANCE

- 11:3-11.1 Required coverage for mopeds

SUBCHAPTER 12. AUTOMOBILE RATE FILERS: FLATTENING OF PREMIUM TAXES AND ASSESSMENTS MADE FOR THE UNSATISFIED CLAIM AND JUDGMENT FUND

- 11:3-12.1 Purpose
- 11:3-12.2 Scope
- 11:3-12.3 Definitions
- 11:3-12.4 Tax and assessment fees; general provisions
- 11:3-12.5 Filing and reporting requirements

SUBCHAPTER 13. COLLISION AND COMPREHENSIVE COVERAGE DEDUCTIBLES AND OPTIONS

- 11:3-13.1 Purpose

- 11:3-13.2 Scope
- 11:3-13.3 Deductibles for private passenger automobile collision and comprehensive coverages
- 11:3-13.4 Filing and reporting requirements
- 11:3-13.5 Named excluded driver

APPENDIX**SUBCHAPTER 14. PERSONAL INJURY PROTECTION OPTIONS FOR STANDARD POLICIES**

- 11:3-14.1 Purpose
- 11:3-14.2 Scope
- 11:3-14.3 Optional medical expense benefits for standard policies
- 11:3-14.4 Optional exclusion of income continuation benefits, essential services benefits, death benefits and funeral expense benefits
- 11:3-14.5 Option to choose health care insurance coverage as primary coverage
- 11:3-14.6 Refund or credit of unearned premium
- 11:3-14.7 Filing requirements
- 11:3-14.8 Application of the option to choose health care insurance coverage as the primary insurer

SUBCHAPTER 15. BUYER'S GUIDE, COVERAGE SELECTION FORM, AND AUTOMOBILE INSURANCE CONSUMER BILL OF RIGHTS FOR STANDARD AND BASIC POLICIES

- 11:3-15.1 Purpose
- 11:3-15.2 Scope
- 11:3-15.3 Definitions
- 11:3-15.4 Compliance
- 11:3-15.5 Minimum standards for New Jersey Auto Insurance Buyer's Guide
- 11:3-15.6 Minimum standards for Coverage Selection Forms
- 11:3-15.7 Use of Coverage Selection Form; Availability
- 11:3-15.8 Penalties
- 11:3-15.9 through 11:3-15.11 (Reserved)

APPENDIX**EXHIBIT 1 STANDARD POLICY COVERAGE SELECTION FORM****EXHIBIT 2 BASIC POLICY COVERAGE SELECTION FORM****SUBCHAPTER 16. RATE FILING REQUIREMENTS: VOLUNTARY MARKET PRIVATE PASSENGER AUTOMOBILE INSURANCE**

- 11:3-16.1 Purpose and scope
- 11:3-16.2 Definitions
- 11:3-16.3 General requirements and filing format
- 11:3-16.4 Insurer informational filings due July 1 of each year
- 11:3-16.5 (Reserved)
- 11:3-16.6 Filings for rates requiring prior approval
- 11:3-16.7 (Reserved)
- 11:3-16.8 Premiums, loss costs, loss and loss adjustment expense data
- 11:3-16.9 Data requirements for expense and profit provisions
- 11:3-16.10 Profit and contingency provision
- 11:3-16.11 Incomplete filings and further proceedings
- 11:3-16.12 Voluntary written exposure and primary classification data
- 11:3-16.13 Prospective loss cost filing requirements for insurers
- 11:3-16.14 through 11:3-16.16 (Reserved)

APPENDIX**EXHIBIT A PRIOR APPROVAL FILINGS****EXHIBIT B DEVIATION APPLICATION FORM****EXHIBIT C WORKSHEET TO DETERMINE NO LIMITATION ON LAWSUIT PREMIUM****EXHIBIT D NEW JERSEY INSURER RATE FILING****EXHIBIT E MARKETING METHODS FOR THE LARGEST PRIVATE PASSENGER AUTO INSURER GROUPS IN NEW JERSEY****EXHIBITS F-K (RESERVED)****SUBCHAPTER 16A. PRIVATE PASSENGER AUTOMOBILE INSURANCE TERRITORIAL RATING PLANS**

- 11:3-16A.1 Purpose and scope

AUTOMOBILE INSURANCE

- 11:3-16A.2 Definitions
- 11:3-16A.3 General requirements
- 11:3-16A.4 Standards for establishment of territories
- 11:3-16A.5 Territorial rating plan filing requirements
- 11:3-16A.6 Review of filings
- 11:3-16A.7 Territorial rating plan review
- 11:3-16A.8 Objection to filings
- 11:3-16A.9 Transition requirements
- 11:3-16A.10 Penalties

SUBCHAPTER 16B. RATE PROCESS FOR LIMITED RATE CHANGES; CALCULATIONS FOR PRIVATE PASSENGER AUTOMOBILE INSURANCE RATE CHANGES

- 11:3-16B.1 Purpose and scope
- 11:3-16B.2 Definitions
- 11:3-16B.3 Rate process for limited rate changes; insurers and rating organizations
- 11:3-16B.4 Rate process for limited rate changes; calculation for private passenger automobile insurance
- 11:3-16B.5 Limitation on filer's rate request
- 11:3-16B.6 Review; general principles; action

APPENDIX

SUBCHAPTER 17. RATE INTERVENOR RULES

- 11:3-17.1 Purpose and scope
- 11:3-17.2 Definitions
- 11:3-17.3 Intervenor registration requirements
- 11:3-17.4 Penalties for intervenors or filers
- 11:3-17.5 Notification of rate increase
- 11:3-17.6 Procedures for intervening in a rate filing
- 11:3-17.7 Awarding of fees and expenses

APPENDIX A. RATE INTERVENOR REGISTRATION

SUBCHAPTER 18. PRIVATE PASSENGER AUTOMOBILE INSURANCE: RATE FILING REVIEW PROCEDURES

- 11:3-18.1 Purpose and scope
- 11:3-18.2 Definitions
- 11:3-18.3 General provisions applicable to all filings
- 11:3-18.4 Procedures for review of prior approval filings
- 11:3-18.5 through 11:3-18.6 (Reserved)
- 11:3-18.7 Other remedies preserved

SUBCHAPTER 19. (RESERVED)

SUBCHAPTER 19A. TIER RATING PLANS AND UNDERWRITING RULES

- 11:3-19A.1 Purpose and scope
- 11:3-19A.2 Definitions
- 11:3-19A.3 General provisions
- 11:3-19A.4 Filing requirements for tier rating plans
- 11:3-19A.5 Standards of approval, disapproval or modification of underwriting rules and tier rating plans
- 11:3-19A.6 Policy renewals and notice to insureds
- 11:3-19A.7 Underwriting rules for eligible persons
- 11:3-19A.8 Penalties
- 11:3-19A.9 (Reserved)

APPENDIX

SUBCHAPTER 20. REPORTING FINANCIAL DISCLOSURE AND EXCESS PROFITS

- 11:3-20.1 Purpose
- 11:3-20.2 Scope
- 11:3-20.3 Definitions
- 11:3-20.4 General reporting requirements
- 11:3-20.5 Excess profit report
- 11:3-20.6 Reporting requirements for insurance holding company systems

- 11:3-20.7 Determination of an excess profit
- 11:3-20.8 Refund or credit of an excess profit
- 11:3-20.9 Excess profit, extraordinary loss, carry forwards
- 11:3-20.10 Order for further information
- 11:3-20.11 Supplemental filings
- 11:3-20.12 (Reserved)
- 11:3-20.13 Penalties

APPENDIX EXCESS PROFIT EXHIBITS—INSTRUCTIONS

SUBCHAPTER 20A. (RESERVED)

SUBCHAPTER 21. PERSONAL INJURY PROTECTION COVERAGE: REDUCED PIP PREMIUM CHARGE FOR ADDITIONAL AUTOS IN ONE-DRIVER HOUSEHOLDS

- 11:3-21.1 Purpose
- 11:3-21.2 Reduction of PIP premium
- 11:3-21.3 Automobiles eligible for premium reduction
- 11:3-21.4 Filing and statistical requirements

SUBCHAPTER 22. COVERAGE OPTION SURVEY PERSONAL INJURY PROTECTION AND TORT THRESHOLD OPTIONS

- 11:3-22.1 Purpose
- 11:3-22.2 Scope
- 11:3-22.3 Coverage option survey requirements

SUBCHAPTER 23. (RESERVED)

SUBCHAPTER 24. DEFENSIVE DRIVING RATE REDUCTIONS

- 11:3-24.1 Purpose and scope
- 11:3-24.2 Definitions
- 11:3-24.3 Rate reduction filing requirements
- 11:3-24.4 Application of defensive driving rate reduction
- 11:3-24.5 Procedure to obtain rate reduction
- 11:3-24.6 Penalties

SUBCHAPTER 25. PRIVATE PASSENGER AUTOMOBILE INSURANCE: NOTIFICATION BY TREATING HEALTH CARE PROVIDERS

- 11:3-25.1 Purpose and scope
- 11:3-25.2 Definitions
- 11:3-25.3 Notification of commencement of treatment
- 11:3-25.4 Content of notice and proof of receipt
- 11:3-25.5 Late notification
- 11:3-25.6 Standards for adjustment of reduction
- 11:3-25.7 Responsibility for payment
- 11:3-25.8 Procedure for appeals
- 11:3-25.9 Reporting requirement
- 11:3-25.10 Compliance

APPENDIX A NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT

APPENDIX B ADDRESS FOR NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT

SUBCHAPTER 26. UNSATISFIED CLAIM AND JUDGMENT FUND: NOTICE OF INTENT

- 11:3-26.1 Claim information
- 11:3-26.2 Claim filing; form

APPENDIX A

SUBCHAPTER 27. UNSATISFIED CLAIM AND JUDGMENT FUND BOARD

- 11:3-27.1 Uninsured's current financial status

SUBCHAPTER 28. UNSATISFIED CLAIM AND JUDGMENT FUND'S REIMBURSEMENT OF EXCESS MEDICAL EXPENSE BENEFITS PAID BY INSURERS

- 11:3-28.1 Purpose and scope
- 11:3-28.2 Definitions
- 11:3-28.3 Report of claims when the carrier has paid at least \$50,000 for medical expense benefits
- 11:3-28.4 Notice of change in the amount of reserves
- 11:3-28.5 Supplemental forms to be submitted to the Fund
- 11:3-28.6 Insurer's continuing obligation to investigate claims
- 11:3-28.7 Reimbursement of excess medical expense benefits paid by insurers
- 11:3-28.8 Audits
- 11:3-28.9 Reporting of losses for personal injury protection payments in excess of \$75,000
- 11:3-28.10 Insurers' obligations to investigate and audit bills for medical benefits
- 11:3-28.11 Modifications to vehicles
- 11:3-28.12 Modifications to a claimant's residence
- 11:3-28.13 Insurer's obligation to obtain recovery of payments for paid medical expense benefit claims
- 11:3-28.14 Insurer's responsibility upon assignment of an uninsured motorist claim
- 11:3-28.15 Procedures for handling an assigned uninsured motorist claim
- 11:3-28.16 (Reserved)
- 11:3-28.17 Penalties

APPENDIX A FORMS; PAYMENT RECORD; QUESTIONNAIRE

APPENDIX B AMORTIZATION FORMULA

APPENDIX C UNSATISFIED CLAIM AND JUDGMENT FUND RECOVERY CERTIFICATION

SUBCHAPTER 28A. (RESERVED)

SUBCHAPTER 29. MEDICAL FEE SCHEDULES: AUTOMOBILE INSURANCE PERSONAL INJURY PROTECTION AND MOTOR BUS MEDICAL EXPENSE INSURANCE COVERAGE

- 11:3-29.1 Purpose and scope
- 11:3-29.2 Definitions
- 11:3-29.3 Regions
- 11:3-29.4 Application of Medical Fee Schedules
- 11:3-29.5 Balance billing prohibited
- 11:3-29.6 (Reserved)

APPENDIX

SUBCHAPTER 30. MOTOR VEHICLE SELF-INSURANCE

- 11:3-30.1 Purpose
- 11:3-30.2 Scope
- 11:3-30.3 Definitions
- 11:3-30.4 General requirements
- 11:3-30.5 Certificate of self-insurance
- 11:3-30.6 Renewals
- 11:3-30.7 Surety bond requirement
- 11:3-30.8 Audits and examinations
- 11:3-30.9 Public entities
- 11:3-30.10 Cancellation of certificate of self-insurance

SUBCHAPTER 31. (RESERVED)

SUBCHAPTER 32. CERTIFICATION OF COMPLIANCE: MANDATORY LIABILITY COVERAGES

- 11:3-32.1 Purpose and scope
- 11:3-32.2 Definitions
- 11:3-32.3 Certification compliance requirements
- 11:3-32.4 Requests for copies of certifications

SUBCHAPTER 33. APPEALS FROM DENIAL OF AUTOMOBILE INSURANCE

- 11:3-33.1 Purpose; scope
- 11:3-33.2 Definitions
- 11:3-33.3 Right to appeal
- 11:3-33.4 Duties of insurer or insurance agent
- 11:3-33.5 Procedure for filing an appeal
- 11:3-33.6 Processing appeals
- 11:3-33.7 Contested case hearings; pleadings
- 11:3-33.8 Penalties
- 11:3-33.9 Compliance

APPENDIX A

APPENDIX B

SUBCHAPTER 34. ELIGIBLE PERSONS QUALIFICATIONS AND AUTOMOBILE INSURANCE ELIGIBILITY POINTS SCHEDULE

- 11:3-34.1 Purpose
- 11:3-34.2 Scope
- 11:3-34.3 Definitions
- 11:3-34.4 Eligible person qualifications
- 11:3-34.5 Automobile insurance eligibility points

APPENDIX SCHEDULE OF AUTOMOBILE INSURANCE ELIGIBILITY POINTS

SUBCHAPTER 35. PRIVATE PASSENGER AUTOMOBILE INSURANCE UNDERWRITING RULES

- 11:3-35.1 Purpose and scope
- 11:3-35.2 Definitions
- 11:3-35.3 General requirements and filing format
- 11:3-35.4 Underwriting rules for eligible persons
- 11:3-35.5 Underwriting rules for rating plans
- 11:3-35.6 Penalties

SUBCHAPTER 35A. PRIVATE PASSENGER AUTOMOBILE INSURANCE—USE OF ALTERNATE UNDERWRITING RULES

- 11:3-35A.1 Scope and purpose
- 11:3-35A.2 Definitions
- 11:3-35A.3 General requirements
- 11:3-35A.4 Growth requirements
- 11:3-35A.5 Alternate underwriting rules
- 11:3-35A.6 Activation of alternate underwriting rules
- 11:3-35A.7 Determination of an uncompetitive market
- 11:3-35A.8 Penalties

APPENDIX

SUBCHAPTER 36. AUTOMOBILE PHYSICAL DAMAGE INSURANCE INSPECTION PROCEDURES

- 11:3-36.1 Purpose and scope
- 11:3-36.2 Definitions
- 11:3-36.3 Mandatory inspection requirements
- 11:3-36.4 Waivers of mandatory inspection
- 11:3-36.5 Deferral of inspections
- 11:3-36.6 Standards and procedures for inspection
- 11:3-36.7 Suspension of physical damage coverages
- 11:3-36.8 Enforcement
- 11:3-36.9 Results and audits
- 11:3-36.10 Severability
- 11:3-36.11 Required amendatory endorsements
- 11:3-36.12 (Reserved)

APPENDIX A ACKNOWLEDGMENT OF REQUIREMENT FOR INSURANCE INSPECTION

APPENDIX B NOTICE OF INSURANCE INSPECTION

APPENDIX C(1)

APPENDIX C(2)

APPENDIX D NOTICE OF SUSPENSION OF PHYSICAL DAMAGE COVERAGE

SUBCHAPTER 37. ORDER OF BENEFIT DETERMINATION BETWEEN AUTOMOBILE PERSONAL INJURY PROTECTION AND HEALTH INSURANCE

- 11:3-37.1 Purpose and scope
- 11:3-37.2 Definitions
- 11:3-37.3 Health benefits providers
- 11:3-37.4 Application of the PIP-as-secondary coverage option
- 11:3-37.5 Health benefit plan standards and the PIP premium reduction
- 11:3-37.6 Order of benefits determination when PIP is secondary coverage
- 11:3-37.7 Determination of PIP medical benefits payable when PIP is secondary coverage
- 11:3-37.8 Health benefits plan coverage ineligibility
- 11:3-37.9 Determination of benefits when PIP is primary coverage
- 11:3-37.10 Explanation of benefits
- 11:3-37.11 Dispute as to primacy of coverage
- 11:3-37.12 Eligibility under two or more automobile policies
- 11:3-37.13 Penalties
- 11:3-37.14 Severability

SUBCHAPTER 38. (RESERVED)

SUBCHAPTER 39. REDUCTIONS IN PREMIUM CHARGES FOR PRIVATE PASSENGER AUTOMOBILES EQUIPPED WITH ANTI-THEFT, VEHICLE RECOVERY AND SAFETY FEATURES

- 11:3-39.1 Purpose
- 11:3-39.2 Scope
- 11:3-39.3 Definitions
- 11:3-39.4 Reductions in rates for anti-theft and vehicle recovery devices
- 11:3-39.5 Categories of anti-theft and vehicle recovery devices
- 11:3-39.6 Reductions in rates for safety features
- 11:3-39.7 Penalties
- 11:3-39.8 Severability

SUBCHAPTER 40. INSURERS REQUIRED TO PROVIDE AUTOMOBILE INSURANCE COVERAGE TO ELIGIBLE PERSONS

- 11:3-40.1 Purpose and scope
- 11:3-40.2 Definitions
- 11:3-40.3 Insurers required to provide automobile insurance coverage to eligible persons
- 11:3-40.4 Penalties

SUBCHAPTERS 41 THROUGH 43. (RESERVED)

SUBCHAPTER 44. SPECIAL RULES FOR EFFECTING COVERAGE FOR PRIVATE PASSENGER AUTOMOBILE INSURANCE

- 11:3-44.1 Purpose and scope
- 11:3-44.2 Definitions
- 11:3-44.3 Duty to provide coverage upon receipt of a completed written application
- 11:3-44.4 New applicants previously insured in another state by the insurer or an affiliate
- 11:3-44.5 Underwriting rules
- 11:3-44.6 Penalties

SUBCHAPTER 45. INSURERS REQUIRED TO PROVIDE SURVEY INFORMATION

- 11:3-45.1 Purpose and scope
- 11:3-45.2 Definitions
- 11:3-45.3 Annual premium survey filing
- 11:3-45.4 Penalties

APPENDIX NEW JERSEY AUTOMOBILE INSURANCE PREMIUM COMPARISON SURVEY

SUBCHAPTER 46. AUTOMOBILE INSURANCE URBAN ENTERPRISE ZONE PROGRAM

- 11:3-46.1 Purpose and scope
- 11:3-46.2 Definitions
- 11:3-46.3 Designation of UEZ and UEZ share
- 11:3-46.4 Qualified insurers
- 11:3-46.5 UEZ agents
- 11:3-46.6 PAIP voluntary rating tier
- 11:3-46.7 Qualified producers
- 11:3-46.8 Review of applications
- 11:3-46.9 Disapproval standards
- 11:3-46.10 Commissions
- 11:3-46.11 Coverage application procedure
- 11:3-46.12 PAIP Plan of Operation
- 11:3-46.13 Reporting requirements
- 11:3-46.14 Penalties

APPENDIX

SUBCHAPTER 47. INSURANCE SCENARIOS

- 11:3-47.1 Purpose and scope
- 11:3-47.2 Definitions
- 11:3-47.3 Insurance scenarios
- 11:3-47.4 Penalties

SUBCHAPTER 1. COMMERCIAL AUTOMOBILE INSURANCE PLAN

11:3-1.1 Purpose and scope

(a) The purpose of this subchapter is to establish a plan pursuant to N.J.S.A. 17:29D-1:

1. To provide the coverages described herein, subject to the conditions stated, for motor vehicles other than those vehicles subject to the New Jersey Personal Automobile Insurance Plan and any other private passenger vehicle that is owned by or driven by a person who meets the definition of an eligible person pursuant to N.J.S.A. 17:33B-13 and N.J.A.C. 11:3-34;
2. To provide for the apportionment of insurance coverage for qualified applicants who are in good faith entitled to but are unable to procure the same, through the voluntary market; and
3. To establish a procedure for the sharing of premiums, losses, and expenses among all insurers who are participants in New Jersey as defined within this subchapter for all risks qualified for coverage under the provisions of this subchapter.

Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

In (a), inserted "other" preceding "private passenger vehicle" in 1, substituted "qualified" for "eligible" preceding "applicants" in 2 and substituted "qualified" for "eligible" preceding "for coverage" in 3.

11:3-1.2 Definitions

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

"CAIP" or "Plan" means the Commercial Automobile Insurance Plan pursuant to this subchapter.

"CAIP manager" means the entity employed by the Governing Committee to manage and conduct the administrative affairs of the CAIP on a daily basis.

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

"Emergency type vehicle" means any land vehicle, used to respond to distress calls, fires, or rescue, propelled by other than muscular power and not run upon rails or tracks. This term includes, but is not limited to, fire trucks, rescue trucks, police cars and ambulances.

"Gross participation" means a participant's Voluntary All Other Automobile Direct Written Premiums derived from information contained in the annual statement times a fraction, the numerator of which is the sum of the plan's total written premiums for that year and the Statewide total Voluntary All Other Automobile Direct Written Premiums which are eligible for depopulation credit for that policy year, and the denominator of which is the Statewide total Voluntary All Other Automobile Net Direct Written Premiums of all participants for that second prior year.

"Light truck" means a vehicle with a gross vehicle weight (G.V.W.) of 10,000 pounds or less.

"Motor vehicle" means any land vehicle propelled otherwise than by muscular power including trailers and semi-trailers, except such vehicles that run only upon rails or tracks.

"Net participation" means a participant's gross participation for that policy year less its business eligible for depopulation credit for that policy year.

"Net participation percentage" means a participant's net participation for that policy year in proportion to the comparable Statewide total net participation for all participants.

"Operating headquarters" means the chief place of business where the principal officers generally transact business, and the place to which reports are made and from which orders emanate. It is the location where the executive offices are, corporate decisions are made and corporate functions are performed.

"Participant" means an insurer licensed and authorized to write motor vehicle liability or physical damage insurance and specifically includes any insurer who writes all other automobile liability and all other automobile physical damage insurance.

"Personal injury protection" means those benefits as set forth at N.J.S.A. 39:6A-4.

"Policy year" means the exposure and premiums for all policies written during a calendar year and all losses attributable to policies written during the same calendar year.

"Private passenger automobile" means a vehicle that meets the definition in N.J.S.A. 39:6A-2a, that is not eligible for coverage through any voluntary or residual market mechanism created by statute, and is owned by an individual or husband and wife; or owned jointly by two or more relatives other than husband and wife; or owned jointly by two or more resident individuals; or owned by a corporation, partnership or unincorporated association, governmental agency, or registered to a professional designation (that is, T/A, PA or P.C.) where such automobiles are furnished to individuals and are not used for business purposes.

"Private passenger type automobile" means a vehicle that meets the definition in N.J.S.A. 39:6A-2a and is owned by a corporation, partnership or any other entity except an individual or husband and wife and used for business purposes.

"Qualified applicant" means the owner or registrant of a motor vehicle registered in New Jersey or to be registered within 60 days who is unable to obtain automobile insurance in New Jersey in the voluntary market and is not in good faith qualified for automobile insurance coverage in any residual market mechanism created by statute other than the CAIP. For multi-state operations, the applicant must have its operating headquarters in New Jersey but vehicles may be registered in other states. No applicant shall be deemed qualified if the principal operator of the vehicle to be insured does not hold a driver's license which is valid in New Jersey, or if a regular operator of the vehicle other than the principal operator does not hold such a license.

"Voluntary All Other Automobile Direct Written Premiums" means automobile liability, personal injury protection, and physical damage premiums written by a participant on New Jersey risks, minus:

1. CAIP direct written premiums included in the figures which the participant wrote as a service carrier for CAIP;
2. Any direct written premiums included in the figures from insureds who are qualified applicants for any residual market mechanism created by statute other than the CAIP;
3. Any reinsurance premiums assumed from other insurers included in the figures;
4. Any premiums for Death and Disability coverage included in the figures;

5. Private passenger nonfleet automobile bodily injury and property damage liability, medical payments, basic and additional personal injury protection, and uninsured and underinsured motorists voluntary premium;

6. Miscellaneous nonfleet specialty personal automobile bodily injury and property damage liability voluntary premiums for any class approved by the Department as specified in the plan of operation; and

7. Taxi bodily injury, property damage liability, uninsured and underinsured motorists and physical damage premiums.

Amended by R.1991 d.45, effective February 4, 1991.

See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Deleted definition of NJAFIUA and references to it; added text to definitions for "Private passenger automobile" and "Voluntary All Other Automobile Direct Written Premiums."

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Inserted "Personal injury protection".

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

In "CAIP", inserted "or Plan" following "CAIP"; deleted "Eligible applicant"; in "Participant", substituted "or" for "and" following "vehicle liability"; in "Private passenger automobile", substituted "or" for "and" preceding "unincorporated association"; in "Private passenger type automobile", inserted "and used for business purposes" following "husband and wife"; added "Qualified applicant"; rewrote "Voluntary All Other Automobile Direct Written Premiums".

11:3-1.3 Creation of the plan

(a) There is created in the State of New Jersey a plan for the administration and apportionment of automobile insurance for qualified applicants to be known as the Commercial Automobile Insurance Plan hereafter referred to as "CAIP."

(b) CAIP shall be administered by the governing committee pursuant to this subchapter and a plan of operation approved by the Commissioner.

(c) Every insurer admitted to transact and transacting motor vehicle insurance in the State of New Jersey shall participate in CAIP to the extent required by this subchapter and the plan of operation.

Amended by R.1996 d.502, effective October 21, 1996.
See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

11:3-1.4 Governing committee

(a) CAIP shall be administered by a governing committee of 14 members.

1. Eight members shall be salaried employees of insurers that are participants in CAIP. Except as provided in (a)4 below, no CAIP servicing carrier or any parent, subsidiary or affiliate thereof, shall serve as a member of the Governing Committee.

2. Three members shall be licensed producers.

3. One member shall be public representative who is knowledgeable about automobile insurance matters but who is not employed by, or otherwise affiliated with, insurance producers, or other entities of the insurance industry.

4. One member shall be a salaried employee of a servicing carrier for the CAIP.

5. The Commissioner or his or her designee shall be an ex-officio member of the committee.

(b) The following organizations shall each nominate two members to represent participants of CAIP:

1. The Alliance of American Insurers;
2. The American Insurance Association; and
3. The National Association of Independent Insurers.

(c) Participants which are not members of the organizations in (b) above shall nominate two members to represent participants in accordance with a fair method set forth in the plan of operation.

(d) The following organizations shall each nominate one member to represent producers:

1. Independent Insurance Agents of New Jersey;
2. Insurance Brokers Association of New Jersey; and
3. Professional Insurance Agents of New Jersey.

(e) All members shall be appointed by the Commissioner and shall serve for one year or until a successor is appointed. Each member may designate an alternate. In the event the Commissioner fails to appoint a nominee, the organization shall nominate another representative.

(f) The governing committee of the existing Commercial Automobile Insurance Plan shall act as the governing committee for CAIP until the CAIP governing committee is appointed pursuant to this section.

(g) All meetings of the governing committee shall be conducted in accordance with this subchapter and the plan of operation.

(h) Pursuant to this subchapter and the plan of operation, the governing committee shall have the following duties:

1. To assume the assets and liabilities of the Commercial Automobile Insurance Plan on behalf of the member insurers;

2. To assume the rights and obligations of the Commercial Automobile Insurance Plan on behalf of the member insurers;

3. To develop and submit for approval by the Commissioner.

i. A plan of operation; and

ii. A rating system, including rates, rules and forms;

4. To appoint, conditionally appoint or terminate:

i. A CAIP manager subject to approval by the Commissioner, which shall be located in this State;

ii. At least two servicing carriers; and

iii. Other employees, professionals, and contractors required to administer CAIP.

5. Enter into and/or negotiate contracts as are necessary or proper to carry out the provisions of this subchapter;

6. Sue or be sued in the name of the CAIP, including taking any legal actions measuring or proper for recovery of any assessments for, on behalf of or against members. A judgment against the CAIP shall not create any direct liability against the governing committee or its individual members, or the individual participating members of the CAIP.

7. To budget expenses, levy assessments, and disburse funds;

8. To investigate complaints and hear appeals from applicants, insureds, producers, servicing carriers or participants about any matter pertaining to the proper administration of the CAIP;

9. To arrange for an independent audit of CAIP each year which shall include all servicing carriers;

10. To furnish all participants with:

- i. An annual written operations report;
- ii. The approved annual budget upon request;
- iii. A copy of the annual audit upon request;
- iv. A copy of the plan of operation, and all amendments;
- v. A copy of all rates, rules and manuals upon request; and
- vi. A copy of the minutes from all meetings upon request;

11. To audit the records of any participant relating to the subject matter of CAIP and establish such policies, records, books of account, documents and related material which shall be maintained for the proper administration of CAIP;

12. To perform such other functions as may be necessary and proper to administer CAIP in accordance with this subchapter and the approved plan of operation;

13. To indemnify on behalf of the member insurers each member of the governing committee, and employees for any and all claims, suits, costs of investigations, costs of defense, settlements or judgments against them on account of an act or omission in the scope of the member's duties or employee's employment. CAIP shall refuse to indemnify if it determines that the act or failure to act was due to actual fraud, willful misconduct or actual malice.

14. Appoint from among its members or from qualified nonmembers appropriate legal, actuarial, claims, and other committees as necessary to provide technical assistance in the operation of the CAIP, policy and other contract design, and any other function within the authority of the CAIP;

- i. The Commissioner or his or her designee may serve as an ex-officio, non-voting member of any committee (except the appeals subcommittee) established pursuant to this section.

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

Rewrote (a)1 and (a)4.

Case Notes

Governing committee of Commercial Automobile Insurance Plan (CAIP) could not decide servicing carrier's claim for exception to limitations period on corrections and adjustments to premium data for apportioning profits and losses of CAIP; six of 11 members of governing committee had per se conflict of interest, as they were employees of other plan participants, and granting carrier requested relief would have resulted in their employers bearing brunt of two million dollar reallocation. Matter of Appeal by Progressive Cas. Ins. Co., 704 A.2d 562, 307 N.J.Super. 93 (A.D.1997).

Commissioner lacked authority to create Appeals Subcommittee composed of industry employees to hear premium disputes under policies issued pursuant to Commercial Automobile Insurance Plan. Chopper Exp., Inc. v. Department of Ins. of State of N.J., 293 N.J.Super. 536, 681 A.2d 1226 (A.D.1996).

11:3-1.5 Participation

(a) At the end of each fiscal period, CAIP's operating profit or loss shall be determined separately for each policy year. Profit shall be credited or distributed to each participant and loss shall be charged against each participant in proportion to each participant's "net participation percentage" for the second prior year which resulted in the profit or loss.

(b) All data necessary to comply with the foregoing participation procedures shall be reported to the CAIP's central statistical agent in the manner described in the approved statistical plan.

(c) Groups of participants under the same ownership and management shall be treated as a single participant. Groups of participants under either the same ownership or management, but not both, may elect to be treated either separately or as a single company.

(d) In the event a participant discontinues writing motor vehicle liability or physical damage insurance in this State and retains its certificate of authority to write such business, it shall continue to pay assessments, provided, however, that if the automobile liability or physical damage business of a participant discontinuing the writing of automobile liability or physical damage insurance in this State has been purchased by, transferred to, or reinsured by another company, the latter shall receive the assessments of the former.

(e) In the event a participant is merged with another company or there is a consolidation of companies, the continuing company shall receive the assessments of the company merged or consolidated, provided, however, the continuing company may be relieved from such obligations if another company has agreed, in a manner satisfactory to the governing committee, to assume such obligations.

(f) Participation shall be suspended upon order of the Commissioner of Banking and Insurance if he or she finds that such action is required by the financial condition of that participant.

(g) All participants in CAIP shall participate in the business written by the Commercial Automobile Insurance Plan pursuant to an approved plan of operation.

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-1.6 Plan of operation

(a) The plan of operation shall provide for the prompt and efficient provision of automobile insurance to qualified applicants. The plan of operation shall provide for, among any other matters:

1. The internal organization and proceedings of the governing committee;

2. Standards and procedures for the appointment, compensation, and termination of and performance standards for the CAIP manager, other employees, professionals and contractors required to administer CAIP along with a producers certification program;

3. Standards and procedures for the number, selection, appointment, compensation, termination of and performance standards for servicing carriers, and the distribution of assignments to those servicing carriers.

4. The extent of coverage to be offered by CAIP to eligible applicants;

5. Procedures to apply for coverage;

6. Premium rules, surcharges and minimum premiums;

7. Procedures for handling premium charge-offs;

8. Procedures for the performance of preliminary premium audits on certain risks identified by the governing committee and approved by the Commissioner;

9. Procedures for a servicing carrier performance audit program;

10. Establishment of a Producer Compliance Unit which shall report directly to the CAIP manager;

11. The amount of commissions to be paid producers;

12. Provisions for the cancellation or the nonrenewal of policies;

13. Methods and means for the collection, investment and disbursement of funds;

14. Development and maintenance of a statistical plan, and manuals incorporating that plan, which shall be subject to the prior approval by the Commissioner in the same manner as the plan of operation;

15. A voluntary depopulation credit program which shall be used in calculating a participant's net participation for the CAIP;

16. Procedures for the provision of coverage to good faith applicants where a producer has violated plan rules; and

17. Development of a basic servicing carrier contract, procedures for making modifications to that contract and the establishment of a specified term to that contract, which term shall not exceed five years.

(b) For the purpose of conformance with the amendments to this chapter effective October 21, 1996, the governing committee shall, by January 19, 1997, submit to the Commissioner, for his or her review and approval, proposed revision to the plan of operation. The governing committee may propose amendments to the plan of operation at any time.

(c) The proposed plan and any amendments shall be reviewed by the Commissioner and approved by him or her if he or she finds it fulfills the purposes provided by this subchapter. If approved, the Commissioner shall certify approval to the governing committee and the plan of operation or amendments shall take effect 10 days after such certification.

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 90 days from the effective date of these amendments or a new plan which is acceptable to the Commissioner within 90 days after the disapproval of a proposed plan, the Commissioner may promulgate a plan of operation and certify same to the governing committee.

3. Any such plan approved by the Commissioner shall take effect 10 days after the certification to the governing committee; provided, however, that until a plan of operation is in effect pursuant to the provisions of this subchapter, the existing Commercial Automobile Insurance Plan temporary placement facility shall be continued in effect. Each participant shall continue to comply with the Commercial Automobile Insurance Plan with respect to all business written under the procedure prior to the effective date of the CAIP plan of operation.

(d) The Commissioner may propose an amendment to the plan of operation by communicating the proposed amendment to the governing committee. If the governing committee does not adopt amendments acceptable to the Commissioner within 30 days, the Commissioner may certify amendments with an effective date to the governing committee. For good cause shown, the Commissioner may certify proposed amendments two days after copies of the proposed amendments are provided to the governing committee.

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

In (a), in the first sentence of the main paragraph, substituted "qualified" for "eligible" preceding "applicants"; added new 3, recodified existing 3-16 as 4-17, rewrote new 17.

Case Notes

Former New Jersey assigned risk scheme in automobile liability coverage mentioned in discussion of methods available to a state to deal with the social consequences of adverse risk selection. *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).

Broker who mailed application for automobile insurance after expiration of prior policy was not de facto agent of servicing insurer under assigned risk plan and lacked authority to bind servicing insurer. *Rodriguez v. Hudson County Collision Co.*, 296 N.J.Super. 213, 686 A.2d 776 (A.D.1997).

11:3-1.7 Coverage

(a) CAIP shall provide to qualified applicants, bodily injury liability and property damage liability coverages as follows:

1. CAIP shall provide basic combined single limit of \$35,000 and statutory uninsured motorist coverage except:

i. When limits in excess of the basic combined single limit of \$35,000 are required by law, the plan shall offer limits adequate to comply with the minimum requirements of that law, except with respect to limits over \$5 million in which case excess coverage is conditioned upon the plan being able to secure facultative reinsurance. CAIP shall provide a policy for limits less than the minimum requirements of the law when evidence of adequate excess insurance is provided by the producer or the insured.

ii. CAIP shall provide limits adequate to comply with the provisions of the financial responsibility law of any state in which the motor vehicle will be operated, but only while the vehicle is being operated in that state.

iii. CAIP shall also offer the optional limits of liability as specified in the plan of operation.

(b) CAIP shall offer to qualified applicants, additional uninsured or underinsured motorist coverage as follows:

1. Additional uninsured and underinsured motorist coverage shall be provided as an option to the named insured up to the limits set forth in N.J.S.A. 17:28-1.1b and subject to the deductibles specified in the plan of operation. The limits for uninsured and underinsured motorist coverage shall not exceed the insured's motor vehicle liability policy limits for bodily injury and property damage respectively.

2. Uninsured and underinsured motorist coverage shall not be increased by stacking the limits of coverage of multiple motor vehicles covered under the same policy of insurance nor shall these coverages be increased by stacking the limits of coverage of multiple policies available to the insured. If the insured had uninsured motorist coverage available under more than one policy, any recovery shall not exceed the higher of the applicable limits of the respective coverages and the recovery shall be prorated between the applicable coverages as the limits of each coverage bear to the total of the limits.

3. Uninsured motorist coverage shall be subject to the policy terms, conditions and exclusions approved by the Commissioner, including, but not limited to, unauthorized settlements, nonduplication of coverage, subrogation and arbitration.

(c) CAIP shall provide to qualified applicants, standard and additional personal injury protection coverage as follows:

1. With respect to those automobiles subject to the New Jersey Automobile Reparation Reform Act, N.J.S.A. 39:6A-1 et seq., CAIP shall provide personal injury protection coverage under every automobile liability policy as required by the Act and shall also offer to the named insured Additional Personal Injury Protection as required by the Act and by regulations promulgated by the Commissioner thereunder.

(d) CAIP shall provide to qualified applicants, physical damage coverage as follows:

1. CAIP shall only offer physical damage coverage to:

- i. Private passenger vehicles;
- ii. Private passenger type vehicles;
- iii. Light trucks;
- iv. Motorcycles;
- v. Recreational trailers (excluding trailers used as residences); and
- vi. Social services vehicles of the private passenger, station wagon, van or minibus type owned by or operated on behalf of a non-profit entity used to transport persons without charge.

2. Notwithstanding (d)1 above, as necessary to ensure the plan's efficient operation, the CAIP Plan of Operation shall provide that physical damage coverage shall not be offered to certain vehicles, including, but not limited to:

- i. Risks consisting of fleets of 10 or more vehicles not including trailers and semi-trailers;
- ii. Vehicles more than 25 or more years old;
- iii. Vehicles with a seating capacity in excess of 20;
- iv. Any emergency type vehicle; and

v. Any vehicle which is operated under a registration plate not issued for a specific vehicle.

3. Comprehensive and collision coverage shall be provided on an actual cash value basis, less deductible, subject to a maximum loss payable of such amount at which physical damage coverage may be exported in accordance with the exportable list promulgated by the Commissioner pursuant to N.J.S.A. 17:22-6.43. CAIP shall also offer optional higher deductibles as specified in the plan of operation.

4. Physical damage coverage shall be offered only in connection with a policy written by the plan affording bodily injury and property damage coverage.

5. Upon request, CAIP shall issue a loss payable clause for the benefit of a lienholder.

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

In (c), substituted "standard" for "basic" following "applicants," in the introductory paragraph, and inserted N.J.S.A. reference and deleted "basic" following "provide" in 1.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

In (d)1vi, inserted "persons" preceding "without charge" and deleted "the elderly or handicapped".

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

Substituted "qualified" for "eligible" throughout; rewrote (d)2 main paragraph.

11:3-1.8 Qualification

(a) As a prerequisite for insurance from CAIP, a prospective insured must attempt, within 60 days prior to the date of application, to obtain automobile insurance in New Jersey, and be unable to obtain such insurance. The prospective insured must certify, in the application form prescribed by CAIP, that the applicant has attempted, but has been unable, to obtain automobile insurance in New Jersey through ordinary methods. An applicant so certifying shall be considered for assignment upon making application in good faith to the CAIP. An application shall be considered in good faith if he or she reports all information of a material nature and does not willfully make incorrect or misleading statements of a material nature in the prescribed application form approved by the Commissioner.

(b) For any risk consisting of 10 or more vehicles, the applicant must also provide:

1. A copy of the notice of cancellation or nonrenewal from the applicant's previous insurer, or an explanation concerning why the applicant was not insured; and

2. A certification that the applicant has been refused insurance within 60 days of the date of application from at least three named insurers licensed to transact automobile business in New Jersey. Such certification shall list the three insurers.

(c) No producer shall bind a risk for CAIP or submit an application for insurance to CAIP if such producer knows that the risk currently has or has been offered coverage from the voluntary market.

(d) A qualified applicant shall not be afforded coverage until it:

1. Submits an application as prescribed in the plan of operation;

2. Pays the premium, or portion thereof, required in the plan of operation;

3. Is accepted for coverage by CAIP as provided for in the plan of operation; and

4. Completes such other requirements as set forth in the plan of operation.

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

In (d), in the main paragraph substituted "qualified" for "eligible".

Case Notes

Broker who mailed application for automobile insurance after expiration of prior policy was not de facto agent of servicing insurer under assigned risk plan and lacked authority to bind servicing insurer. *Rodriguez v. Hudson County Collision Co.*, 296 N.J.Super. 213, 686 A.2d 776 (A.D.1997).

11:3-1.9 Rates and policy forms

(a) CAIP shall continue to use the rates, rules, surcharges, minimum premiums, classifications and policy forms approved for the Commercial Automobile Insurance Plan until modified or changed pursuant to this subchapter.

(b) The governing committee shall file all rates, rules, surcharges, minimum premiums, classifications and policy forms to be used by CAIP for the prior approval of the Commissioner. Proceedings to review these filings shall be conducted pursuant to N.J.S.A. 17:29A-1 et seq. All rates shall consider the experience of risks insured by the plan and shall not be excessive, inadequate or unfairly discriminatory. Every rate filing shall include an analysis of the adequacy of the rating plans.

(c) Premiums for risks shall be subject to the rating plan established in the plan of operation.

(d) Any risk with five or more vehicles not including trailers and semi-trailers shall be considered as a fleet. CAIP shall file base rates for fleets with the Commissioner for his or her prior approval which are different than the rates for non-fleet risks if CAIP determines that the loss expectancy of fleet risks insured by CAIP is different than the loss expectancy of non-fleet risks insured by CAIP.

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

Moved "Every rate filing shall include an analysis of the adequacy of the rating plans." from end of (c) to end of (b); in (c), substituted "Premiums for risks shall be subject to the" for "For any risk with less than 10 vehicles, the premium shall be subject to a merit"; substituted "five" for "10" preceding "or more vehicles"; deleted (e) and (f).

11:3-1.10 Right to petition for appeal to the Commissioner

(a) An applicant, insured, producer, servicing carrier 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 in accordance with applicable provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

SUBCHAPTER 2. NEW JERSEY PERSONAL AUTOMOBILE INSURANCE PLAN

11:3-2.1 Purpose and scope

(a) This subchapter establishes a plan pursuant to N.J.S.A. 17:29D-1 for the providing and apportionment of personal private passenger automobile insurance coverage for automobiles which are owned or operated by qualified applicants.

(b) The purposes of this subchapter are:

1. To provide the coverages described herein, subject to the conditions stated;

2. To establish a procedure for the equitable distribution of risks assigned to insurance companies; and

3. To preserve to the public the benefits of price competition by encouraging maximum use of the voluntary private insurance system.

(c) The provisions of this subchapter shall apply to all insurers admitted to transact private passenger automobile insurance in this State and all qualified applicants for automobile insurance through the PAIP, except as otherwise provided in this subchapter.

11:3-2.2 Definitions

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

An "affiliate" of, or a person "affiliated" with, a specific person, means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

"Automobile" means a private passenger automobile of a private passenger or station wagon type that is owned or hired, and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or camper type vehicle used for recreational purposes, owned by an individual or jointly by individuals who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching; and solely for the purpose of this plan, a motorcycle as defined in N.J.S.A. 39:1-1. An automobile owned by a farm family copartnership or corporation, which is principally garaged on a farm or ranch and otherwise meets this definition, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.

"Automobile insurance" means direct insurance against injury or damage, including the legal liability therefor, arising out of the ownership, operation, maintenance or use of automobiles, including, but not limited to, personal injury protection insurance, bodily injury liability insurance, property damage liability insurance, physical damage insurance, and uninsured and underinsured motorist insurance.

"Automobile insurance urban enterprise zone" or "UEZ" means a geographic area identified by zip codes and designated by the Commissioner pursuant to N.J.A.C. 11:3-46.

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

"Department" means the New Jersey Department of Banking and Insurance.

"Insurer" means any person or persons, corporation, association, partnership, company, or other legal entity authorized to transact the business of private passenger automobile insurance in this State, except any residual market mechanism created by or pursuant to statute.

“LAD carrier” means a limited assignment distribution carrier which is a participating insurer which agrees to accept the assignments of another insurer pursuant to this subchapter and procedures set forth in the plan of operation.

“PAIP” means the Personal Automobile Insurance Plan established pursuant to this subchapter.

“Personal private passenger automobile insurance” means a policy of automobile insurance principally used to provide primary insurance on private passenger automobiles which are owned individually, or jointly by individuals who are residents of the same household, and used for personal, family, or household needs.

“Qualified eligible person” means a person who meets the definition of an eligible person at N.J.A.C. 11:3-34.4 but who has been denied an automobile insurance policy by an insurer permitted to use its alternate underwriting rules pursuant to N.J.A.C. 11:3-35A.

Amended by R.1993 d.548, effective November 15, 1993.

See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Amended by R.2004 d.165, effective April 19, 2004.

See: 35 N.J.R. 4429(a), 36 N.J.R. 1929(a).

Added “Automobile insurance urban enterprise zone” and “Qualified eligible person”.

11:3-2.3 Creation of the plan

(a) There is created in the State of New Jersey a plan for the administration and apportionment of personal private passenger automobile insurance for qualified applicants to be known as the New Jersey Personal Automobile Insurance Plan, hereafter referred to as “PAIP.”

(b) The PAIP shall be administered by a governing committee pursuant to this subchapter and a plan of operation approved by the Commissioner.

(c) The administrative offices of the PAIP shall be located within the State of New Jersey.

11:3-2.4 Exemptions

(a) Every insurer shall participate in the PAIP to the extent required by this subchapter and the plan of operation.

(b) The requirements of this subchapter shall not apply to the following:

1. Insurers that have not issued or renewed policies of private passenger automobile insurance in New Jersey since December 31, 1983;

2. Insurers that have issued or renewed policies of private passenger automobile insurance in New Jersey since December 31, 1983, but only in accordance with a

commercial lines rating system filed and approved pursuant to N.J.S.A. 17:29AA-1 et seq.

3. Insurers transacting private passenger automobile insurance business in New Jersey subject to a plan of orderly withdrawal approved in accordance with N.J.A.C. 11:2-29, but only to the extent that waiver of participation in the PAIP is explicitly provided by the terms of the approved plan of orderly withdrawal; or

4. Insurers transacting private passenger automobile insurance business in New Jersey subject to an order issued by the Commissioner in accordance with N.J.S.A. 17:33B-23 and 24, but only to the extent provided by the terms of the order.

(c) Insurers that currently insure, or have insured since December 31, 1983, only certain types of automobiles (for example, motor homes, recreational vehicles, antique automobiles or motorcycles) shall participate in the PAIP but only for the particular types of automobiles currently being insured.

(d) Insurers claiming to be excluded from participation pursuant to the provisions of (b) or (c) above shall comply with the following:

1. Such insurers shall file with the PAIP no later than 60 days from the effective date of this rule a certified statement containing the following information:

i. The insurer's name, including the NAIC group number;

ii. A statement that the insurer is not required to participate in the PAIP or receive assignments through the PAIP;

iii. The factual basis upon which the insurer relied to determine that it is not required to comply fully with this subchapter;

iv. The particular provision of this rule under which the insurer is included; and

v. A certification by an officer of the insurer that the statement is complete, correct and accurate to the best of the officer's information, knowledge and belief based upon the officer's personal review of all relevant records.

2. The certified statement shall be sent to the PAIP at the following address:

PAIP Exemptions

New Jersey Personal Automobile Insurance Plan

2000 Midlantic Drive

Laurel Corporate Center

Suite 450

Mt. Laurel, NJ 08054

3. A copy of the information filed pursuant to (c)1 and 2 above shall be filed with the Department at the following address:

ARM Unit
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625-0325

New Rule, R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-2.5 Governing committee

(a) The PAIP shall be administered by a governing committee of 14 members.

1. Eight members shall be salaried employees of an insurer which is a participant in PAIP.
2. Three members shall be licensed producers.
3. One member shall be a public representative who is knowledgeable about automobile insurance matters but who is not employed by, or otherwise affiliated with, insurers, insurance producers, or other entities of the insurance industry.
4. One member shall be a salaried employee of an approved LAD carrier for the PAIP, provided that neither the LAD carrier nor any affiliate of the LAD carrier otherwise serves as a member of the governing committee.
5. The Commissioner shall be an ex-officio, non-voting member of the committee. The Commissioner may designate an alternate.

(b) The following organizations shall each nominate two members to represent insurer participants of PAIP:

1. The Alliance of American Insurers;
2. The American Insurance Association; and
3. The National Association of Independent Insurers.

(c) Insurers which are not members of the organizations in (b) above shall nominate two members to represent insurer participants in accordance with a fair method set forth in the plan of operation.

(d) The following organizations shall each nominate one member to represent producers:

1. Independent Insurance Agents of New Jersey;
2. Insurance Brokers Association of New Jersey; and
3. Professional Insurance Agents of New Jersey.

(e) All members shall be appointed by the Commissioner. The members of the initial governing committee appointed pursuant to this subchapter shall serve for two years or until a successor is appointed. Thereafter, all members shall serve for one year or until a successor is appointed. Each member may designate an alternate. In the event the Commissioner fails to appoint a nominee, the organization shall nominate another representative.

(f) All meetings of the governing committee shall be conducted in accordance with this subchapter and the plan of operation.

(g) The governing committee shall have the power and duty to:

1. Develop and submit for approval to the Commissioner:
 - i. A plan of operation;
 - ii. A rating system, including rates, rules and forms; and
 - iii. A plan for a producer certification program, which may not exclude those producers with no affiliation with an insurer.
2. Appoint, conditionally appoint or terminate:
 - i. A PAIP manager, subject to approval by the Commissioner, which shall be located in this State, to be responsible for the conduct and administrative affairs of the PAIP; and
 - ii. Other employees, professionals, and contractors required to administer the PAIP.
3. Enter into contracts as are necessary or proper to carry out the provisions of this subchapter;
4. Sue or be sued in the name of the PAIP, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members. A judgment against the PAIP shall not create any direct liability against the governing committee or its individual members, or the individual participating members of the PAIP. The PAIP shall not be liable for claims made on or pursuant to individual policies issued through the PAIP;
5. Budget expenses, levy assessments, and disburse funds;
6. Investigate complaints and hear appeals from applicants, insureds, producers, LAD carriers, or insurers about any matter pertaining to the proper administration of the PAIP;
7. Arrange for the independent audit of the PAIP each year;
8. Furnish all insurers with:
 - i. An annual written operations report;

- ii. The approved annual budget upon request;
- iii. A copy of the annual audit upon request;
- iv. A copy of the plan of operation, and all amendments;
- v. A copy of all policy forms, rates, rules and manuals upon request; and
- vi. A copy of the minutes from all meetings upon request;

9. Audit the records of any insurer relating to the subject matter of PAIP and establish such policies, records, books of account, documents and related material which shall be maintained for the proper administration of PAIP;

10. Indemnify each member of the governing committee and PAIP employees for any and all claims, suits, costs of investigations, cost of defense, and settlements or judgments against them on account of an act or omission in the scope of the member's duties or employee's employment. The PAIP shall refuse to indemnify if it is determined that the act or failure to act was due to actual fraud, willful misconduct or actual malice;

11. Appoint from among its members or from qualified nonmembers appropriate legal, actuarial, claim, and other committees as necessary to provide technical assistance in the operation of the PAIP, policy and other contract design, and any other function within the authority of the PAIP;

- i. The Commissioner may serve as an ex-officio, non-voting member of any committee established pursuant to this section. The Commissioner may designate an alternate; and

12. Perform such other functions as may be necessary and proper to administer PAIP in accordance with this subchapter and the approved plan of operation.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3-2.6 Plan of operation

(a) The plan of operation shall provide for the prompt and efficient provision of personal private passenger automobile insurance to qualified applicants. The plan of operation shall provide for, among other matters:

- 1. The internal organization and proceedings of the governing committee;
- 2. Standards and procedures for:
 - i. The appointment, compensation, and termination of producers, the PAIP manager, and other employees, professionals and contractors required to administer the PAIP;
 - ii. The appointment, compensation, and termination by insurers of LAD carriers (consistent with any

requirements established by regulation by the Commissioner);

3. Performance standards for insurers, producers, LAD carriers, the PAIP manager, and other employees, professionals and contractors required to administer the PAIP;

4. A producer certification program, which may not exclude producers with no affiliation with a voluntary market insurer;

5. The extent of coverage to be offered by PAIP to qualified applicants;

6. Procedures to apply for coverage;

7. Commissions to be paid producers;

8. Procedures for cancellation or the nonrenewal of policies;

9. Methods and means for the collection, investment and disbursement of funds;

10. Development and maintenance of a statistical plan and manuals incorporating that plan, which shall be subject to the prior approval by the Commissioner in the same manner as the plan of operation; and

11. Such other provisions as are deemed necessary by the governing committee for the operation of the PAIP.

(b) The governing committee shall, by May 1, 1992, submit to the Commissioner, for his or her review and approval, a proposed plan of operation. The governing committee may propose an amendment to the plan of operation at any time.

(c) The proposed plan and any amendments shall be submitted to the Commissioner for his or her review and approval. 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 May 1, 1992, 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.

3. The Commissioner may review the plan of operation at any time and may propose amendments to the governing committee. If the governing committee does not adopt amendments acceptable to the Commissioner within 30 days, the Commissioner may certify amendments and their effective date to the governing committee.

tee. For good cause shown, the Commissioner may certify proposed amendments two days after copies of the proposal are provided to the governing committee.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3-2.7 Coverage

(a) PAIP shall provide to qualified applicants bodily injury liability, property damage liability, personal injury protection, uninsured/underinsured motorists and physical damage coverages at the minimum levels required by law, including all options related thereto.

(b) PAIP shall provide a variety of increased limits for the above coverages up to the following:

1. \$250,000 per person/\$500,000 per accident for bodily injury liability coverage, and \$100,000 for property damage liability coverage, or a combined single limit of \$500,000 for bodily injury liability and property damage liability coverage;

2. \$250,000 per person/\$500,000 per accident for uninsured/underinsured motorists bodily injury liability coverage and \$100,000 for uninsured/underinsured motorists property damage liability coverage, or a combined single limit of \$500,000 for uninsured/underinsured bodily injury liability and property damage liability coverages.

(c) The PAIP shall provide additional personal injury protection coverages as set forth in N.J.S.A. 39:6A-10.

(d) The PAIP shall provide physical damage coverages with no less than the minimum deductibles required pursuant to N.J.S.A. 17:29A-39. PAIP shall offer higher deductibles as provided by N.J.A.C. 11:3-13.3.

1. All physical damage coverages shall be on an "actual cash value" basis, less deductible, subject to a maximum loss payable of \$30,000, or such amount at which physical damage coverage may be placed in the surplus lines market as set forth on the exportable list promulgated by the Commissioner pursuant to N.J.S.A. 17:22-6.43.

2. For purposes of this section, "actual cash value" means the replacement cost of the automobile, less physical depreciation.

Case Notes

Motorcycle insurer, which provided only the statutory minimum third-party coverages was not obligated to offer insured opportunity to purchase underinsured motorist (UIM) coverage up to combined statutory limit, since insureds could not purchase UIM coverage above their liability limits. *Selective Ins. Co. of America v. Hojnoski*, 317 N.J.Super. 331, 722 A.2d 118 (A.D.1998).

11:3-2.8 Eligibility

(a) PAIP shall provide coverage to all qualified applicants. For purposes of this subchapter, a "qualified applicant" means:

1. A person who is not an "eligible person" as defined in N.J.A.C. 11:3-34.4 or who is a qualified eligible person; and

2. A person domiciled in New Jersey, who is an owner of an automobile registered and principally garaged in this State or will be registered and principally garaged in this State within 60 days.

(b) "Qualified applicant" shall also include military personnel with respect to an automobile if, at the time application is made, the applicant is a nonresident who is stationed in this State, whose automobile is registered in another State and garaged in this State.

(c) No person shall, however, be deemed a qualified applicant, if the principal operator of the automobile to be insured does not hold a driver's license which is valid in this State; or if a regular operator of the automobile other than the principal operator does not hold such a license; or if timely payment of premium is not tendered; or if the principal operator of the automobile does not furnish the information necessary to effect insurance; or if such person rents or leases automobiles to others which are used for commercial purposes.

(d) As a prerequisite to consideration for assignment under the PAIP, the applicant must certify, in the prescribed application form approved by the Commissioner, that he or she has attempted, within 60 days prior to the date of application, to obtain automobile insurance in the State and that he or she is a qualified applicant as set forth in (a), (b) and (c) above. An applicant so certifying shall be considered for assignment upon making application in good faith to the PAIP. An application shall be considered in good faith if he or she reports all information of a material nature and does not willfully make incorrect or misleading statements in the prescribed application form approved by the Commissioner.

(e) The governing committee shall establish procedures in the plan of operation with respect to documentation to be provided by the applicant and producer showing 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;
3. Claim history for the preceding three years;
4. Driving history for each operator; and
5. Copies of vehicle registration(s).

(f) The governing committee shall establish procedures for the cancellation or nonrenewal of policies to persons who are not or are no longer qualified applicants.

SUBCHAPTER 2A. SPECIAL AUTOMOBILE INSURANCE POLICY

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, and 39:6A-3.2 and 3.3.

Source and Effective Date

R.2003 d.497, effective December 15, 2003.
See: 35 N.J.R. 3519(b), 35 N.J.R. 5599(a).

11:3-2A.1 Purpose and scope

(a) The purpose of this subchapter is to assist certain low income individuals in this State and encourage their greater compliance in satisfying the mandatory private passenger automobile insurance requirements imposed by N.J.S.A. 39:6A-3.2.

(b) This subchapter shall apply to all insurers transacting private passenger automobile insurance in this State, the PAIP and to all insurance producers licensed in this State.

11:3-2A.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 Banking and Insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“Emergency care” means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include, but not be limited to, immediate pre-hospitalization care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. It shall also include all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement after the patient is discharged from acute care.

“Emergency personal injury protection coverage” means the payment of benefits without regard to negligence, liability or fault of any kind, only to the named insured and dependant members of his or her family, as defined by the Federal Medicaid program, residing in his or her household, who sustain bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering

into, alighting from or using the automobile of the named insured, with the permission of the named insured.

“Insurer” means an entity authorized or admitted to transact insurance in this State pursuant to N.J.S.A. 17:17-1 et seq. or 17:32-1 et seq., as applicable.

“Insurance producer” means a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance.

“LAD carrier” means a limited assignment distribution carrier that is a participating insurer and that agrees to accept assignments of another insurer pursuant to this subchapter and procedures set forth in the plan of operation.

“PAIP” means the New Jersey Personal Automobile Insurance Plan established pursuant to N.J.S.A. 17:29D-1 and N.J.A.C. 11:3-2.

“UCJF” means the Unsatisfied Claim and Judgment Fund, established pursuant to N.J.S.A. 39:6-61 et seq.

11:3-2A.3 General provisions

(a) The special automobile insurance policy shall be administered by the PAIP in accordance with a Special Policy plan of operation prepared by PAIP and approved by the Commissioner. The plan of operation shall include:

1. The procedure for the writing of Special Insurance Policies by:
 - i. Assignment of special automobile insurance policies to the member insurers of the PAIP pursuant to the apportionment methodology of the PAIP Plan of Operation; or
 - ii. The sharing of the premium, losses and expenses of the special automobile policies among the member insurers of the PAIP;
2. The designation of one or more LAD carriers or servicing carriers to issue and service special automobile insurance policies;
3. A rating system to be used for a special automobile insurance policy. The special automobile insurance policy shall have a Statewide uniform rate, established without regard to territorial or tier factors, to be utilized by all insurers. The Commissioner may adjust the rate annually by Order;
4. The policy form and the application for the special automobile insurance policy for the Special Policy, which shall clearly and conspicuously set forth the limitations on benefits provided under the policy;
5. A Coverage Selection Form for the Special Policy that meet the requirements of N.J.S.A. 39:6A-3.2 as amended by section 46 of P.L. 2003, c.89; and

6. Such other provisions as are deemed necessary by the Governing Committee for the operation of the PAIP.

(b) Special automobile insurance policies shall not be included in the determination of a competitive market pursuant to N.J.S.A. 17:33B-15d, as amended by § 38 of P.L. 2003, c.89.

11:3-2A.4 Eligibility for special automobile insurance policy

(a) The special automobile insurance policy shall only be available to individuals who are eligible for and enrolled in the Federal Medicaid program pursuant to N.J.S.A. 30:4D-3i(1) through (14).

(b) The PAIP special automobile insurance policy plan of operation shall provide procedures for verification of the Medicaid eligibility of applicants.

11:3-2A.5 Coverages

(a) The following coverages shall be included in all special automobile insurance policies:

1. Emergency personal injury protection coverage for emergency care not to exceed \$250,000 per person per accident; and
2. A death benefit in the amount of \$10,000.

(b) The limitation on lawsuit tort option provided in subsection a of N.J.S.A. 39:6A-8 shall apply to every named insured and any other person to whom the special automobile insurance policy applies.

(c) The special automobile insurance policy shall not provide liability, collision, comprehensive, uninsured or underinsured motorist coverage.

11:3-2A.6 Election of special automobile insurance policy

No insurer shall issue a special automobile insurance policy unless the named insured has signed a document entitled Special Policy Coverage Selection Form approved by the Commissioner.

SUBCHAPTER 2B. (RESERVED)

SUBCHAPTER 3. BASIC AUTOMOBILE INSURANCE POLICY

11:3-3.1 Purpose and scope

(a) This subchapter provides rules to be utilized by insurers in developing the policy forms and rates for basic automobile insurance policies to be filed with and approved by the Department in accordance with the provisions of N.J.S.A. 39:6A-3.1.

(b) This subchapter shall apply to all insurers writing private passenger automobile insurance on personal lines policy forms, including the New Jersey Personal Automobile Insurance Plan established by N.J.A.C. 11:3-2.

11:3-3.2 Definitions

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

“Basic automobile insurance policy” or “basic policy” means that automobile insurance policy offered pursuant to N.J.S.A. 39:6A-3.1 and this subchapter.

“Commissioner” means the Commissioner of the Department of Banking and Insurance.

“Department” means the Department of Banking and Insurance.

“Insurer” means any person or persons, corporation, association, partnership, company, reciprocal exchange, or other legal entity authorized or admitted to transact private passenger automobile insurance in this State, or any one member of a group of affiliated companies that transacts business in accordance with a common rating system.

“Medically necessary” is as defined in N.J.A.C. 11:3-4.2.

“Personal injury protection” or “PIP” means the benefits and coverages set forth at N.J.S.A. 39:6A-4 and 39:6A-3.1 and N.J.A.C. 11:3-4.

“Significant disfigurement” means the result and/or manifestation of a serious traumatic injury that is observable as a permanent and substantial defect in the appearance and functional ability of the person injured. “Significant disfigurement” is a serious outward change that substantially detracts from the appearance and functional ability of the person injured.

“Standard automobile insurance policy” or “standard policy” means that policy form filed by private passenger automobile insurers and approved by the Commissioner that contains the coverages and options pursuant to N.J.S.A. 39:6A-4.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c)
Inserted “Significant disfigurement”.

11:3-3.3 General provisions

(a) All insurers writing private passenger automobile insurance and the Personal Automobile Insurance Plan shall file for approval with the Department their rates, rules and policy forms for a basic automobile insurance policy to be issued in accordance with N.J.S.A. 39:6A-3.1 and this subchapter.

(b) An insurer shall make available the basic policy at either a single tier rate or at multiple tier rates, consistent with its tier rating system filed and approved pursuant to N.J.A.C. 11:3-19A. If more than one basic policy rate is offered, each shall be identified as part of a standard, non-standard or preferred tier.

(c) If a named insured has elected basic automobile insurance coverage and other immediate family members or resident relatives of the named insured have higher policy limits under a standard policy, the provisions of N.J.S.A. 39:6A-4.2 shall apply and the named insured shall only be entitled to the coverages provided under his or her basic policy.

(d) Basic policies shall provide the tort option provided under N.J.S.A. 39:6A-8a.

(e) Initial rates by coverage for basic policies filed in accordance with this subchapter shall demonstrate consistency with the rates in the insurer's standard policy, adjusted for reduced coverage limits.

(f) Insurers shall file for approval an initial basic policy rating system by January 20, 1999.

11:3-3.4 Coverages; mandatory and optional

(a) The following coverages shall be included in all basic policies:

1. Personal injury protection medical expense benefits coverage in an amount not to exceed \$15,000 per person, per accident; except that all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requiring critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician shall be covered in an amount not to exceed \$250,000, including the \$15,000 above. The medical expense benefits provided herein shall be in accordance with N.J.A.C. 11:3-4; and

2. Liability insurance coverage insuring against loss resulting from liability imposed by law for property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile in an amount or limit of \$5,000, exclusive of interest and costs, for damage to property in any one accident.

(b) Insurers shall also make available in the basic policy, at the option of the insured, liability insurance coverage for bodily injury or death in an amount or limit of \$10,000, exclusive of interest and costs, on account of the injury or death of one or more persons in any one accident.

(c) Insurers may make available with the basic policy, at the option of the insured, comprehensive and collision

coverage with deductibles filed and approved pursuant to N.J.A.C. 11:3-13.

(d) Basic policies shall not contain any other coverages, options, limits or deductibles other than those which are set forth in (a) through (c) above. Increased policy limits, the health insurance primary option for automobile medical expense coverage and uninsured/under-insured motorist coverages shall not be provided in basic policies.

11:3-3.5 Election of basic automobile insurance policy coverage and reporting

(a) No insurer shall issue a basic automobile insurance policy unless the named insured has signed a written document entitled "basic automobile insurance policy coverage selection form" set forth in N.J.A.C. 11:3-15.7.

(b) For the years 1999 through 2003, each insurer writing basic automobile insurance policies shall report the number of basic automobile insurance in-force exposures together with the age of the named insured and the territories in which the named insured resides on a form prescribed by the Commissioner and in accordance with the provisions of N.J.A.C. 11:3-3A.

Amended by R.2003 d.95, effective March 3, 2003.

See: 34 N.J.R. 3470(a), 35 N.J.R. 1289(a).

In (b), deleted "as of December 31" following "exposures", deleted ", and filed no later than the next occurring February 15" following "Commissioner" and added a N.J.A.C. reference.

11:3-3.6 Filing requirements

(a) Insurers initially filing basic policy rating systems shall include the following:

1. A complete set of policy forms and endorsements that provide the mandatory and optional coverages as set forth in this subchapter;
2. Rates and rules as necessary;
3. An actuarial memorandum that supports the rate differentials from the insurer's standard policy rates;
4. The declaration page;
5. The rating information form; and
6. The personal lines filing forms as set forth in N.J.A.C. 11:3-16.3(f) and (g).

(b) Subsequent amendments to the rating systems shall be filed pursuant to N.J.A.C. 11:3-16 and other applicable statutes and rules.

SUBCHAPTER 3A. REPORTING REQUIREMENTS AND FILING DEADLINES

Authority

N.J.S.A. 17:1-8.1, 17:1-15(e), 17:1C-19 and 17:29A-5.

Source and Effective Date

R.2003 d.95, effective March 3, 2003.
See: 34 N.J.R. 3470(a), 35 N.J.R. 1289(a).

11:3-3A.1 Purpose and scope

(a) This subchapter consolidates reporting obligations from various rules into one subchapter to result in one efficient, time-saving procedure.

(b) This subchapter applies to all insurers that write private passenger automobile insurance in this State as defined in N.J.A.C. 11:3-3A.2.

11:3-3A.2 Definitions

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

“Insurer” means any person authorized to write automobile insurance in New Jersey, including any residual market mechanism, and includes all affiliated companies with a group.

“Private passenger automobile” means a vehicle that meets the definition of “automobile” set forth at N.J.S.A. 39:6A-2.

11:3-3A.3 Report requirements

(a) All private passenger automobile insurers are required to file the following reports on a semi-annual basis, reflecting data from the last 12 months, and showing the residual market separately from the voluntary data, for the evaluation dates of December 31 and June 30 of each year:

1. The Consolidated Report;
2. The Limits of Liability Report;
3. The Coverage Option Survey—Personal Injury Protection (“PIP”) Deductibles, Threshold Options; and
4. PIP Medical Expense Limits Report.

(b) The Consolidated Report shall include the following reports: In Force Exposures; Primary Classification; Tier Report; and Basic versus Standard Exposures.

1. The Consolidated Report shall be filed in accordance with the template found at <http://www.state.nj.us/dobi>. The Consolidated Report forms shall be filed for the following four subheadings:

- i. Voluntary Standard Policy In-Force Exposure and Written Premiums;
- ii. Voluntary Basic Policy In-Force Exposures and Written Premiums;

iii. PAIP Standard Policy In-Force Exposures and Written Premiums; and

iv. PAIP Basic Policy In-Force Exposures and Written Premium.

2. The Consolidated Report shall:

i. Include the total number of exposures for each report itemized by classification, tier and territory;

ii. Be completed for each of the company’s rating tiers as well as a summary of all tiers combined;

iii. Include in-force exposure and written premium for each of 12 classifications based on age, gender and use; and

iv. Not be modified in any way except to include extra tiers within the original spreadsheet for insurers who have additional tiers not listed on the template.

(c) The Limits of Liability Report shall be provided on seven separate spreadsheets and shall be filed in accordance with the template found at <http://www.state.nj.us/dobi> which itemizes limits of liability by territory for the following subheadings:

1. Standard policy no threshold—bodily injury split limits of liability;
2. Standard policy verbal threshold—bodily injury split limits of liability;
3. Standard policy verbal threshold—property damage split limits of liability;
4. Standard policy no threshold—property damage split limits of liability;
5. Standard policy verbal threshold—combined single limit;
6. Standard policy no threshold—combined single limit; and
7. Basic policy—liability limits.

(d) The Coverage Option Survey—PIP Deductibles, Threshold Options Report shall be filed in accordance with the template found at <http://www.state.nj.us/dobi>, and shall:

1. Be filed for both standard policies and basic policies;
2. Reflect the total number of automobiles with in-force coverage; and
3. Indicate the named driver exclusion, medical expense only, personal injury protection deductible, health primary or automobile primary and lawsuit threshold or no threshold options selected with respect to each automobile by territory and total.

(e) The PIP Medical Expense Limits Report shall be filed in accordance with the template found at <http://www.state.nj.us/dobi>, listing the total number of standard and basic combined in-force exposures for the six standard medical expense limits (\$15,000; \$50,000; \$75,000; \$150,000; \$250,000; and excess of \$250,000) and total by territory.

(f) Reports with an evaluation date of December 31 shall be due by January 31.

(g) Reports with an evaluation date of June 30 shall be due by July 31.

(h) Reports shall be submitted using the Excel templates, available on the Department's website at <http://www.state.nj.us/dobi>, on one of the following media:

1. E-mail (preferred media);
2. CD-ROM; or
3. Floppy Diskette.

(i) The Excel templates shall not be modified by the user in any way except as stated above in (b)2iv above.

(j) Reports shall be submitted to:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
PO Box 325
Trenton, NJ 08625-0325
E-mail: reports@dobi.state.nj.us

11:3-3A.4 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties pursuant to N.J.S.A. 17:33-2 and as otherwise authorized by law.

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

11:3-4.1 Scope and purpose

(a) This subchapter implements the provisions of N.J.S.A. 39:6A-3.1, 39:6A-4 and 39:6A-4.3 by identifying the personal injury protection medical expense benefits and emergency personal injury protection coverage for which reimbursement of eligible charges will be made by automobile insurers under basic, standard and special automobile insurance policies and by motor bus insurers under medical expense benefits coverage.

(b) This subchapter applies to all insurers that issue policies of automobile insurance containing PIP coverage, emergency personal injury protection coverage and policies

of motor bus insurance containing medical expense benefits coverage.

(c) This subchapter shall apply to those policies that are issued or renewed on or after March 22, 1999.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

In (a), inserted "and emergency personal injury protection coverage" following "medical expense benefits", deleted "and" following "automobile insurers under basic", inserted "and special automobile insurance" preceding "policies and by motor bus insurers"; in (b), inserted "emergency personal injury protection coverage" following "automobile insurance containing PIP coverage".

Case Notes

Statute and the regulations promulgated by the Commissioner represented a complex legislative and regulatory package designed to reform automobile insurance law in New Jersey, and the courts of New Jersey were in the best position to consider the validity of the applicable regulations under state law. *Chiropractic America v. Lavachchia*, 180 F.3d 99 (3rd Cir. N.J. 1999).

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. *Quality Health Care v. DOBI*, 348 N.J.Super. 272, 791 A.2d 1085.

11:3-4.2 Definitions

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

"Basic automobile insurance policy" or "basic policy" means those private passenger automobile insurance policies issued in accordance with N.J.S.A. 39:6A-3.1 and N.J.A.C. 11:3-3.

"Clinically supported" means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
2. Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;
3. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

"Decision point" means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. The determina-

tion whether to administer one of the tests listed in N.J.A.C. 11:3-4.5(b) is also a decision point for both identified and all other injuries.

“Decision point review” means the procedures in an insurer’s approved decision point review plan for the insurer to receive notice and respond to requests for proposed treatment or testing at decision points.

“Diagnostic test” means a medical service or procedure utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical therapy, chiropractic or psychological diagnosis, for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

“Eligible charge” means the treating health care provider’s usual, customary and reasonable charge or the upper limit of the medical fee schedule as found in N.J.A.C. 11:3-29.6, whichever is lower.

“Emergency care” means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

“Emergency personal injury protection coverage” means the coverage provided by a Special Automobile Insurance Policy pursuant to section 45 of P.L. 2003, c.89.

“Health care provider” or “provider” means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to:

1. A hospital or health care facility that is maintained by State or any political subdivision;
2. A hospital or health care facility licensed by the Department of Health and Senior Services;
3. Other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiological and diagnostic testing, free-standing emergency clinics or offices, and private treatment centers;

4. A nonprofit voluntary visiting nurse organization providing health care services other than a hospital;

5. Hospitals or other health care facilities or treatment centers located in other States or nations;

6. Physicians licensed to practice medicine and surgery;

7. Licensed chiropractors;

8. Licensed dentists;

9. Licensed optometrists;

10. Licensed pharmacists;

11. Licensed chiropodists (podiatrists);

12. Registered bioanalytical laboratories;

13. Licensed psychologists;

14. Licensed physical therapists;

15. Certified nurse mid-wives;

16. Certified nurse practitioners/clinical nurse-specialist;

17. Licensed health maintenance organizations;

18. Licensed orthotists and prosthetists;

19. Licensed professional nurses;

20. Licensed occupational therapists;

21. Licensed speech-language pathologists;

22. Licensed audiologists;

23. Licensed physicians assistants;

24. Licensed physical therapy assistants;

25. Licensed occupational therapy assistants; and

26. Providers of other health care services or supplies, including durable medical goods.

“Identified injury” means those injuries identified by the Department in the subchapter Appendix as being suitable for medical treatment protocols in accordance with N.J.S.A. 39:6A-3.1a and 39:6A-4a.

“Insurer” means any person or persons, corporation, association, partnership, company, reciprocal exchange or other legal entity authorized or admitted to transact private passenger automobile insurance in this State, or any one member of a group of affiliated companies that transacts business in accordance with a common rating system. Insurer does not include an entity that is self-insured pursuant to N.J.S.A. 39:6-52. For purposes of communicating with insureds and providers concerning the administration of decision point review plans, “insurer” also means the insurer’s PIP vendor.

(d) The informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the information in (d)1 through 9 below. In order to make the requirements of this subchapter easier for insureds and providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. How to contact the insurer or vendor to submit decision point review/precertification requests including the telephone, facsimile numbers or email addresses. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;

2. An explanation of the decision point review process including a list of the identified injuries and the diagnostic tests in N.J.A.C. 11:3-4.5(b). The materials shall include copies of the Care Paths or indicate how copies may be obtained;

3. A list of the medical procedures, treatments, diagnoses, diagnostic tests, durable medical equipment or other services that require precertification, if any;

4. An explanation of how the insurer will respond to decision point review/precertification requests, including time frames. The materials should indicate that:

i. Telephonic responses will be followed up with a written authorization, denial or request for more information within three business days;

5. An explanation of the insurer's option to require a physical examination pursuant to (e) below;

6. An explanation of the penalty co-payments imposed for the failure to submit decision point review/precertification requests where required in accordance with N.J.A.C. 11:3-4.4(d);

7. An explanation of the insurer's voluntary network or networks for certain types of testing, durable medical equipment or prescription drugs authorized by N.J.A.C. 11:3-4.8, if any;

8. An explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical equipment is denied or modified, including insurer's internal appeal process and how to use it; and

9. An explanation of the insurer's restrictions on assignment of benefits, if any.

(e) A physical examination of the injured party shall be conducted as follows:

1. The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic tests or durable medical equipment. An insurer shall include reasonable procedures for the notification of

the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or durable medical equipment will be denied for failure to appear at scheduled medical examinations.

2. The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice in (e)1 above unless the injured person agrees to extend the time period.

3. The medical examination shall be conducted by a provider in the same discipline as the treating provider.

4. The medical examination shall be conducted at a location reasonably convenient to the injured person.

5. The injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.

6. The insurer shall notify the injured person or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

7. Insurers may include in their description point review plan a procedure for the denial or reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

(f) In administering decision point review and precertification, insurers shall avoid undue interruptions in a course of treatment. As part of their decision point review plans, insurers may include provisions that encourage providers to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. An agreed comprehensive treatment plan may replace the requirements for notification to the insurer at decision points and for treatment, diagnostic testing or durable medical equipment requiring precertification. In addition, the insurer may provide that reimbursement for treatment, diagnostic tests or durable medical equipment consistent with the agreed plan will be made without review or audit.

(g) An insurer shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved fraud or misrepresentation, as defined in

N.J.A.C. 11:16-16.2, by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

Amended by R.2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Deleted a former (c); and recodified former (d) and (e) as (c) and (d).

Repeal and New Rule, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Section was "Decision point review".

11:3-4.8 Voluntary networks

(a) No insurer shall file a decision point review plan utilizing a voluntary network or networks unless the network is a health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and 8:38A-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6, or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and 8:38B.

(b) Voluntary networks may be offered for the provision of the following types of non-emergency benefits only:

1. Magnetic Resonance Imagery;
2. Computer Assisted Tomography;
3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs performed by the treating physician;
4. Durable medical equipment with a cost or monthly rental in excess of \$50.00; or
5. Prescription drugs.

(c) Insurers that offer voluntary networks either directly or through a PIP vendor shall meet the following requirements:

1. The insurer shall notify all insureds upon application for and issuance of the policy and upon renewal of the types of benefits for which it has voluntary networks. Use of the network by the insured is voluntary but bills for out-of-network services or equipment are subject to the penalty deductibles set forth in N.J.A.C. 11:3-4.4(f).
2. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make available to the insured and the treating medical provider information about approved networks and providers in

the network, including addresses and telephone numbers. Insureds shall be able to choose to go to any provider in the network.

(d) An insurer offering a voluntary network or networks directly or through a PIP vendor shall submit the following information to the Department with its Decision Point Review Plan:

1. A narrative description of the benefits to be offered through the network or networks;
2. The identity and a description of the network and the specific services or supplies to be provided by the network or networks;
3. A description of the procedures by which benefits may be obtained by persons using the network; and
4. A statement of how the network meets the requirement of (a) above.

(e) Any voluntary network used by an insurer pursuant to this subchapter shall agree to disclose to a participating provider, upon written request, a list of all the clients or other payers that are entitled to a specific rate under the network's contract with the participating provider.

Amended by R.2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Rewrote the section.

Repeal and New Rule, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

11:3-4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage. Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer's decision point review plan for making decision point review and precertification requests;
2. A requirement that as a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider's failure to follow the requirements of the insurer's Decision Point Review Plan; and/or
3. A requirement that as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

6. The plan shall provide for the fair and efficient conduct of adversarial hearings when other methods of dispute resolution are either unsuccessful or inappropriate, consistent with traditional notions of due process and fundamental fairness. It shall address, at least, the following procedural issues;

- i. Discovery;
- ii. Receipt of evidence by the dispute resolution professional;
- iii. Submission of briefs or memoranda of law and fact;
- iv. Provision for decisions without testimony on consent of parties;
- v. Notice and place of hearing;
- vi. Methods to request adjournments;
- vii. Presentation of testimony and evidence at a hearing; and
- viii. Supplementation of the record.

(c) If consistent with its dispute resolution plan, a dispute resolution organization may utilize one or more dispute resolution professionals specifically to handle preliminary matters on actions including motions to disqualify an appointed DRP.

11:3-5.5 Dispute resolution professionals

(a) A dispute resolution professional employed by the dispute resolution organization shall be either:

1. An attorney licensed to practice in New Jersey with at least 10 years' experience in cases involving personal injury or workers' compensation;
2. A former judge of the Superior Court or the Workers' Compensation Court, or a former Administrative Law Judge; or
3. Any other person, qualified by education and at least 10 years' experience, with sufficient understanding of automobile insurance claims and practices, contract law, and judicial or alternate dispute resolution practices and procedures.

(b) Dispute resolution professionals shall avoid conflicts of interest as prohibited at N.J.A.C. 11:3-5.12 in any matter assigned to them for determination.

1. Dispute resolution professionals shall complete and file with the dispute resolution organization a conflict of interest questionnaire that shall provide sufficient detail about financial interests of themselves and their immediate family so as to avoid any assignment to a particular case where there is a conflict of interest. Conflict of interest questionnaires shall remain confidential with the dispute resolution organization, and the information set forth therein shall only be disclosed as necessary to

individuals responsible for assigning cases to dispute resolution professionals, or reviewing motions to disqualify an assigned dispute resolution professional.

2. If during the course of an assignment a dispute resolution professional determines that he or she has conflict of interest, based upon facts determined in the course of the proceedings, then the DRP shall promptly advise the administrator of the circumstances, who shall assign another DRP.

3. A party may challenge the assignment of a particular DRP by submitting the specific grounds for challenge in accordance with the rules of the dispute resolution organization approved by the Commissioner.

(c) Dispute resolution professionals shall be compensated by the administrator in accordance with the terms of the contract designating the administrator. Compensation shall not be contingent in any way upon the decision or determination of the DRP.

(d) Dispute resolution professionals shall create and maintain such records as may be necessary to carry out their responsibilities and provide such records to the administrator as required in the contract designating the administrator.

11:3-5.6 Conduct of PIP dispute resolution proceedings

(a) A request for dispute resolution of a PIP dispute may be made by the injured party, the insured, a provider who is an assignee of PIP benefits or the insurer, in accordance with the terms of the policy as approved by the Commissioner. The request for dispute resolution may include a request for review by a medical review organization. The request shall be made to the administrator and copies sent to other parties.

1. Every insurer shall establish a single address where requests for dispute resolution shall be sent. Insurers shall notify the administrator of the address and any changes thereto. The administrator shall make the list of insurer addresses available to the user community on a web page and any other available means of communication.

(b) Upon receipt of the request, the administrator shall promptly assign the matter to dispute resolution professional. The administrator shall notify all parties of the DRP assigned.

(c) If the request for dispute resolution includes a request for review by a medical review organization, the administrator shall refer the matter to a certified medical review organization contemporaneously with the assignment of the DRP, and shall notify the parties and the DRP that the matter has been referred. If the initial request does not include a request for review by a medical review organization, then a request for such review may be made by any party to the assigned DRP. The DRP may refer a matter to a MRO on his or her own initiative upon a finding that the dispute concerns the diagnosis, medical necessity of treat-

ment or diagnostic test administered to the injured person, whether the injury is causally related to the accident or is the product of a preexisting condition, or the protocols utilized by a provider. Whenever a DRP receives or initiates a request for MRO review, he or she shall transmit it to the administrator for referral who shall refer the matter to a certified MRO and notify the parties that the matter has been referred.

1. The administrator shall refer cases on a random or rotating basis to an MRO that does not have a conflict of interest, in accordance with the administrator's dispute resolution plan. Referrals shall be made in such a manner so as not to disclose the medical reviewer the identity of the insurer, nor to disclose to the insurer the identity of the medical reviewer.

2. Upon request of the MRO, a provider whose services are the subject of review shall promptly furnish a written report of the history, condition, treatment dates and results of diagnostic tests performed, and shall produce and permit the copying and inspection of all records relating to the history, treatment and condition of the injured person, and shall submit all necessary documentation as requested. Upon request of the MRO through the administrator, the insurer shall submit any and all documentation concerning its review of the treatment and testing of the injured person, and any reports by its reviewing provider why reimbursement for the treatment, test or item of durable medical equipment was denied.

3. The MRO may request an injured person to submit to a mental or physical examination by an independent provider in the same discipline as the treating providers who is not affiliated with either the treating provider, the insurer or the MRO health care provider performing the review. Any such examination shall be conducted in a place reasonably convenient to the injured person. The MRO shall make available to the examining provider any pertinent medical records.

4. If at any time the MRO determines that it has a conflict of interest in performing a particular review, it shall notify the administrator which shall refer the case to another MRO.

i. Under such circumstances, the first-assigned MRO shall transmit to the newly assigned MRO such documents from the treating provider and the insurer as it has accumulated on the case, as may be directed by the administrator.

ii. The first-assigned MRO shall not be entitled to any reimbursement for work performed on the transferred case.

(d) Determination by the dispute resolution professional shall be in writing and shall state the issues in dispute, the DRP's findings and legal conclusions based on the record of the proceedings and the determination of the medical review organization, if any. The findings and conclusions shall be made in accordance with applicable principles of substantive law, the provisions of the policy and the Department's rules. The award shall set forth a decision on all issues submitted by the parties for resolution.

1. If the DRP finds that the determination of a medical review organization is overcome by a preponderance of the evidence, the reasons supporting that finding shall be set forth in the written determination.

2. The award shall apportion the costs of the proceedings, regardless of who initiated the proceedings, in a reasonable and equitable manner consistent with the resolution of the issues in dispute.

3. The award may include attorney's fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

(e) The award shall be signed by the dispute resolution professional. The original shall be filed with the administrator, and copies provided to each party. If the award requires payment by the insurer for a treatment or test, payment shall be made, together with any accrued interest pursuant to N.J.S.A. 39:6A-5, within 20 days of receipt of a copy of the determination.

(f) The final determination of the dispute resolution professional shall be binding upon the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A. 2A:23A-13 for review of the award.

Amended by R.2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

In (d)3, deleted "or respondent" following "successful claimant".

Amended by R.2004 d.218, effective June 7, 2004.

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a).

In (a), added 1.

Case Notes

N.J.A.C. 11:3-5.6(d)(3) was an invalid expression of legislative intent and was voided. *New Jersey Coalition of Health Care Professionals, Inc. v. New Jersey Department of Banking and Insurance, Division of Insurance*, 323 N.J.Super. 207, 732 A.2d 1063 (N.J.Super.A.D. 1999).

11:3-5.7 Recordkeeping

(a) The administrator shall maintain records of all determinations for a period of five years.

(b) The administrator shall file a copy of each determination, except consent determinations, with the Department in either hard copy or electronic form, as provided in the contract designating the administrator.

1. Any determination filed with the Department shall be indexed and coded so as to facilitate retrieval.

2. The name of any injured party, except when appearing in the caption of the matter or used as identification of the particular case, shall be redacted in the copy filed with the Department so as to protect the privacy of the injured person.

(c) The administrator shall keep such other records as may be required by the Commissioner and as set forth in the contract designating the administrator.

11:3-5.8 Medical review organizations

(a) Medical review organizations shall be authorized to determine in connection with the PIP dispute resolution process set forth in this subchapter:

1. Whether the medical treatment or diagnostic test is medically necessary;

2. Whether the treatment is in accordance with medically recognized standard protocols including those protocols approved by the Commissioner and set forth in N.J.A.C. 11:3-4;

3. Whether the treatment is consistent with symptoms or diagnosis of the injury;

4. Whether the injury is causally related to the accident ;

5. Whether the treatment is of a palliative rather than a restorative nature; and

6. Whether medical procedures and tests that have been repeated are medically necessary.

(b) The findings of a medical review organization shall be presumed to be correct, but may be rebutted by a preponderance of the evidence submitted to the dispute resolution professional.

11:3-5.9 Standards for medical review organizations

(a) Medical review organizations shall be capable of performing medical reviews for all primary specialties and disciplines.

(b) Medical review organizations shall employ a medical director to actively participate in the review of cases to assure quality and consistency.

(c) Medical review organizations shall utilize health care providers in the same discipline as the treating provider to perform the reviews who meet the following standards:

1. Reviewing health care providers shall be active practitioners who obtain a minimum of one-half of their income from practice in their area of specialty;

2. Reviewing health care providers shall be licensed in New Jersey and board certified in their specialty;

3. Reviewing health care providers shall have at least two years' experience in medical review, or be certified as a medical review physician; and

4. Reviewing health care providers shall have completed an orientation with the MRO, including medical review instruction and report writing.

(d) A medical review organization shall have adequate procedures in place to assure confidentiality of patient records.

1. All MRO files shall be indexed and referred to by reference number rather than patient name.

2. Medical files shall be maintained in a secure area of the MRO's offices.

3. Only the MRO shall request additional documents relating to the injured person's medical condition, or direct that the injured person be physically examined.

(e) A medical review organization shall utilize procedures to provide for the fair and open exchange of information and records related to the review between the treating health care provider, any provider that has reviewed the case on behalf of the insurer, and the MRO's reviewing health care provider.

(f) A medical review organization shall complete its review and submit its report to the dispute resolution professional in accordance with the medical exigencies of the case, but in no event in excess of 20 business days from receipt of medical records from the treating health care provider.

(g) A medical review organization shall have a procedure for obtaining mental or physical examinations of injured persons that may be required in the course of its review.

(h) A medical review organization shall utilize written review procedures. In reaching its determinations, the MRO shall consider all information submitted by the parties and information deemed appropriate by the MRO, including: pertinent medical records, consulting physician reports and other documents submitted by the parties; applicable commonly accepted protocols, professional standards and practices by national standard setting organizations, and protocols and diagnostic tests approved by the Commissioner and set forth in N.J.A.C. 11:3-4.

(i) A medical review organization shall utilize audit procedures to ensure compliance with statutory and regulatory requirements.

(j) A medical review organization shall retain records of its determinations for five years.

11:3-5.10 Medical review organization certification process

(a) The Commissioner shall certify a medical review organization to provide medical review services in connection

with the resolutions of PIP disputes if the Commissioner determines that the MRO complies with the standards set forth in N.J.A.C. 11:3-5.9 to provide an impartial review of the medical necessity or appropriateness of treatments, health care services or items of durable medical equipment for which medical expense benefits may be provided under personal injury protection coverage.

(b) For the purpose of obtaining certification by the Commissioner to act as a medical review organization to perform medical review in connection with the resolution of PIP disputes, an MRO shall submit two copies of a written application that sets forth the information in (b) below to:

Medical Review Organization Certification
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625-0325

(c) The MRO application shall include the following:

1. A list of the names, addresses and specialties of the individuals health care providers, that will provide the medical review services. If the MRO will be limited in its service area, the application shall provide a map of the service area, including the providers by specialty;
2. A copy of the MRO's certificate of incorporation and by-laws;
3. A diagram of the MRO's organizational structure;
4. The location of the MRO's place of business where it administers its services and maintains its records;
5. A listing and biography of the MRO's officers and directors, or the individuals in the organization responsible for administration of medical reviews, including the medical director;
6. A detailed description of the MRO's experience in the review of medical care;
7. A description of its procedures for review of medical treatments, diagnostic tests and items of durable medical equipment in conjunction with PIP medical expense benefits;
8. A current list identifying all property/casualty insurers, health insurers, health maintenance organizations and health care providers with whom the MRO maintains any health related business arrangement. The list shall include a brief description of the nature of the arrangement, so as to permit the administrator to avoid assignments that may create a conflict of interest;
9. Such other information as the Commissioner may specifically request in connection with the certification of a particular applicant; and
10. A fee in the amount of \$1,000 payable to the Department of Banking and Insurance.

(d) The materials specified in (c) above shall be retained by the Department and may be referred to the Department of Health and Senior Services for consultation as necessary. Any significant changes in the materials filed with the Department shall be reported as an amendment to the materials filed within 30 days of the change.

(e) The Department, in consultation with the Department of Health and Senior Services, shall review the materials and grant or deny certification within 45 days of receipt of a complete filing. The Commissioner may extend the time an additional 30 days for good cause shown, and shall notify the applicant of any extension. A decision to deny certification shall be in writing and include an explanation of the reason for the denial.

(f) Initial certification shall be effective for a period of two years. Certified MROs shall reapply for certification 90 days prior to expiration by submitting the items set forth in (b)1, 6, 7, 8, 9 and 10 above and any changes to items previously submitted in (b)2, 3, 4 and 5 above. Renewal certification may be effective for a period of up to five years.

(g) All data or information in the MRO's application for certification shall be confidential and shall not be disclosed to the public, except as follows:

1. The MRO's certificate of incorporation;
2. The MRO's address;
3. The names of the MRO's officers and directors, or the individuals in the organization responsible for the administration of medical reviews including the medical director; and
4. The date of certification of the MRO and date that certification expires.

(h) Upon certification, the Department shall advise the administrator of the name and address of the MRO, any limitations on its geographical service area and information about persons with whom it maintains health related business arrangements.

(i) The Commissioner may suspend or revoke the certification of an MRO upon finding that the MRO no longer meets the standards set forth in N.J.A.C. 11:3-5.9; that medical review services are not being provided in accordance with the requirements of this subchapter; or that the certification was granted based on false or misleading information.

1. Proceedings to revoke or suspend the certification shall be conducted pursuant to N.J.A.C. 11:17D.
2. Upon request of the MRO for a hearing, the matter shall be transferred to the Office of Administrative Law for a hearing conducted pursuant to the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:3-5.11 Fees

(a) The initial fee for a determination by a Medical Review Organization shall be \$575.00. The Commissioner may adjust the fee every two years by order based on the rise in the medical component of the Consumer Price Index as published by the United States Department of Labor. Such fee adjustments shall be initiated in this subchapter through a notice of administrative change published in the New Jersey Register.

(b) When a mental or physical examination is performed in connection with the medical review organization's services, the health care provider performing the examination shall be paid the fee provided for that service set forth on the Department's medical fee schedule, N.J.A.C. 11:3-29.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote (a).

11:3-5.12 Prohibition of conflicts of interest

(a) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall have any personal or financial interest, direct or indirect, or engage in any business or transaction which is in conflict with the proper conduct of his or her duties under this subchapter.

(b) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall act in such capacity in any matter wherein he or she has a direct or indirect personal or financial interest that might reasonably be expected to impair his or her objectivity or independence of judgment.

(c) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall accept any gift, favor, service or other thing of value under circumstances from which it might be reasonably inferred that such gift, service or other thing of value was given or offered for the purpose of influencing him or her in the conduct of duties under this subchapter.

(d) No dispute resolution professional shall accept from any person, whether directly or indirectly and whether by him or herself or through a spouse or any family member or through any partner or associate or controlled business, any gift, favor, service, employment or offer of employment or any other thing of value which he or she knows or has reason to believe is offered with the intent to influence the performance of his or her duties as a dispute resolution professional.

(e) No dispute resolution professional shall make any determination in any PIP dispute in which he or she directly or indirectly or through a spouse, family member or by

partner or associate or controlled business has any personal or financial interest.

SUBCHAPTER 6. INSURANCE IDENTIFICATION CARDS**11:3-6.1 Scope**

In accordance with N.J.S.A. 39:3-29.1, this subchapter concerns the issuance, design and content of auto insurance identification cards issued by insurance companies in this State. This subchapter shall not apply to policies covering commercial motor vehicles regulated by the U.S. Department of Transportation or the New Jersey Board of Public Utilities.

As amended, R.1983 d.648, effective January 17, 1984.

See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Reference to dates deleted.

Amended by R.2004 d.166, effective April 19, 2004.

See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).

Rewrote the section.

Case Notes

Policy provision defining an eligible person as a spouse only if resident in the same household as insured held void; named insured's deletion of estranged wife; reformation of policy ordered. *Matland v. United Services Automobile Ass'n*, 174 N.J.Super. 499, 417 A.2d 46 (Law Div.1980).

11:3-6.2 Permanent identification cards

(a) A permanent insurance identification card shall conform to the following specifications:

1. The minimum size shall be three inches by five inches, and the maximum size shall be 5½ inches by 8½ inches.
2. The weight shall not be lighter than 20 pounds white bond.
3. The front of the card shall include the following:
 - i. The company name: Group name may be shown instead if it will identify the specific company involved. Insurance company logos are permitted;
 - ii. Named insured: The surname of the insured must agree with surname shown on the motor vehicle registration certificate. The Division of Motor Vehicles will conduct verification on surname basis;
 - iii. Address: The replacement of identification cards when there is a change of address will be optional with the insurance companies;
 - iv. Policy number: The complete policy number will be listed;
 - v. Effective date and expiration date: month, day, and year.

vi. Description of the vehicle: Year, make and vehicle identification number shall be noted on the insurance identification card. The model of the vehicle may be shown as the make. The make of the vehicle may be abbreviated, but the complete vehicle identification number (VIN) must be shown.

vii. In the case of fleets, dealership or leasing companies where the owner insures the vehicles, the make, year and VIN need not be recorded. In lieu of the make, year and VIN, the insurer may insert "ALL OWNED VEHICLES" or "FLEET". If the lessee insures the vehicles, the name of the owner as shown on the motor vehicle registration must be shown on the I.D. card in addition to the name of the insured if the designation "FLEET" is used without the VIN;

viii. Heading: The heading across the top shall read: State of New Jersey Insurance Identification Card;

ix. The insurance company code as established by the New Jersey Division of Motor Vehicles will be printed immediately preceding the insurance company name;

x. The name and address of the insurance company or the office or agency issuing the identification cards must be shown.

4. The reverse of card shall include the address, and may include a facsimile number and E-mail address, if any, established by the insurer for the filing of notification of the commencement of medical treatment by treating medical providers under N.J.A.C. 11:3-25. This information shall be provided under the following title: "ADDRESS FOR NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT"

5. This notice may be placed on the front or reverse of the identification card and may be printed on the card or affixed on the card by way of a label that contains the required information.

(b) Servicing carriers of any residual market mechanism authorized by statute shall issue an insurance identification card in accordance with (a) above. The card shall indicate that coverage is being issued by the servicing carrier on behalf of the residual market mechanism.

As amended, R.1973 d.140, eff. May 31, 1973.

See: 5 N.J.R. 150(a), 5 N.J.R. 229(b).

As amended, R.1973 d.247, eff. August 31, 1973.

See: 5 N.J.R. 350(b).

As amended, R.1983 d.648, eff. January 17, 1984.

See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Further specifications for ID cards added and alternative type of card introduced.

Amended by R.1991 d.45, effective February 4, 1991.

See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

In (d): deleted NJAFIUA reference and added text referring to "residual market mechanism authorized by statute."

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1997 d.14, effective January 6, 1997 (operative March 7, 1997).

See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).

Added (b)5 and (b)6.

Amended by R.2004 d.166, effective April 19, 2004.

See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).

Deleted former (a) and (c); recodified former (b) as new (a); recodified former (d) as new (b); rewrote new (a).

Case Notes

Policy provision defining an eligible person as a spouse only if resident in the same household as insured held void; named insured's deletion of estranged wife from coverage held void; reformation of policy ordered. *Matland v. United Services Automobile Ass'n*, 174 N.J.Super. 499, 417 A.2d 46 (Law Div.1980).

11:3-6.3 Temporary identification card

(a) The format and content of the temporary card shall be the same as those for a permanent identification card except as noted below.

1. Title: "TEMPORARY" to precede heading on card;

2. Policy number: Indicate policy number if available; otherwise, the application or binder number is acceptable;

3. Effective date: Month, day and year that coverage becomes effective. Expiration date is not required;

4. Expiration: The card shall contain the following statement: "This card expires 60 days after the effective date shown above";

As amended, R.1973 d.35, eff. January 26, 1973.

See: 5 N.J.R. 20(b).

As amended, R.1974 d.208, eff. July 24, 1974.

See: 6 N.J.R. 322(b).

As amended, R.1983 d.648, eff. January 17, 1984.

See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Language changes and clarification.

Amended by R.1991 d.45, effective February 4, 1991.

See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Deleted subsection (b), describing components of the New Jersey Automobile Insurance Plan.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.2004 d.166, effective April 19, 2004.

See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).

Rewrote the section.

11:3-6.4 General provisions

(a) The order of the information to be contained on the identification cards may be rearranged in order to accommodate fixed printout systems already established by a company.

(b) Additional information may be printed on the reverse side of the identification cards, provided the additional information is appropriately captioned and is not at variance with the information required.

(c) One identification card shall be issued for each vehicle insured under the policy. Replacement identification card or cards will be issued at the request of the insured in the event of loss.

(f) Nothing in these rules or their application shall be construed to authorize insurers to act in contravention of any applicable State or Federal law prohibiting discrimination on impermissible bases.

New Rule, R.1999 d.270, effective August 16, 1999.
See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

Former N.J.A.C. 11:3-8.6, Suspension of nonrenewals, recodified to N.J.A.C. 11:3-8.7.

Administrative correction.
See: 32 N.J.R. 809(b).

11:3-8.7 Suspension of nonrenewals

Notwithstanding the provisions of this subchapter, if the plan for automobile insurance established pursuant to N.J.S.A. 17:29D-1 is not accepting new applications for coverage pursuant to N.J.S.A. 17:29D-1(d), no insurer transacting automobile insurance in this State shall refuse to renew any private passenger automobile insurance policy in this State.

Emergency New Rule, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).

See: 22 N.J.R. 3766(b).

Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.

See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).

Provisions of emergency new rule readopted without change.

Recodified from N.J.A.C. 11:3-8.6 by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

Former N.J.A.C. 11:3-8.7, Reporting requirements, recodified to N.J.A.C. 11:3-8.8.

11:3-8.8 Records

Insurance companies shall maintain records of nonrenewals for not less than five years which shall include a copy of the notice of nonrenewal, data concerning the allowable number of nonrenewals in each territory computed in accordance with N.J.A.C. 11:3-8.5(a)2, and data concerning the actual number of newly insured automobiles and nonrenewals in each territory for each category, computed in accordance with N.J.A.C. 11:3-8.5(a)3. Such records and data shall be made available to the Department upon request.

New Rule, R.1986 d.418, effective October 6, 1986.

See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).

Emergency Repeal and New Rule, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).

See: 22 N.J.R. 3766(b).

Recodified from 11:3-8.5.

Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.

See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).

Provisions of emergency repeal and new rule, R.1990 d.626 readopted without change.

Recodified from N.J.A.C. 11:3-8.7 and amended by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

Rewrote the section. Former N.J.A.C. 11:3-8.8, Separability, recodified to N.J.A.C. 11:3-8.9.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Rewrote the section.

11:3-8.9 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 not be affected.

New Rule, R.1986 d.418, effective October 6, 1986.

See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).

Recodified from 11:3-8.6 as part of Emergency Amendments filed as R.1990 d.626, effective November 26, 1990, operative April 1, 1991.

See: 22 N.J.R. 3766(b).

Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.

See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).

Recodified from N.J.A.C. 11:3-8.8 by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

Former N.J.A.C. 11:3-8.9, Penalties, recodified to N.J.A.C. 11:3-8.10.

11:3-8.10 Penalties

(a) Any person violating the provisions of this subchapter shall be subject to such penalties as may be authorized by law.

(b) In addition to any such penalties, the Commissioner may, after notice and hearing, suspend or revoke the rights of any insurer or group of insurers under N.J.A.C. 11:3-8.4.

New Rule, R.1986 d.418, effective October 6, 1986.

See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).

Recodified from 11:3-8.7 as part of Emergency Amendments filed as R.1990 d.626, effective November 26, 1990, operative April 1, 1991.

See: 22 N.J.R. 3766(b).

Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.

See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).

Recodified from N.J.A.C. 11:3-8.9 by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

APPENDIX

EXHIBIT A

New Jersey Auto Consumers' Rights Q&A

New Jersey Department of Banking and Insurance

PO Box 325

Trenton, NJ 08625-0325

1-800-446-7467

Shopping for Auto Insurance? Start now and know your rights.

Below are some of the most commonly asked questions about auto insurance and the answers every consumer should have before shopping for a new policy. But remember, it is difficult to take advantage of your rights if you wait until the last minute.

● *Can a company refuse to sell auto insurance to me?*

No, not as long as you are an "eligible" driver under the law, based primarily on motor vehicle violations, at-fault accidents and lapses in coverage. More than 97 percent of New Jersey drivers are eligible for coverage by all but a very few companies. If your application is declined, the company must tell you the reason, in writing.

● *There are no insurance agents in my neighborhood? Where can I get insurance?*

Call the Department of Banking and Insurance for an annual premium comparison survey and a list of all companies that sell insurance in New Jersey. Many are "direct writers," who sell insurance over the telephone or by mail.

● *Can I be denied insurance because of where I live or my race, sex, or age?*

No. Insurance companies are barred by law from refusing to sell auto insurance coverage based on any of those factors.

● *An insurance agent refused to tell me about rates. Is this right?*

No. Insurance companies and agents must provide general pricing information for your area upon request. If you meet with an agent to get a "quote," or specific pricing for your policy, any agent who sells for multiple companies must give you quotes for each one.

● *Will I have to wait several weeks to get an appointment to buy auto insurance coverage?*

No. If a company uses appointments, you should be scheduled so that you can get coverage before your current policy expires. Tell the agent your current expiration date, and get an appointment well in advance so your coverage will not lapse. Give yourself time to shop around—you might get a better price. Remember that processing the application will take some time, so don't wait until the last minute.

● *What documents do I have to provide to get insurance?*

That can vary, so be sure to ask and make a list of what is needed. You will be asked to provide a copy of your driver's license and registration certificate and you may be asked to supply other information or documents. Companies cannot require you to provide a copy of your driver's "abstract," or Division of Motor Vehicle record. You may wish to bring one if you do not have time to wait for the company to obtain one. It's up to you.

● *How much time does an insurance company have to approve or reject my application once it is completed?*

The company has 5 business days from the time it receives a completed application to approve or decline it, and the clock starts running *when the company receives the application*, not when you put it in the mail. If you buy through an agent, ask how long it will take for the company to receive your application and you will know when to expect an answer.

● *Can I do anything to reduce the cost of my insurance?*

Yes. Give yourself enough time to shop around. Prices vary from company to company. When you apply for insurance coverage, you will be asked to complete a "coverage selection form." Read the form carefully. You can pay less by taking advantage of cost-saving options available. Buy *only* the insurance you need. You can help lower the cost of insurance by reporting insurance fraud and spotting aggressive drivers who cause accidents.

● *Who should I call?*

To obtain shopping information,

Insurance Consumer Hotline

1-800-446-7467

To report suspected fraud

Office of the Insurance Fraud Prosecutor

1-800-877-55FRAUD

To report aggressive drivers

New Jersey State Police

1-888-723-7623

New Rule, R.1998 d.43, effective January 20, 1998.

See: 29 N.J.R. 3107(a), 30 N.J.R. 366(b).

Recodified from N.J.A.C. 11:3-8 Appendix Exhibit C by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

Former N.J.A.C. 11:3-8 Appendix Exhibit A, Nonrenewal report—A, repealed.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

EXHIBIT B (RESERVED)

Repealed by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

Exhibit was "Nonrenewal report—B".

EXHIBIT C (RESERVED)

Recodified to N.J.A.C. 11:3-8 Appendix Exhibit A by R.1999 d.270, effective August 16, 1999.

See: 30 N.J.R. 2564(a), 31 N.J.R. 2383(b).

**SUBCHAPTER 9. RATING INFORMATION;
AUTOMOBILE INSURANCE ON PRIVATE
PASSENGER CARS**

**11:3-9.1 Rating information; private passenger cars;
automobile insurance**

(a) Every automobile insurance policy subject to New Jersey rates and providing coverage for an individually owned (or jointly owned by husband and wife; or two or more relatives resident of the household) private passenger automobile and/or any motor vehicle rates as a private passenger automobile shall be accompanied by rating information applicable to the premium determination. Such information must include the criteria pertaining to any individual driver classification plan used by the company and shall recite any rules that apply to the chargeability of accidents and convictions.

(b) If the declaration page or extension certificate or similar documents to the insured identifies the insured's car by a code, or other abbreviation, the rating information may be supplied by a rating information form that interprets the code number or abbreviation.

(c) Every company shall develop a rating information format adapted to the classification system approved for and used by the company in this State. Such format shall be submitted to the Commissioner of Banking and Insurance for approval initially within 30 days of the effective date of this regulation, and subsequently within 15 days of any revision of the classification system approved for the company. Filings of the rating information format by a rating organization shall be applicable to members and subscribers of such organization unless such companies deviate from the rating organization's classification system.

(d) This regulation shall be effective August 31, 1973. Use of approved forms will be required on all new and renewal business with effective dates January 1, 1974 and thereafter.

R.1973 d.206, effective August 31, 1973.

See: 5 N.J.R. 150(b), 5 N.J.R. 282(b).

Amended by R.1991 d.45, effective February 4, 1991.

See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Deleted subsection (b) regarding New Jersey Automobile Insurance Plan and recodified existing (c)-(e) as (b)-(d) with no change in text.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-9.2 (Reserved)

R.1975 d.130, eff. July 1, 1975.

See: 7 N.J.R. 113(a), 7 N.J.R. 276(d).

Repealed by R.1996 d.246, effective June 3, 1996.

See: 27 N.J.R. 2048(a), 28 N.J.R. 3002(b).

Section was "Private passenger automobile rating class; revoked or suspended operator".

**SUBCHAPTER 10. AUTO PHYSICAL DAMAGE
CLAIMS**

11:3-10.1 Scope

This subchapter applies to claims arising under motor vehicle collision and comprehensive coverages.

Amended by R.1985 d.629, effective December 16, 1985.

See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).

Section heading was Application.

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. *Chick's Auto Body v. State Farm Mutual Automobile Insurance Co.*, 168 N.J.Super 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

11:3-10.2 Definitions

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

"Actual cash value", unless otherwise specifically defined by law or policy, means the lesser of the amounts for which the insured or the designated representative can reasonably be expected to:

1. Repair the motor vehicle to its condition immediately prior to the loss; or
2. Replace the motor vehicle with a substantially similar vehicle. The amount shall include all moneys paid or payable as sales taxes on the motor vehicle repaired or replaced. This paragraph shall not be construed to prevent an insurer from issuing a policy where the amount of damages to be paid in the event of a total loss is a specified dollar amount.

"Agreed price" or "figure" means the amount agreed to by the insurer and the insured, or their representatives, as the reasonable cost to replace the motor vehicle or to repair damages to the motor vehicle resulting from the loss, without considering any deductible or deductions.

"Designated representative" means a person designated by the insured to represent the insured in negotiations with the insurer in an attempt to settle the claim. The designated representative may be any person authorized by the insured who may act legally in his or her behalf.

"Motor vehicle" shall have the meaning ascribed in N.J.S.A. 39:1-1.

"Substantially similar vehicle" means a vehicle of the same make, model, year and condition, including all major options of the insured vehicle. Mileage must not exceed that of the insured vehicle by more than 4,000 miles. Mileage differences of more than 4,000 miles may, at the option of the insured, be exchanged for the presence or absence of options or a cash adjustment.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. *Chick's Auto Body v. State Farm Mutual Automobile Insurance Co.*, 168 N.J.Super 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

Measure of value applicable under policy's theft coverage held to be fair market value; insured, owner of modified vehicle, held entitled to recover only the average market value of an ordinarily equipped automobile of the same make, model and year. *Titus v. West American Insurance co.*, 143 N.J.Super. 195, 362 A.2d 1236 (Law Div.1976).

11:3-10.3 Adjustment of partial losses

(a) If the insurer intends to exercise its right to inspect, or cause to be inspected by an independent appraiser, damages prior to repair, the insurer shall have seven working days following receipt of notice of loss to inspect the insured's damaged vehicle, which is available for inspection, at a place and time reasonably convenient to the insured; commence negotiations; and make a good faith offer of settlement.

(b) Negotiations must be conducted in good faith, with the basic goal of promptly arriving at an agreed price. Early in negotiations, the insurer must inform and confirm in writing to the insured or the insured's designated representative all deductions that will be made from the agreed price, including the amount of applicable deductible.

(c) If the insurer inspects the damaged vehicle or causes it to be inspected, the insurer shall promptly upon completing the inspection furnish the insured or the designated representative of the insured with a detailed written estimate of the cost of repairing the damage resulting from the loss, specifying all appropriate deductions.

(d) No insurer shall negotiate the settlement of any physical damage claim involving an automobile as defined at N.J.S.A. 39:13-1b with an unlicensed auto body repair facility or in any manner utilize an unlicensed facility in the adjustment, negotiation or settlement of such a claim. It shall be the responsibility of the insurer to make a reasonable and diligent effort to determine whether the facility is properly licensed.

(e) Subject to the requirements of (d) above, the insured may use any repair facility of his or her own choice. With respect to automobile damage claims, the insurer shall notify in writing any insured who elects to use his or her own repair facility that, pursuant to law, any entity engaged in the business of auto body repairs must be duly licensed.

The notice shall further advise the insured that the insurer is prohibited by law from negotiating, adjusting or settling an automobile damage claim with an unlicensed facility. The written notice shall be furnished at the time of acknowledgment of the claim as provided at N.J.A.C. 11:2-17.6 or upon the furnishing of its written estimate, as specified at (c) above, whichever is sooner. The insurer must make all reasonable efforts to obtain an agreed price with the facility selected by the insured. The insurer may recommend, and if the insured requests, must recommend a qualified repair facility at a location reasonably convenient to the insured motor vehicle who will repair the damaged motor vehicle at the insurer's estimated cost of repairs, but in either event the provisions of (g) below apply.

(f) All estimates, including revisions and adjustments, prepared by any repair facility, estimator or appraiser must be included in each claim file.

(g) If the insured's vehicle is repaired at a repair facility whose name is furnished by the insurer under (e) above for a sum estimated by the insurer as the reasonable cost to repair the vehicle, the insurer:

1. Shall select a repair facility that issues written guarantees that any work performed in repairing damaged vehicles meets generally accepted standards for safe and proper repairs;

2. Shall cause the damaged vehicle to be restored to the condition it was in prior to the loss, at no additional cost to the insured and within a reasonable time, if the repair facility does not repair the damaged vehicle in accordance with generally accepted standards for a safe and proper repair.

(h) Whenever an insurer elects to repair its insured's vehicle, that is, physically take the vehicle and have it repaired, the election must be in writing addressed to the insured and contain a reasonable estimate of the time period within which the vehicle will be repaired. The insurer shall guarantee, in writing, that the work performed meets generally accepted standards for safe and proper repairs.

(i) Deductions for betterment and depreciation are permitted only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and depreciation shall be limited to the lesser of an amount equal to the proportion that the expired life of the part to be repaired or replaced bears to the normal useful life of that part, or the amount by which the resale value of the vehicle is increased by the repair or replacement. Calculations for betterment, depreciation and normal useful life must be included in the insurer's claim file.

(j) Deductions for previous damage or prior condition of the vehicle must be measurable, discernible, itemized and specific as to the dollar amount, and those deductions must

be included in the insurer's claim file. The deductions shall be limited to the amount by which the resale value of the motor vehicle is increased by the estimation of the previous damage or the correction of the prior condition.

(k) The insurer must mail or hand deliver to the insured or the designated representative its proof of loss or payment within five working days after the insured has accepted the insurer's offer.

(l) The insured shall have the right to receive the proceeds of any settlement. The insurer may not insist on making settlement proceeds jointly payable to the insured and the repair facility, or payable to the repair facility only.

(m) The insured may elect to have the insurer pay the repair facility directly in order to expedite recovery of the motor vehicle. The insured must make this election in writing.

Amended by R.1985 d.629, effective December 16, 1985.

See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).

Substituted "the insurer" for "it".

Amended by R.1987 d.249, effective June 15, 1987.

See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).

Substantially amended.

Amended by R.1995 d.471, effective August 21, 1995 (operative January 1, 1996).

See: 27 N.J.R. 437(a), 27 N.J.R. 3172(a).

In (e) allowed limitation of insured's choice of repair facilities as optional part of insurance contract and in (l) allowed payment directly to repair facility under such contract.

Public Notice: Extension of operative date of R.1995 d.471 to March 1, 1996.

See: 27 N.J.R. 5031(a).

Amended by R.1997 d.84, effective February 18, 1997.

See: 28 N.J.R. 4562(a), 29 N.J.R. 550(c).

In (e), deleted provision relating to contracting for use of specified repair facilities; and in (l), deleted provision relating to direct payments if there is a contract for use of a specific repair facility.

Case Notes

Judgment against unidentified permissive user would not be required for passenger to make claim for automobile liability insurance; if there was a 'covered person' who was operating the car, the insurance company was contractually required to provide indemnity for that person's fault, and insurer was bound to negotiate in good faith with passenger. *Samuel v. Doe*, 158 N.J. 134, 727 A.2d 1016 (N.J. 1999).

Insurers' activities in estimating repair costs held not an Antitrust Act violation. *Chick's Auto Body v. State Farm Mutual Automobile Insurance Co.*, 168 N.J.Super. 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

11:3-10.4 Adjustment of total losses

(a) If the insurer elects to make a cash settlement, it must bear in mind at all times that the insured's position is that of a retail consumer and the settlement value arrived at must be reasonable and fair for a person in that position. Written, itemized valuations showing all options and deductions shall be included in the insurer's claim file and presented to the insured no later than the date of payment. If the insurer elects to make a cash settlement, its offer, subject to applicable additions or deductions, must be one of the following plus applicable sales tax:

1. The average of the retail values for substantially similar motor vehicles as listed in the editions current for the date of loss of two valuation manuals approved by the Commissioner.

i. The average figure arrived at may be reduced or increased by considering all factors, including, but not limited to, mileage tables and the presence or absence of extras.

ii. If the destroyed vehicle included an option which is listed in one manual but not in the other, the value of the option shall not be averaged. The insured shall receive full value for the option by carrying over the amount listed to the other manual. The option carry-over shall apply only in those instances where the option has not been considered by the used vehicle guide either as a separate item or included in the vehicle's base value.

iii. If a manual is submitted for approval by the Commissioner its accuracy must meet objective criteria for the values of substantially similar vehicles of at least 85 percent of all makes and models for the last 15 years and shall include all major options. A sufficient number of vehicles shall be used for each year, make and model to represent a cross-section sufficient to determine fair market values. At the time of request for approval, the source of the manual's data must be revealed to the Commissioner in a manner that can be verified by the Department. Manuals approved for use on or after January 1, 1976 are "Automobile Red Book" and "Older Car/Truck Red Book" published by Maclean Hunter Market Reports, Inc. and the "N.A.D.A. Official Used Car Guide" and "N.A.D.A. Official Older Car Guide" published by the National Automobile Dealers Used Car Guide Company.

2. A quotation obtained by the insurer for a substantially similar motor vehicle from a dealer located within a reasonable distance from the principal place of garagement of the insured vehicle. Unless otherwise agreed by the insured, a reasonable distance shall not exceed 25 miles from the principal place of garagement. The vehicle must be available for purchase by the insured and the insured must be able to purchase it for the insurer's cash offer plus applicable deductions. The insurer shall maintain in its claim file proof of the vehicle's availability and the name and location of the dealer, stock number, vehicle identification number and description of the substantially similar vehicle.

3. The fair market value of the insured vehicle, determined by using a source including a computerized database approved by the Commissioner that meets all of the following minimum criteria:

i. The source must give primary consideration to the values of vehicles in the local market area, but if necessary to obtain a reasonable cross-section of the market, may consider vehicles in the next closest area.

11:3-10.7 Subrogation agreements

(a) If an insured has received payment under his or her physical damage coverage that is subject to a deductible, the insured shall share, pro rata, with the insurer any net recovery received by the insurer from third parties.

(b) Net recovery shall be the total recovery less the insurer's allocated loss adjustment expenses attributable to such recovery. The formula for computing net recovery and the insured's share of recovery of the deductible may be stated as follows:

1. Total recovery – Allocated loss adjustment expenses = Net recovery.

$$\frac{\text{Deductible}}{\text{Total loss}} \times \text{Net recovery} = \text{Insured's Share of recovery.}$$

2. Application of formula: Assume a loss of \$500.00 subject to a \$100.00 deductible with \$50.00 in allocated loss adjustment expenses:

i. If there is full recovery of \$500.00: computation of net recovery:
\$500.00 – \$50.00 = \$450.00

Computation of insured's share of recovery:

$$\frac{\$100.00}{\$500.00} \times \$450.00 = \$90.00$$

ii. If there is a partial recovery of \$300.00: computation of new recovery: \$300.00 – \$50.00 = \$250.00

Computation of insured's share of recovery:

$$\frac{\$100.00}{\$500.00} \times \$250.00 = \$50.00$$

(c) Unless the insurer returns its insured's full deductible the insured shall attempt to effect full recovery in clear liability cases and shall not enter into any intercompany agreements that provide for the acceptance of lesser amounts on a formula basis.

(d) If an insurer has paid a physical damage claim that is subject to a deductible and it elects not to pursue its subrogation claim where the probability of recovery exists, the insurer shall so notify its insured in writing within 60 calendar days after it has paid the claim, except that the notification shall be given at least 30 days prior to the running of any applicable statute of limitations or period required for notice of claim. If an insurer does not notify its insured within the time periods prescribed above and the statute of limitations or period required for notice or claim has expired, the insurer shall forthwith remit to its insured the full amount of the insured's deductible.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
Substituted "the insured" for "it".

11:3-10.8 Repair estimates

If the insurer requires that its insured obtain more than one estimate of motor vehicle damage, the reasonable cost of such additional estimates, if any, shall be borne by the insurer unless the estimator does the work.

11:3-10.9 Referral of insured to the at-fault party

There shall be no attempt to discourage an insured from filing a physical damage claim, nor shall an insurer encourage its insured to assert a claim against a third party in lieu of filing a physical damage claim under the insured's policy.

11:3-10.10 Examinations by the New Jersey Department of Banking and Insurance

To ensure compliance with this rule, the Department of Banking and Insurance personnel will investigate the market performance of insurers. To enable Department personnel to reconstruct an insurer's activities pursuant to the provisions of this rule, each insurer must maintain a complete file on each claim settled pursuant to this rule. The claim file shall contain all communications, transactions, notes and work papers relating to the claim. With respect to automobile damage claims, the file 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 papers in the file must be accurately dated by the insurer.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
"Rule" substituted for "regulation".
Amended by R.1987 d.249, effective June 15, 1987.
See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).
Added text "With respect to . . . of the automobile."
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. *Chick's Auto Body v. State Farm Mutual Automobile Insurance Co.*, 168 N.J.Super 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

SUBCHAPTER 11. MOPED INSURANCE

11:3-11.1 Required coverages for mopeds

(a) No policy insuring against loss resulting from liability imposed by law for bodily injury, death and property damage sustained by any person arising out of the ownership, operation or use of a motorized bicycle as defined in N.J.S.A. 39:1-1, as amended, shall be issued in the State to the owner (or parent or guardian of an owner under 18 years of age) of any motorized bicycle principally garaged or operated in this State unless it includes coverage for the owner and operator in the following minimum amounts or limits.

1. Bodily injury;

i. An amount or limit of \$15,000, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and

ii. An amount or limit, subject to such limit for any one person so injured or killed, of \$30,000, exclusive of interest and costs, on account of injury to or death of more than one person, in any one accident.

2. Property damage: An amount or limit of \$5,000 in the aggregate for damage to property of others resulting from one accident.

(b) Every liability insurance policy as described in (a) above, issued or renewed on or after April 22, 1985, shall provide personal injury protection coverage benefits, in accordance with N.J.S.A. 39:6A-4, to pedestrians who sustain bodily injury in this State caused by the named insured's motorized bicycle or caused by being struck by or from the motorized bicycle.

(c) Every business entity or individual owner who rents motorized bicycles shall maintain liability insurance coverage pursuant to N.J.S.A. 39:4-14.3e in the minimum amounts or limits set forth in (a) above.

(d) Any such coverages as described in subsections (a), (b) and (c) above shall describe the make and model, piston displacement, and serial number (VIN) of each motorized bicycle insured. This information shall also constitute the description of vehicle required on insurance identification cards, and N.J.A.C. 11:3-5.1 through 6.4 shall apply to moped coverage except where the language is clearly inappropriate.

(e) The policy period for the coverages described in subsection (a) of this section shall commence at 12:01 A.M. of the effective date shown in the policy declaration page, unless expressly set forth in the policy or in a binder or other contracts for temporary insurance.

(f) Any insurer authorized to write motor vehicle coverage may write moped coverage.

R.1978 d.12, eff. January 19, 1978.

See: 9 N.J.R. 585(c), 10 N.J.R. 69(c).

Amended by R.1985 d.72, effective February 19, 1985 (operative April 22, 1985).

See: 16 N.J.R. 3285(a), 17 N.J.R. 458(c).

(b) added; old (b)-(d) recodified to (c)-(e).

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

In (b), substituted "April 22, 1985" for "the operative date of this subsection"; deleted (b)1.

SUBCHAPTER 12. AUTOMOBILE RATE FILERS: FLATTENING OF PREMIUM TAXES AND ASSESSMENTS MADE FOR UNSATISFIED CLAIM AND JUDGMENT FUND

11:3-12.1 Purpose

The New Jersey Automobile Insurance Reform Act of 1982 (N.J.S.A. 17:29A-33 et al.) requires that each insurer calculate and collect, on a flat and uniform basis per insured automobile statewide, the taxes which are paid pursuant to N.J.S.A. 54:18A-1 et seq. and certain assessments made pursuant to N.J.S.A. 39:6-64, 66 and 67. This subchapter provides rules for the implementation of these requirements.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

11:3-12.2 Scope

(a) This subchapter applies to every insurer authorized to transact the business of automobile insurance in the State and every rating organization engaged in the business of rate-making for such insurers.

(b) The provisions of this subchapter are not intended to supersede or amend any other law or regulation.

11:3-12.3 Definitions

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

"Assessments" mean any assessment to be made pursuant to N.J.S.A. 39:6-64, 66 and 67, excluding assessments made to reimburse a filer for medical benefits payable under N.J.S.A. 39:6A-4 or 39:6A-3.1 in excess of \$75,000.

"Commissioner" means the Commissioner of Banking and Insurance.

"Filer" means a rating organization or any insurer making its own rates.

"Insurer" means any person or persons, corporation, association, partnership, or company authorized by the laws of this State to transact the business of insurance in this State.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of rate-making for two or more insurers.

"Taxes" mean those taxes required to be paid pursuant to N.J.S.A. 54:18A-1 et seq.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

In "Assessments", inserted a reference to N.J.S.A. 39:6A-3.1.

11:3-12.4 Tax and assessment fees; general provisions

(a) Pursuant to N.J.S.A. 17:29A-33 et seq., each automobile filer shall calculate and collect taxes and assessments for its insureds on a flat uniform fee basis per insured automobile statewide.

1. The flat and uniform fee per insured automobile required in (a) above shall be included in all new or renewal automobile policies issued on or after January 1, 1984.

(b) The fee shall be charged on any additional automobile which is acquired during the policy period. The amount of the fee shall be proportional to the remainder of the policy term.

(c) In the event of the cancellation of the policy or the deletion of the automobile from a policy, the fee shall be refunded in proportion to the earned premium for the period that the policy or coverage on the deleted automobile was in force.

11:3-12.5 Filing and reporting requirements

(a) Each automobile insurer shall submit to the Commissioner for approval a rate filing designated to place the premium structure of the filer in compliance with the requirements of the New Jersey Automobile Insurance Reform Act of 1982 and this subchapter.

1. The rate filing submitted to the Commissioner shall include the uniform tax and assessment fee to be used by the filer.

2. Each filer shall submit to the Commissioner for approval any alteration, amendment or supplement to the rate filing specified in (a) above.

(b) Within 30 days of the effective date of this subchapter, every automobile filer shall submit to the Commissioner for approval the rate filing specified in (a) above including the uniform tax assessment fee to be used by the filer in the calendar year commencing January 1, 1984.

(c) All filings required to be submitted pursuant to this subchapter shall be prepared in accordance with insurance laws and regulations including applicable provisions of N.J.S.A. 17:29A-1 et seq. and N.J.A.C. 11:1-2 and the Department's existing filing procedures.

(d) The filing of a rating organization shall be applicable to the members and subscribers of the organization.

1. Members or subscribers may submit to the Commissioner for approval a separate filing which deviates from the rating organization's filing. Such filings shall be prepared and submitted in accordance with the requirements of this subchapter.

(e) The Commissioner may require the filing of such additional data or information as he deems necessary to

implement the provisions of this subchapter, including, but not limited to, premium information on miscellaneous coverages such as rental reimbursement, additional personal injury protection and underinsured motorists as well as excess limits premiums for bodily injury and property damage liability coverages.

Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

SUBCHAPTER 13. COLLISION AND COMPREHENSIVE COVERAGE DEDUCTIBLES AND OPTIONS

11:3-13.1 Purpose

The New Jersey Automobile Insurance Reform Act of 1982 (N.J.S.A. 17:29A-39) requires that each insurer offer a range of deductibles up to at least \$2,000 for private passenger automobile collision and comprehensive coverage. This subchapter provides rules for the implementation of the requirement and provides other options that insurers shall offer.

As amended, R.1984 d.3, effective January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.

See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).

Range of deductibles increased to \$2,000; coinsurance options added.

Amended by R.1987 d.142, effective March 16, 1987.

See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).

Deleted (a)1 through i.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1998 d.594, effective December 21, 1998.

See: 30 N.J.R. 2567(a), 30 N.J.R. 4446(a).

Added "and provides other options that insurers shall offer" at the end.

11:3-13.2 Scope

This subchapter applies to every insurer authorized to transact the business of automobile insurance in this State and every rating organization engaged in the business of rate-making for such insurers.

Case Notes

Insured had no right to jury trial in action seeking personal injury protection benefits from insurer. *Manetti v. Prudential Property and Casualty Insurance Co.*, 196 N.J.Super. 317, 482 A.2d 520 (App.Div. 1984).

11:3-13.3 Deductibles for private passenger automobile collision and comprehensive coverage

(a) The minimum schedules of deductibles for private passenger automobile collision and comprehensive coverages which each insurer shall offer, pursuant to P.L. 2003, c.89, N.J.S.A. 17:29A-39 are as follows:

1. Deductibles for collision coverage:

\$100.00	\$750.00
\$150.00	\$1,000
\$250.00	\$1,500
\$500.00	\$2,000

i. An insurer may offer a \$200.00 collision deductible in lieu of, or in addition to, the \$250.00 deductible contained in (a)1 above.

2. Deductibles for comprehensive coverage:

\$100.00	\$750.00
\$150.00	\$1,000
\$250.00	\$1,500
\$500.00	\$2,000

i. An insurer may offer a \$200.00 comprehensive deductible in lieu of, or in addition to, the \$250.00 deductible contained in (a)2 above.

3. The \$2,000 amount referenced in (a)1 and 2 above may be adjusted in \$100.00 or \$250.00 increments by order of the Commissioner. Such orders shall be issued no more frequently than every 36 months, as the Commissioner deems appropriate, to reflect the cumulative increases or decreases, since the deductibles were last set, in the components of the Consumer Price Index, All Urban Consumers (CPI-U) for the Northeast Region. Such changes shall be reflected in this subsection through a notice of administrative changes published by the Department in the New Jersey Register.

(b) In addition to the required schedules in (a) above, an insurer may offer other intermediary ranges of deductibles as well as deductibles which are in excess of \$2,000.

1. The offering of such intermediary and additional deductibles shall be subject to the Commissioner's approval as set forth in N.J.A.C. 11:3-13.4.

(c) Insurers may offer actual case value comprehensive coverage.

(d) Where no selection of a deductible in a specific amount for collision and comprehensive coverage is made in writing by an applicant for an initial policy of auto insurance, an insurer shall provide a deductible in a default amount of \$750.00 each for collision and comprehensive coverage. Insurers shall inform insureds that this default amount will be selected upon the failure to affirmatively select a deductible in a specific amount.

As amended, R.1984 d.3, effective January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.
 See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).
 Deductibles of \$1,500.00 and \$2,000.00 added.
 Amended by R.1987 d.142, effective March 16, 1987.
 See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).
 Amended by R.1996 d.58, effective February 5, 1996.
 See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
 Amended by R.2003 d.467, effective December 1, 2003 (operative January 1, 2004).
 See: 35 N.J.R. 3083(a), 35 N.J.R. 5420(b).

In (a), rewrote the introductory paragraph, added the deductible of \$750.00 in 1 and 2 and added 3; added (d).

11:3-13.4 Filing and reporting requirements

(a) The filing of a rating organization shall be applicable to the members and subscribers of the organization who have authorized the organization to file on their behalf.

1. Members or subscribers may submit to the Commissioner for approval a separate filing which deviates from the rating organization's filing. Such filings shall be prepared and submitted in accordance with the requirements of this subchapter.

As amended, R.1984 d.3, eff. January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.

See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).

The text of 13.4 was recodified to this cite and amended to reference coinsurance options.

Amended by R.1987 d.142, effective March 16, 1987.

See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).

This section was recodified from section 5. The old section 4 "Coinsurance options applicable separately to private passenger automobile collision and comprehensive coverages" was originally filed as an emergency amendment as R.1983 d.537 and was readopted effective January 4, 1984 as R.1984 d.3.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Deleted former (a) and (b); and recodified former (c) to (a).

11:3-13.5 Named excluded driver

(a) For purposes of this subchapter, a "named excluded driver" means a driver who is specifically identified in the endorsement as a person who is excluded from physical damage coverage for specified automobile(s) and whose operation of a specified automobile(s) covered under the policy at the time of an accident would result in the denial of a physical damage claim for that automobile(s) made by the named insured or any loss payee. For the purpose of this section, physical damage coverage means both collision and comprehensive coverages (also referred to as "other than collision" coverage), or comprehensive coverage if purchased on a stand-alone basis.

(b) The premium charged for the physical damage coverage on the specified automobile(s) to which the named excluded driver endorsement applies shall not reflect the claim experience or driving record or rating classification of the named excluded driver or drivers.

(c) The named excluded driver endorsement shall be made available by personal private passenger automobile insurers to their insureds. Election of a named excluded driver endorsement shall be in writing and signed by a named insured in accordance with the subchapter Appendix incorporated herein by reference. The named excluded driver endorsement shall continue in force for the specified automobile(s) on subsequent renewal or replacement policies unless:

1. The specified automobile(s) is removed from the policy;

2. A new automobile replaces the specified automobile(s) on the policy; or

3. The insurer or its authorized representative receives a written request signed by a named insured electing to discontinue the endorsement.

(d) The request to exclude or reinstate a named driver shall become effective in the following manner:

1. For new policies, the request shall become effective on the date of issuance;

2. For mid-term policy changes, the request shall be effective the day following the date of postmark or, when

personal delivery is made or if the postmark is illegible, the day following the receipt by the insurer or insurance producer of the signed Request To Exclude Named Driver form or request to reinstate the excluded driver;

3. For changes upon renewal, the changes shall be effective on the date of the next policy renewal if postmarked or received by the insurer or by an insurance producer prior to the renewal date.

(e) The named excluded driver(s) and vehicle(s) shall be listed on the declaration page or on a supplemental declaration page.

Insurance Commissioner acted properly when he required that coverage selection form contain provision referring consumers to their automobile insurance companies in event of questions on coverage. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Model coverage selection form, was not arbitrary, unreasonable or capricious, and was substantially consistent with statutory language. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Two statutes, one requiring that coverage selection form state the percentage difference in premium rates or dollar savings between the two tort options for suing for noneconomic loss and the other requiring that coverage selection form identify range of premium rate credit or dollar savings or both; were not inconsistent. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

11:3-15.7 Use of coverage selection form; availability

(a) For all new policies, an insurer or an insurance producer shall receive a Coverage Selection Form signed by the named insured and indicating the prospective insured's coverage choices. Coverage shall not become effective until the signed Coverage Selection Form is received from the named insured, unless otherwise authorized by law.

(b) For the mid-term policy changes set forth in (b)1 through 5 below, the insurer shall receive a Coverage Selection Form signed by the named insured prior to making the change.

1. Change of policy type to Standard or Basic;
2. Change of Lawsuit Option (Standard Policy only);
3. Change of primary coverage for PIP medical expense benefits coverage (from or to Health Insurer Primary) (Standard Policy only);
4. Change in PIP Medical Expense Coverage Limit (Standard Policy only); and
5. Addition or deletion of Liability Coverage (Basic Policy only).

(c) An insurer may require that other policy changes be made by signed Coverage Selection Form.

(d) All coverage changes that are required to be made by a signed Coverage Selection Form, either by this subchapter or by the insurer, shall become effective in the following manner, except when coverage for comprehensive or collision is effected by a required inspection pursuant to N.J.A.C. 11:3-36.

1. For new policies, the choices on the Coverage Selection Form shall be effective on the policy effective date ;
2. For mid-term policy changes, the choices on the Coverage Selection Form shall be effective the day following the date of postmark or, when personal delivery is made or if the postmark is illegible, the day following receipt of the signed Coverage Selection Form by the insurer or an insurance producer. If the change is made

electronically, the change shall be effective the day following date of receipt as determined in accordance with N.J.S.A. 12A:12-15;

3. For changes upon renewal, the changes shall be effective on the date of the next policy renewal if post-marked or received by the insurer or by an insurance producer prior to the renewal date.

New Rule, R.1989 d.117, effective February 21, 1989.

See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).

Section was "Statement on the possible coordination of other health benefits coverage with the personal injury protection medical expense options".

Amended by R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).

See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

Amendments made to bring rule in line with changes in N.J.S.A. 39:6A-23 made by P.L. 1988 c.119.

Amended by R.1990 d.580, effective November 19, 1990 (operative January 1, 1991).

See: 22 N.J.R. 1681(a), 22 N.J.R. 3488(b).

Amended to be consistent with N.J.A.C. 11:3-15.6; the text of the Coverage Selection Form is amended both to clarify the current Form and requirements and to respond to changes required by the "Fair Automobile Insurance Reform Act of 1990".

R.1992 d.218, effective May 18, 1992.

See: 24 N.J.R. 523(a), 24 N.J.R. 1898(b).

In (h), added Note to 3, Warning statement to 7 and 8, and prohibition against domicile misstatement to (2).

Amended by R.1994 d.195, effective April 18, 1994.

See: 26 N.J.R. 85(a), 26 N.J.R. 1659(a).

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1998 d.412, effective August 3, 1998.

See: 30 N.J.R. 1747(a), 30 N.J.R. 2927(a).

In (a), substituted "of sufficient size to be easily readable" for "size eight and one-half inches by 11 inches" at the end of the first sentence. Repeal and New Rule, R.1998 d.595, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3577(a), 30 N.J.R. 4452(a).

Section was "Minimum standards for coverage selection form".

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

In (e), inserted the second sentence.

Amended by R.2004 d.117, effective March 15, 2004.

See: 35 N.J.R. 3523(a), 36 N.J.R. 1420(a).

In (b)1, substituted "Standard to Basic" for "from Basic to Standard or Standard to Basic".

Amended by R.2005 d.83, effective March 7, 2005.

See: 36 N.J.R. 4207(a), 37 N.J.R. 775(a).

In (d), inserted the last sentence in 2; deleted (e).

Case Notes

Buyer's guide and coverage selection form in regulations promulgated by Insurance Commissioner to implement revisions to no-fault automobile insurance law did not contain inherent bias or confusion on basis that Commissioner made reference to "basic limit" as opposed to "basic tort option." *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Buyer's guide and coverage selection form which gave basic tort option, as opposed to no-threshold option, a favorite status, was justifiable. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Insurance Commissioner acted properly when he required that coverage selection form contain provision referring consumers to their automobile insurance companies in event of questions on coverage. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Insurance Commissioner's proposed regulations, which implemented revisions to nonfault automobile insurance law requiring consumers to select between two options of coverage for automobile accident-related bodily injury, did not have to require that coverage selection form inform consumers of exact dollar amount of premium savings arising from election. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Model coverage selection form, proposed by regulations promulgated by Insurance Commissioner for implementing legislative revisions to no-fault automobile insurance law requiring consumers to select between two options of coverage for automobile accident-related bodily injury. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Statute requiring that no-fault automobile insurance coverage selection form state the percentage difference in premium rates or dollar savings between the two tort options for suing for noneconomic loss was not inconsistent with statute requiring that coverage selection form identify range of premium rate credit or dollar savings or both. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

When promulgating regulations to implement revisions to no-fault automobile insurance law, Commissioner's use of term "lawsuit threshold" in buyer's guide and coverage selection form, as opposed to "verbal threshold", did not lead to confusion. *Emmer v. Merin*, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

11:3-15.8 New Jersey Automobile Insurance Consumer Bill of Rights

(a) The insurer shall produce a Consumer Bill of Rights by reproducing the New Jersey Automobile Insurance Consumer Bill of Rights available on the Department's website at <http://www.state.nj.us/dobi/autorigths>. The Department shall notify insurers of any changes to the Consumer Bill of Rights by Bulletin. Insurers shall provide the Consumer Bill of Rights, as revised, with new and renewal business 60 days after the date of the Bulletin.

(b) The Consumer Bill of Rights shall be reproduced in the format as presented on the website, duplicating the language provided therein, and to the extent practicable, the layout, fonts, type-point sizes, colors and illustrations. Notwithstanding the foregoing, all language bolded on the Consumer Bill of Rights as depicted on the Department's website shall be bolded and no type-point size less than 10 point shall be used.

(c) The Consumer Bill of Rights shall contain:

1. An overview containing the purpose of the Bill of Rights;
2. The consumer's obligations with regard to their insurance;
3. The duties of the insurer concerning the application process;
4. The consumer's general insurance rights regarding denials and right to purchase;

5. The consumer's right to appeal a cancellation of insurance;

6. Instructions on how to be an educated insurance consumer; and

7. A statement advising the insured or applicant that additional information concerning the Coverage Selection Form and Buyer's Guide is available by contacting the insurer or the producer.

New Rule, R.2004 d.117, effective March 15, 2004.

See: 35 N.J.R. 3523(a), 36 N.J.R. 1420(a).

Former N.J.A.C. 11:3-15.8, Penalties, recodified to N.J.A.C. 11:3-15.9.

11:3-15.9 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as prescribed by law.

New Rule, R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).

See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

Amended by R.1990 d.580, effective November 19, 1990 (operative January 1, 1991).

See: 22 N.J.R. 1681(a), 22 N.J.R. 3488(b).

Amended to clarify when a Coverage Selection Form must be used and when the changes made thereon become effective.

R.1992 d.218, effective May 18, 1992.

See: 24 N.J.R. 523(a), 24 N.J.R. 1898(b).

In (c), added exception regarding comprehensive and collision.

Repealed by R.1998 d.595, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3577(a), 30 N.J.R. 4452(a).

Section was "Use of Coverage Selection Form".

New Rule, R.1989 d.117, effective February 21, 1989.

See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).

Recodified from N.J.A.C. 11:3-15.10, R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).

See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

Recodified from N.J.A.C. 11:3-15.11 by R.1998 d.595, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3577(a), 30 N.J.R. 4452(a).

Recodified from N.J.A.C. 11:3-15.8 R.2004 d.117, effective March 15, 2004.

See: 35 N.J.R. 3523(a), 36 N.J.R. 1420(a).

11:3-15.10 (Reserved)

Recodified from N.J.A.C. 11:3-15.9, R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).

See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

Repealed by R.1998 d.595, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3577(a), 30 N.J.R. 4452(a).

Section was "Effect on other notice requirements".

11:3-15.11 (Reserved)

New Rule, R.1989 d.117, effective February 21, 1989.

See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).

Recodified from N.J.A.C. 11:3-15.10, R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).

See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

Recodified to N.J.A.C. 11:3-15.8 by R.1998 d.595, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3577(a), 30 N.J.R. 4452(a).

**SUBCHAPTER 16A. PRIVATE PASSENGER
AUTOMOBILE INSURANCE TERRITORIAL
RATING PLANS**

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 17:29A-48 et seq. and 17:29A-36.

Source and Effective Date

R.2005 d.126, effective April 18, 2005.
Sec: 36 N.J.R. 3979(a), 37 N.J.R. 1197(a).

11:3-16A.1 Purpose and scope

(a) This subchapter sets forth the standards and requirements for the establishment of territory maps by insurers, rating organizations, and the Automobile Insurance Territorial Rating Plan Advisory Commission, pursuant to N.J.S.A. 17:29A-48 et seq. and 17:29A-36, and for the amendments to rating plans by insurers and rating organizations.

(b) This subchapter applies to all insurers that are licensed and authorized to transact personal private passenger automobile insurance in the voluntary market, rating organizations and the Automobile Insurance Territorial Rating Plan Advisory Commission.

11:3-16A.2 Definitions

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

“Basic automobile insurance policy” or “basic policy” means a private passenger automobile insurance policy issued in accordance with N.J.S.A. 39:6A-3.1 and N.J.A.C. 11:3-3.

“Commission” means the Automobile Insurance Territorial Rating Plan Advisory Commission established pursuant to N.J.S.A. 17:29A-50.

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Common territory map” means the territory map filed by the Commission and approved by the Commissioner or, where no map filed by the Commission is approved, a substitute map certified by the Commissioner.

“Department” means the New Jersey Department of Banking and Insurance.

“Exposure” means one car insured for property damage liability coverage in a Basic or Standard policy for a period of 12 months.

“Filer” means a rating organization or any insurer making its own rates.

“Insurer” means an entity or affiliated group of entities authorized or admitted to transact personal private passenger automobile insurance business in this State.

“PAIP” means the New Jersey Personal Automobile Insurance Plan established in accordance with N.J.S.A. 17:29D-1 et seq.

“PIP coverage” means personal injury protection coverage as described in N.J.S.A. 39:6A-4 or 39:6A-3.1.

“Rating organization” means an entity licensed as a rating organization pursuant to N.J.S.A. 17:29A-2.

“Standard automobile insurance policy” or “standard policy” means a private passenger automobile insurance policy issued in accordance with N.J.S.A. 39:6A-4.

“State border” means the land or water border between New Jersey and New York State, Pennsylvania, Delaware, the Atlantic Ocean, Raritan Bay or Delaware Bay.

“Territory map” means a list of territories defined by zip code and a representation of the territories on a map of New Jersey pursuant to N.J.A.C. 11:3-16A.4(a).

11:3-16A.3 General requirements

(a) Every insurer, including the PAIP, shall have an approved territorial rating plan, which shall include a territory map, territorial relativity factors and territorial base rates that are in accordance with the provisions of N.J.S.A. 17:29A-48 et seq. and 17:29A-36, and this subchapter.

1. Insurers shall use the same territory map for basic and standard policies.

(b) The territory map in the insurer’s territorial rating plan shall be one of the following:

1. The common territory map;

2. The territory map approved by the Commissioner for the rating organization of which the insurer is a member; or

3. An individual territorial plan developed by the insurer and approved by the Commissioner in accordance with this subchapter.

11:3-16A.4 Standards for establishment of territories

(a) A territory shall be a geographic area of the State defined by contiguous zip codes, that follow municipal boundaries as closely as possible. If a zip code crosses a municipal boundary that forms a territorial boundary, the filer shall place the zip code entirely in one territory. Filers shall report statistical data by zip code.

(b) Each territory shall border on at least two other territories, or one territory and a State border.

(c) In establishing the common territory map, the Commission shall use data representing the largest available compilation from insurers. A rating organization that files a territory map shall use the combined data of its subscribers. An insurer filing its own territory map shall use its own data, or other relevant industry data that may be available for its use, or any combination of the two. The territory map filing shall include an explanation of any adjustments or weighting of the raw data used.

(d) In order to create an equable distribution of exposures throughout the State, each territory shall be comprised of no less than 20,000 exposures for one year. The exposure count shall be based on data used by the Commission to determine the common territory map. The maximum number of territories in any territorial map shall not exceed 50 territories.

(e) No territorial rating plan shall result in territories that are arbitrary, unfairly discriminatory, or created in a manner that is primarily for marketing purposes rather than measuring relativity of exposure to probable loss, or created in a manner that can be used to avoid the filer's obligations under N.J.S.A. 17:33B-15.

11:3-16A.5 Territorial rating plan filing requirements

(a) An insurer's filing shall indicate which of the maps permitted by N.J.A.C. 11:3-16A.3(b) it intends to use. The

filing shall be submitted on 3½ inch diskette, zip disk or CD, and in hard copy.

(b) Filers shall provide the following New Jersey direct data by coverage and by zip code for basic and standard policies:

1. Not less than three-year:

i. Basic or total limits incurred losses, net of subrogation and other recoveries. Total limits losses may include PIP losses subject to reimbursement pursuant to N.J.S.A. 17:30A-8a(11);

ii. Paid or incurred allocated loss expenses;

iii. Earned exposures;

iv. Incurred claims; and

v. Average rating factors (for filers submitting on a pure premium methodology);

2. The most recent year's on-level earned premium;
3. The most recent year's in-force exposures;
4. The current base rates;
5. Indicated base rates by territory; and
6. Proposed base rates by territory.

(c) An insurer that uses the common territory map and relativities or the approved territory map of a rating organization and its relativities is only required to file the items in (b)2 through 4 and (b)6 above to demonstrate the rate neutrality.

(d) The Commissioner may request any additional information that may be necessary to evaluate the territorial plan filing.

(e) For filers submitting based on a pure premium methodology, the indicated territorial relativity from a filer's own historical data shall be adjusted to take into account any differences in the distribution of business between territories that is already reflected in other rating variables. This can be done by dividing the historical incurred losses in (b)1i above by the average rating factor in (b)1v above by zip code by year. Average factors in (b)1v above shall, if using basic limits data, include all rating factors combined other than territory and increased limits factors, and shall, if using total limits data, include all rating factors other than territory.

(f) The credibility of the filer's data shall be based upon a full credibility standard of 3,000 claims by territory. Partial credibility by territory shall be calculated based upon the square root of the filer's number of claims by territory divided by the full credibility standard.

(g) To the extent that the filer's own historical experience by territory is less than 100 percent credible, the filer shall weight the territorial indexes from its own experience with an alternate territorial index.

1. If the filer uses the common territory map, then the alternate index shall consist of the territorial rate relativities filed by the Commission and approved by the Commissioner.

2. If the filer uses a territory map approved for a rating organization, the alternate index shall be that of the members of the rating organization.

3. If an insurer files its own territory map, then the alternate index shall consist of either the prior average indicated or approved relativity applicable to the filer, or the indicated or approved relativities based on relevant industry data that may be available for its use for the zip codes making up the proposed territory, with the relativities weighted together by the latest year of exposures in each zip code by coverage.

(h) Pursuant to N.J.S.A. 17:29A-48(e), territories created in accordance with this subchapter shall not result in disproportionate differences in territorial relativity factors between contiguous territories with similar driving environments or mix of driving environments.

(i) Pursuant to N.J.S.A. 17:29A-36, the initial territorial relativity for any territory shall not be significantly disproportionate to the current relativity for that territory. For the purposes of this subchapter, the current relativity means the relativity that is in effect on the date of the initial filing pursuant to this subchapter. The current relativity shall be calculated for each zip code and compared with the indicated or selected relativity in accordance with (h) above for the territory in which the zip code is now located. The territorial relativity for a zip code shall be based on a Statewide average relativity of 1.000.

(j) Insurers shall not be required to make separate filings of basic policy data. However, filings made in accordance with this subsection shall comply with the provisions of N.J.S.A. 17:29A-36a concerning the basic policy.

11:3-16A.6 Review of filings

(a) All filings and other items submitted to the Commissioner pursuant to this subchapter shall be sent to the Department at the following address:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

(b) The time periods for the Department's review of territorial rating plan filings made pursuant to this subchapter are as set forth below:

1. Sixty days for insurers that use the common territory map, the territory map approved for a rating organization or a map that modifies either the common territory or rating organization map, as provided in N.J.A.C. 11:3-16A.3(b)3. For good cause, the Department may extend the review period for 30 days.

2. Ninety days for filers that are filing their own territory map. For good cause, the Department may extend the review period for a reasonable time, not to exceed 45 days.

(c) If the filing is incomplete, the Department shall so advise the filer not later than 20 business days after the receipt of the filing. If the Department does not advise the filer that the filing is incomplete, it shall be deemed to be complete on the 20th business day after receipt.

1. Notice to the filer that the filing is incomplete shall specify the missing item(s) or information. The notice shall advise the filer that a new 20-day time period for the Department's completeness review of the filing starts

again upon receipt by the Department of the information intended to cure the deficiency.

2. If the Department requests further information from the filer pursuant to N.J.A.C. 11:3-16A.5(c), the time frame for the Department's review of the filing is tolled until the information is received.

3. A determination by the Department that a filing is complete relates solely to the inclusion in the filing of the items requested by N.J.A.C. 11:3-16A.5 and shall not be considered a finding regarding the accuracy or reasonableness of the information or calculations.

(d) The Department shall not approve any filing that does not comply with N.J.S.A. 17:29A-48 et seq. and 17:29A-36 and this subchapter.

11:3-16A.7 Territorial rating plan review

(a) Each filer shall periodically review, no less frequently than once every five years, the continued validity of its territorial rating plan and report its findings in a format to be established by the Commissioner by Order.

(b) The Commissioner shall convene the Commission to review the continued validity of the common territory map at least once every five years.

11:3-16A.8 Objection to filings

(a) Any filer may object to an approved filing made in accordance with this subchapter on the grounds that it:

1. Is anti-competitive;
2. Does not meet the standards established in N.J.S.A. 17:29A-48 and this subchapter; or
3. Results in the filer not meeting its obligations pursuant to N.J.S.A. 17:33B-15.

(b) The filer shall have the burden of proof in making an objection to an approved filing.

(c) Any objection to an approved filing shall be in writing with all supporting materials. Two copies shall be sent to the Department at the address for filings set forth at N.J.A.C. 11:3-16A.6(a).

(d) The Department will review the objection and may ask for additional information from the filer making the objection. The Department may also ask for a response to the objection from the filer against whom the objection was made.

(e) The Department shall respond to the objection within 90 days of receipt of all information from the filer.

11:3-16A.9 Transition requirements

(a) The Commission shall file a territory map in accordance with N.J.A.C. 11:3-16A.4 and territorial relativities in accordance with N.J.A.C. 11:3-16A.5 for the Commissioner's approval.

1. The Commissioner shall approve or disapprove the filing within 30 days. If the Commissioner disapproves all or any part of the Commission's filing, it shall be returned with recommendations. The Commission may accept the recommendations of the Commissioner or may propose a new territory map within 30 days after the return of a disapproved map. If the Commission does not file a map acceptable to the Commissioner within 30 days of the disapproval of the original map, the Commissioner shall certify his or her own map.

(b) If a rating organization intends to file a territory map and relativities, the filing shall be made no later than 60 days after the Commissioner's approval or certification of the common territory map. For good cause shown, the rating organization may request an extension of the filing deadline.

(c) No later than 180 days after the Commissioner's approval or certification of the common territory map, every insurer, including the PAIP, shall file a territory map, territorial relativities and amendments to its rating plan that meet the requirements of this subchapter. For good cause shown, an insurer or the PAIP may request an extension of the filing deadline.

1. If an insurer that intends to use its own territorial map fails to make an acceptable filing, the Commissioner may by Order require it to use the common territory map.

2. The insurer shall demonstrate that the initial filing is revenue neutral by coverage in accordance with N.J.S.A. 17:29A-36d.

3. The PAIP shall use the common territory map and the relativities developed by the Commission.

11:3-16A.10 Penalties

Failure to comply with the provisions of this subchapter shall result in the imposition of penalties as authorized by law.

SUBCHAPTER 16B. RATE PROCESS FOR LIMITED RATE CHANGES; CALCULATIONS FOR PRIVATE PASSENGER AUTOMOBILE INSURANCE RATE CHANGES

Authority

N.J.S.A. 17:1-8.1; 17:1-15e; 17:29A-1 et seq.; 17:29A-46.6 and 46.7 and P.L. 1997, c.151, section 35.

Source and Effective Date

R.2001 d.481, effective December 17, 2001.
See: 33 N.J.R. 2574(a), 33 N.J.R. 4371(a).

11:3-16B.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the process for a private passenger automobile insurer or rating organization to file limited rate changes to its rating system as permitted by N.J.S.A. 17:29A-46.6.

(b) This subchapter shall also apply to rates filed by:

1. All insurers, affiliated groups of insurers and rating organizations writing or transacting private passenger automobile insurance in the voluntary market in this State; and

2. The New Jersey Personal Automobile Insurance Plan.

(c) These rules shall apply to base rate changes by coverage, territorial base rate changes, expense fees, class factors, deductibles, increased limit factors and discounts and credits.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).

In (a), deleted "expedited" preceding "process" and inserted "limited rate" preceding "changes"; in (b)1, inserted ", affiliated groups of insurers" following "All insurers".

11:3-16B.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 Department of Banking and Insurance in the State of New Jersey.

"Coverage" means:

1. Split limit bodily injury ("BI");
2. Split limit property damage ("PD");
3. Combined single limit ("CSL");
4. Personal injury protection including medical payments ("PIP");
5. BI, PD and PIP combined ("PACK");
6. Uninsured and underinsured motorists, bodily injury and property damage combined ("UM");
 - i. For developing the indications by coverage, UM data shall be combined with liability data in 1, 3 or 5 above;
7. Comprehensive ("COMP"); and
8. Collision ("COLL").

"Earned premium" ("EP") means direct, earned premium net of dividends paid or incurred.

"Personal Automobile Insurance Plan" or "PAIP" means the New Jersey Personal Automobile Insurance Plan established by N.J.A.C. 11:3-2.

"Rate change" means a rate increase of no more than seven percent overall or not more than 10 percent in any single coverage. Rate change also means any decrease in rates or a change in rates that is revenue neutral.

"Written premium" ("WP") means direct, written premium net of dividends paid or incurred.

Amended by R.2003 d.500, effective December 15, 2003.

See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).

Rewrote "Rate change" and "Written premium".

11:3-16B.3 Rate process for limited rate changes; insurers and rating organizations

(a) An insurer and/or rating organization, pursuant to N.J.S.A. 17:33B-31, may file for a rate change in accordance with this subchapter. The insurer shall provide the following information in support of its filing:

1. A cover letter notifying the Department of its intention to make a rate change according to the provisions of this subchapter; the company's file number, a statement of the percentage and total dollar amount of the change in rates by coverage for each company included in the filing with subtotals by group of coverages (liability versus physical damage) and an overall total in the format of Appendix Exhibit E of N.J.A.C. 11:3-16 incorporated herein by reference; a statement containing the effective date of the change for new and renewal policyholders; and the name, telephone number and mailing address of the company officer familiar with the filing to whom further inquiries regarding the filing may be directed;

2. A checklist that sets forth the information in Exhibit A in the subchapter Appendix incorporated herein by reference;

3. An exhibit, supported by an actuarial certification, that illustrates that the new rates are within the ranges permitted by N.J.S.A. 17:29A-36 and 29A-46.6(e);

4. The manual rating pages containing the territorial base rates by coverage to be implemented, accompanied by an explanatory memorandum showing the calculation of the new rates by coverage, using the existing rates by coverage as the starting point in the calculation; and

5. Completed rating examples using the examples set forth in N.J.A.C. 11:3-19A.3, which shows the proposed premium amounts.

(b) The filer may supplement a complete filing in response to questions from the Department about matters that require clarification or additional explanation, provided that the prompt review of the filing within the time frames set forth in this subchapter is not adversely affected.

Amended by R.2003 d.500, effective December 15, 2003.

See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).

In (a), inserted "the company's file number," following "the provisions of this subchapter;" and "for new and renewal policyholders" following "of the change" in 1 and deleted the last sentence of 4.

**11:3-16B.4 Rate process for limited rate changes;
calculation for private passenger automobile
insurance**

(a) General requirements for limited rate change filings are as follows:

1. Filers shall provide coverage indications based on three accident years of data. For coverages that are fully credible based on less than three years of data, filers may use two accident years of data to calculate indications for those coverages;
2. Indications may be based on either total limit or basic limit data for the liability coverages;

3. Coverage indications shall be calculated as follows:

- i. Filers that only sell split limits policies shall submit separate BI and PD indications;
- ii. Filers that only sell CSL policies shall submit one CSL indication. However, the BI and PD portion of losses shall be developed and trended using separate loss development triangles and trend factors;
- iii. Filers that sell both split limits and CSL policies can either submit separate BI, PD and CSL indications or allocate the CSL data between BI and PD;
- iv. Filers that sell PACK policies can submit one indication for the policy but the BI, PD and PIP portion of the losses shall be developed and trended using separate loss development triangles and trend factors; and

Raised the percentages from there to seven throughout; in (c), raised the single coverage percent from five to ten percent; rewrote (d) and added (e).

11:3-16B.6 Review; general principles; action

(a) If the Commissioner determines that the filing includes all the information and calculations required to support the rate change, then the Commissioner shall approve the filing.

(b) A filing will be deemed submitted when it is received by the Department's Property and Casualty Office and is accompanied by:

1. All the documents, exhibits and calculations required by this subchapter; and
2. A certification of a qualified actuary, specifying that the filing is complete and complies with this subchapter.

(c) After a filing has been submitted in accordance with (b) above, the Department, within 20 days of receipt, shall conduct a preliminary review to determine if it is in compliance with N.J.S.A. 17:29A-46.6 and this subchapter. If the filing is in compliance, it shall be deemed complete by the Department. If a filing is not in compliance, the filer will be notified of deficiencies in the filing within 20 days of receipt. If the filer is not notified of deficiencies within 20 days of receipt, it shall be deemed complete and is under review.

(d) The Commissioner shall render a decision on a filing requesting an increase of up to three percent within 30 days after receipt of the filing. A decision on a filing requesting an increase of more than three percent, but not more than seven percent, shall be rendered within 45 days after receipt of the filing.

(e) The Commissioner, pursuant to (a) above and N.J.S.A. 17:29A-46.6d, shall render one of the following determinations on the filing:

1. Approve the rate change filing as filed;
2. Disapprove the rate change filing; or
3. Approve a modified rate change filing.

(f) In the event additional time is needed to act on a complete rate change filing, the Commissioner may extend the time periods for review specified in (d) above by no more than 15 days.

(g) A disapproval or modification of the filing by the Commissioner shall be considered a final agency decision in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(h) If a filer has a pending application for prior approval rate change submitted in accordance with N.J.A.C. 11:3-16.6, the filer shall promptly amend such pending filing to reflect any rate change approved in accordance with this subchapter.

(i) If a filer has a pending application for a limited rate change pursuant to this subchapter, the filer shall promptly amend such pending filing to reflect any rate change approved in accordance with N.J.A.C. 11:3-16.6.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
Rewrote the section.

APPENDIX

Exhibit A

<u>Section</u>	<u>Description</u>	<u>Page Number</u>
16B.3(a)1	<ul style="list-style-type: none"> ● Cover letter notifying DOBI of intention to modify rates ● Statement of proposed changes (with \$ and %) by coverage ● Exhibit E (% Change, \$ Effect, and Current/Proposed Expense Fee by coverage) (from N.J.A.C. 11:3-16) ● Statement of Effective Date of Change ● Name/Telephone/Address of Company Officer ● Includes Company file number ● Includes New/Renewal effective dates 	
16B.3(a)2	This checklist	
16B.3(a)3	<ul style="list-style-type: none"> ● Compliance with N.J.S.A. 17:29A-36 <ul style="list-style-type: none"> ● No class factor above 2.50 ● No territory above 1.35 (incl. expense fees) ● No 65+ charged > 1.25 x 65+ average ● Compliance with N.J.S.A. 17:29A-46.6(e) 	
16B.3(a)4	<ul style="list-style-type: none"> ● Actuarial Certification of above ● Revised Manual Pages ● Includes calculation of new rates 	
16B.3(a)5	Rating Examples	
16B.4(a)1	Indications by coverage based on three years of data (or two years if fully credible with that data)	
16B.4(a)2	Liability data can be either at basic or total limits	Basic/Total
16B.4(a)3	Required Indications by Types Sold: <ul style="list-style-type: none"> ● Only split limit: separate BI and PD (with UM) ● Only CSL: CSL (with UM) with losses developed separately ● Both split & CSL: separate BI & PD (with UM), with CSL either allocated or done separately ● Only Package: PACK (with UM) with losses developed separately 	
16B.4(b)1	Earned Premium by coverage by accident year	
16B.4(b)2	On-Level factors based on company NJ rate changes	
16B.4(b)3	Comp & Coll Premium Trend Factors from ISO or internal data (with data and methodology used for internal)	
16B.4(c)1	NJ incurred loss and incurred ALAE (may be combined) by accident year by coverage (paid loss OK for COMP and COLL).	
16B.4(c)2	Loss Development Factors based on average of last five years excluding	

<u>Section</u>	<u>Description</u>	<u>Page Number</u>	<u>Section</u>	<u>Description</u>	<u>Page Number</u>
	high and low (that is, middle three of five years' factors)		16B.4(i)	If proposing territorial changes, territorial indication based on three years of data with credibility standard of 3,000 claims per territory (complement is Statewide indication above or current relativity)	
16B.4(c)3	<ul style="list-style-type: none"> ● BI/PIP developed to 87 months, tail factor of 1.05 PD/Comp/Coll developed to 51 months, tail factor of 1.00 Loss Trend Factors based on latest approved ISO filing or latest available NJ Fast Track, separately for frequency and severity by coverage. For Fast Track, 12 quarter rolling average used. For COMP, countrywide Fast Track data permitted. Must use paid claims (not incurred claims).		16B.4(j)	If expense fees changing, standard expense fee calculation. For other items changing, changes based on three-year relative loss ratios.	
16B.4(c)4	ULAE Factor is ratio of incurred ULAE to incurred Loss + ALAE, and comes from latest three available IEEs.		16B.4(k)	Alternate Methodology permitted (optional, see regulation)	
16B.4(c)5	Law changes accounted for: <ul style="list-style-type: none"> ● AICRA (effective 3/21/99) (all coverages) ● Primary Seatbelt (effective 5/1/00) (one percent BI and PIP) ● Graduated Licensing (effective 1/1/01) (one percent BI, PD, PIP, COLL) 		16B.5(a)-(b)	Request overall limited to smaller of seven percent or indicated change	
16B.4(c)6	Catastrophe Factor permitted for Comp from either ISO or internal data (minimum 10 years)		16B.5(c)	Request by coverage limited to smaller of 10 percent or indicated change	
16B.4(d)1	Commission and Brokerage Expenses based on NJ WP From Page 14 (three-year average)		16B.5(d)	Last limited rate change filing approved at least 12 months ago	Yes/No
16B.4(d)2	General Expense and Other Acquisition Expense based on CW EP from IEE (three-year average)				
16B.4(d)3	Expenses (1 and 2 above) capped by N.J.A.C. 11:3-16 Appendix H Calculation (see www.nj.gov/dobi for current expense caps)				
16B.4(d)4	Tax, License, and Fee Expense based on NJ WP from Page 14 (three-year average)				
16B.4(d)5	Profit and Contingencies provision based on Return on Equity Formula				
16B.4(d)6	Total Capped Expenses is sum of 3 through 5 above				
16B.4(e)	Permissible Loss Ratio is 1 minus (d)6				
15B.4(f)1	DOBI Credibility Standards BI/PD/CSL/PACK at total limits: 4,000 claims BI/PD/CSL/PACK at basic limits: 3,000 claims PIP/COMP/COLL: 3,000 claims				
16B.4(f)2	Company Calculated Credibility Standards (optional)				
16B.4(f)3	Credibility determined using square root rule, minimum 50 percent.				
16B.4(g)	Complement of credibility assigned to Loss Ratio Trend (Loss Trend divided by Premium Trend), trend period is effective date of last filing to proposed effective date.				
16B.4(h)1	Projected Ultimate Loss + LAE Ratio is (c)/(b)				
16B.4(h)2	Raw indication is (h)1/(e)				
16B.4(h)3	Credibility-weighted indication is as described				
16B.4(h)4	Overall indication is weighted average by latest year's earned premium				

Amended by R.2003 d.500, effective December 15, 2003.
 See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
 Rewrote the section.

SUBCHAPTER 17. RATE INTERVENOR RULES

Authority

N.J.S.A. 17:1-8.1, 17:1-15c and 17:29A-46.7 and 46.8.

Source and Effective Date

R.2001 d.270, effective August 6, 2001.
 See: 33 N.J.R. 1305(a), 33 N.J.R. 2694(a).

11:3-17.1 Purpose and scope

The purpose of these rules is to establish standards and procedures for persons who wish to intervene in private passenger automobile rate filings pursuant to N.J.A.C. 11:3-16.

11:3-17.2 Definitions

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

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Filer” means a rating organization or any insurer making its own rates or loss costs or a portion thereof, establishing or proposing to establish a new rate or rate change.

“Insurer” or “insurance company” means an entity authorized or eligible to transact the business of insurance in New Jersey.

“Intervenor” means a person or entity registered by the Commissioner of Banking and Insurance to intervene in rate filings. In order to be an intervenor, the person or entity shall file with the Department by submitting the registration form in accordance with N.J.A.C. 11:3-17.3.

“Rate filing” means a filing by an automobile insurer writing private passenger automobile insurance in this State, made pursuant to N.J.S.A. 17:29A-14 and N.J.A.C. 11:3-16, that seeks an overall rate increase. It does not include an expedited prior approval filing made pursuant to N.J.S.A. 17:29A-46.6; or a filing made pursuant to any statutory change in coverage; a policy form filing, tier rating filing, or classification rating plan.

“Rate increase” means a change in base rates or loss costs by coverage that results in an overall increase in premium.

“Substantial contribution” means that the intervenor substantially contributed, as a whole, to the Commissioner’s Final Decision and Order on the rate filing, by presenting relevant issues, evidence or arguments which were separate and distinct from those emphasized by the Department of Banking and Insurance staff or any other party, such that the intervenor’s participation resulted in more relevant credible, and nonfrivolous information being available for the Commissioner to make his or her decision than would have been available to the Commissioner had the intervenor not participated.

Amended by R.2001 d.441, effective November 19, 2001.
See: 33 N.J.R. 2730(a), 33 N.J.R. 3280(a), 33 N.J.R. 3897(a).
Added “Substantial contribution”.

11:3-17.3 Intervenor registration requirements

(a) Any person or entity that wishes to register as an intervenor in a rate filing shall certify to the following qualifications in the application form incorporated herein by reference as Appendix A to this subchapter:

1. Expertise in the insurance laws of this State;
2. An understanding of the actuarial principles employed in establishing rates and rating systems;

3. Sufficient access to a qualified actuary (for example, a Fellow of the Casualty Actuarial Society or a Member of the American Academy of Actuaries) and sufficient expertise to conduct a technical examination of a rate filing;

4. Sufficient resources to intervene in the rate filing process as provided in this subchapter; and

5. A demonstrated commitment to represent the interest of consumers and accept a duty of fidelity to do so.

(b) Persons or entities who have met the requirements in (a) above may register with the Department by submitting the following:

1. A completed registration form (Appendix A); and

2. A registration fee of \$100.00 dollars which shall accompany the registration form. A check or money order for the fee shall be made payable to the New Jersey Department of Banking and Insurance.

(c) An annual renewal fee of \$100.00 shall be made payable to the New Jersey Department of Banking and Insurance.

(d) Registration and renewal information shall be sent to the Department at the following address:

New Jersey Department of Banking and Insurance
Property/Casualty
Attention: Rate Intervenor Registration
20 West State Street
PO Box 325
Trenton, New Jersey 08625-0325

11:3-17.4 Penalties for intervenors or filers

(a) The Commissioner shall revoke the registration of an intervenor if he or she determines that:

1. The intervenor no longer meets the qualifications; or
2. The intervenor is convicted of a crime or loses a professional license for misconduct.

(b) An intervenor shall be forever barred from registration for conviction of a crime of the third degree if he or she solicits, accepts or agrees to accept any benefits as consideration for knowingly violating or agreeing to violate a duty of fidelity to which he or she is subject pursuant to N.J.S.A. 17:29A-46.8.

(c) A filer shall be barred from making a filing for any rate increase for a period of one year if the filer confers, or offers, or agrees to confer, any benefit the acceptance of which would be criminal pursuant to N.J.S.A. 17:29A-46.8. The Commissioner shall deny the rate filing of any filer convicted pursuant to N.J.S.A. 17:29A-46.8.

(d) The Commissioner shall notify an intervenor by certified mail of his or her revocation of registration as an intervenor pursuant to N.J.S.A. 17:29A-46.8.

(e) Revocation of an intervenor's registration shall be made by the Commissioner on his or her own motion or upon motion by a member of the public.

11:3-17.5 Notification of rate increase

(a) Upon receipt of a rate filing from a filer for a rate increase, the Commissioner shall:

1. Within five days of receipt of a rate filing, cause to be published a notification of the proposed rate increase in at least two newspapers of general circulation throughout the State; and
2. Promptly notify all registered intervenors by e-mail or fax within two days of receipt; and by notice on the Department's website of the receipt of a rate filing.

11:3-17.6 Procedures for intervening in a rate filing

(a) Procedures for review of rate filings shall be conducted in accordance with N.J.A.C. 11:3-18 and this subchapter.

(b) An intervenor shall notify the Department and the filer in writing, by mail or fax of its intent to intervene no later than 15 days after the Department's receipt of the rate filing. An intervenor may request and then shall receive a copy of the rate filing and any amendments and supplements thereto and shall pay the cost of copying and mailing as provided by N.J.S.A. 47:1A-2. Notice to the Department shall be sent to:

New Jersey Department of Banking and Insurance
Property/Casualty
Attention: Auto Unit/Rate Intervenor
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 777-0019

If the intervenor does not notify the Department and the filer of its intention to continue intervention within seven days after receipt of the copy of the rate filing, its notice of intention to intervene with respect to that filing is deemed withdrawn.

(c) If the Department determines that the filing is complete in that it satisfies the requirements set forth in N.J.A.C. 11:3-16, no supplemental information beyond limited requests to seek clarifying or explanatory information shall be permitted for the intervenor. The following procedures may be used by the intervenor to obtain clarifying, explanatory or supplemental information if necessary:

1. Not later than 30 days after the Department's receipt of the rate filing, the intervenor may request in writing to the filer that the filer provide relevant information that may be necessary to clarify or explain information contained in the filing. Not later than 15 days after receipt of any such request, the filer shall provide the clarifying or explanatory information to the intervenor and simultaneously to the Department.

2. Copies of all correspondence and any additional information exchanged by the parties shall also be provided to the Department. All correspondence to and from the intervenor shall be prominently marked "Rate Intervenor Correspondence."

3. If a filer denies an intervenor's information request pursuant to (c)1 above, the intervenor may petition the Commissioner for an order directing the filer to provide additional information that is required to clarify or explain information contained in the rate filing. This petition shall be submitted to the Department and the filer simultaneously within 10 days of the filer's denial or failure to respond or it shall be deemed waived.

- i. The petition shall include a list of the information requested and show good cause why the additional information is required. The filer may respond within five days to the Department and the intervenor.

- ii. Upon receipt of such petition, and after consideration of any responsive statement by the filer, the Commissioner shall either direct the filer to provide all or part of the information within a specified time, or deny the petition.

4. If a filer denies an intervenor's information request because the filer believes that the information is a trade secret or is otherwise confidential under New Jersey law, the filer shall notify the intervenor and the Department of these reasons not later than 10 days from receipt of the intervenor's request. After review of the filer's reasons for denial, the Commissioner shall either direct the filer to provide all or part of the information within a specified time, or deny the intervenor's request.

(d) The intervenor's Final Report on the rate filing shall be filed with the Department and provided to the filer within 75 days after the Department's receipt of the rate filing or 14 days prior to the hearing in accordance with N.J.A.C. 11:3-18.4, whichever is earlier.

Amended by R.2001 d.441, effective November 19, 2001.
See: 33 N.J.R. 2730(a), 33 N.J.R. 3280(a), 33 N.J.R. 3897(a).
In (b), added the sentence following the address.

11:3-17.7 Awarding of fees and expenses

(a) Any request for reimbursement shall be accompanied by an affidavit of expenses and shall simultaneously be submitted to the Department and the filer within 30 days of the Commissioner's Final Decision and Order on the rate filing. The request shall include a statement by the intervenor which details its substantial contribution to the adoption of the Commissioner's Final Decision and affirms that the intervenor has not violated the duty of fidelity. If the Commissioner determines that the intervenor has made a substantial contribution to the adoption of any order or decision by the Commissioner or a court in connection with the proceedings pursuant N.J.S.A. 17:29A-46.8, the Commissioner shall issue an Order directing the filer to pay the reasonable advocacy and witness fees and expenses of the intervenor.

(b) The Commissioner shall award reasonable advocacy and witness fees and expenses after consideration of the required affidavits, and upon a determination that the intervenor has demonstrated that he or she has made a substantial contribution to the adoption of any order or decision in connection with a rate filing made pursuant to N.J.S.A. 17:29A-46.8. The award shall be paid for by the filer.

APPENDIX A

New Jersey Department of Banking and Insurance
Office of Property/Casualty
RATE INTERVENOR REGISTRATION

Name _____

(Street Address) (City/Town) (State) (Zip Code)

(Area Code)-Phone Number Fax Number E-Mail Address

*Rate Intervenors are subject to a registration fee of \$100.00, which shall accompany this registration form and shall be made payable to: New Jersey Department of Banking and Insurance. Rate Intervenors are also subject to an annual renewal fee.

- (I) (We) have expertise in the insurance laws of this State.
- (I) (We) have an understanding of the actuarial principles employed in establishing rates and rating systems.
- (I) (We) have sufficient access to a qualified actuary and possess sufficient expertise to conduct a technical examination of a rate filing.
- (I) (We) have sufficient resources to intervene in the rate filing process as provided in N.J.A.C. 11:3-17.
- (I) (We) represent the interest of consumers and accept a duty of fidelity to do so.
- (I) (We) have not been convicted of any crime or lost a professional license for misconduct.
- (I) (We) certify that the foregoing statements made are true. (I am) (We are) aware that if any of the statements are willfully false, (I am) (We are) subject to punishment.

_____ Date

_____ Signature

For filings made in 2004, only the most recent four (2001-2004) years of expense information shall be required. For filings made in 2005, only the most recent five years (2001-2005) of expense information shall be required. For filings made in 2006, only the most recent six years (2001-2006) of expense information shall be required. For calendar-accident years for which expense information is not submitted in accordance with this clause, the expense provisions shall be calculated as the average of the years submitted.

Exhibit Five

All data in Exhibit Five is countrywide for CYs Year -1 through Year -7 and is not split by coverage.

- Part 1, Item 1: Agents Balance
- Part 1, Item 2: Unearned Premium Reserve
- Part 2, Item 1: Interest, Dividends and Real Estate Income
- Part 2, Item 2.1: Investment Expense Incurred
- Part 2, Item 2.2: Depreciation on Real Estate
- Part 2, Item 2.3: Unaffiliated Preferred Stock
- Part 2, Item 2.4: Affiliated Preferred Stock
- Part 2, Item 2.5: Unaffiliated Common Stock
- Part 2, Item 2.6: Affiliated Common Stock
- Part 2, Item 2.7: Other Invested Assets
- Part 2, Item 2.8: Real Estate for Company's Own Occupancy
- Part 2, Item 4.1: Bonds Acquired
- Part 2, Item 4.2: Mortgage Loans on Real Estate
- Part 2, Item 4.3: Real Estate Acquired (except that portion acquired for the insurer's own occupancy)
- Part 2, Item 4.4: Collateral Loans
- Part 2, Item 4.5: Cash on Hand and on Deposit
- Part 2, Item 4.6: Short Term Investments
- Part 2, Item 4.7: Derivative Investments

For filings made in 2004, only the most recent four (2001-2004) years of information shall be required. For filings made in 2005, only the most recent five years (2001-2005) of information shall be required. For filings made in 2006, only the most recent six years (2001-2006) of information shall be required. For calendar-accident years

for which information is not submitted in accordance with this clause, the provisions shall be calculated as the average of the years submitted.

Exhibit Six

All data in Exhibit Six is for the New Jersey Automobile Insurance Risk Exchange (NJ AIRE) and is AYs Year -1 through Year 7, evaluated @ 15 months and an estimate for AY Year 0 (applicable for BI only).

- Part 1: AIRE Allocation by AY received during the CY, as reported on the NJ AIRE Form 3 Reimbursement Report. Data for the latest AY shall be the company's best estimate; plus AIRE Investment Income by AY received during the CY, as reported on the NJ AIRE Annual Cash Settlement True-Up Report. Data for the latest AY shall be the company's best estimate.
- Part 4: AIRE Assessment by AY paid during the CY, as reported on the NJ AIRE Form 3 Reimbursement Report. Data for the current AY shall be the company's best estimate.

Exhibit Seven

All data in Exhibit 7 is for New Jersey business only and is for the CYs Year 0 through Year -16.

Item 1: List any excess profit refund paid in the applicable CYs

Item 2: List any excess profit carry forward used in the applicable AYs.

Exhibit Eight

All data in Exhibit 8 is for the New Jersey business only and is for the CY Year 0 through Year 16 and is for all coverages combined.

Item 1: List any extraordinary loss incurred in the applicable CYs.

Item 2: List any extraordinary loss carry forward used in the applicable AYs.

Item 4: List any funds reinvested into New Jersey in the applicable CYs.

Item 5: List any reinvestment carry forward used in the applicable AYs.

Exhibit Nine

All data on Exhibit 9, except for Items 19 and 23, is generated from other exhibits.

- Item 19: State the profit and contingencies provision on a pre-tax basis from the insurer's last approved New Jersey rate filing.
- Item 23: State whether or not the insurer is part of an insurance company holding system.

EXHIBIT ONE

Exhibit One removes UCJF and PLIGA Assessments, Excess Medical Benefit Reimbursements and other exclusions from Statewide premiums, losses and allocated loss adjustment expenses. Exhibit One consists of 36 sheets, one for each coverage for each of 9 CYs, beginning the year immediately prior to the year of submission and is uniform across all coverages.

For all columns, Item 2 is the sum of Items 2a-2f for premiums and Items 2a-2e for loss and ALAE from the Input Sheet. Item 3 is Item 1 - Item 2.

For Col (3), Item 5A is the sum of the excess profit refund paid, extraordinary loss incurred, and reinvestment into New Jersey listed in the Exhibits Seven and Eight portion of the Input Sheet. Item 5B = Item 3 Item 5A.

EXHIBIT TWO

Exhibit Two allocates CY Case Incurred Loss and ALAE to AYs and is uniform across all coverages.

Col (1) is the incremental Paid Loss for each AY in that CY only, taken from the Input Sheet.

Col (2) is the cumulative Paid Loss for each AY up to and including that CY.

Col (3) is the Case Unpaid Loss for each AY as of the end of that CY, taken from the Input Sheet.

Col (4) = Col (2) + Col (3).

Col (5) is the incremental Paid ALAE for each AY in that CY only, taken from the Input Sheet.

Col (6) is the cumulative Paid ALAE for each AY up to and including that CY.

Col (7) is the Case Unpaid ALAE for each AY as of the end of that CY, taken from the Input Sheet.

Col (8) = Col (6) + Col (7).

Col (9) = Col (4) + Col (8).

Col (10) is the incremental Paid Loss for each AY in the first quarter of that CY only, taken from the Input Sheet.

Col (11) = Col (2) + Col (10). For the most recent accident quarter, it is simply Col (10).

Col (12) is the Case Unpaid Loss for each AY as of the end of the first calendar quarter, taken from the Input Sheet.

Col (13) = Col (11) + Col (12).

Col (14) is the incremental Paid ALAE for each AY in the first quarter of that CY only, taken from the Input Sheet.

Col (15) = Col (6) + Col (14). For the most recent accident quarter, it is simply Col (14).

Col (16) is the Case Unpaid ALAE for each AY as of the end of the first calendar quarter, taken from the Input Sheet.

Col (17) = Col (15) + Col (16).

Col (18) = Col (13) + Col (17).

Col (19) through Col (23) are applicable only for Sheets 1 through 7 for each coverage.

Col (19) is the countrywide Direct Incurred Loss for that CY, taken from the Input Sheet.

Col (20) is the countrywide Direct Incurred ALAE for that CY, taken from the Input Sheet.

Col (21) = Col (19) + Col (20).

Col (22) is the countrywide Direct Incurred ULAE for that CY, taken from the Input Sheet.

Col (23) = Col (22) ÷ Col (21). The ULAE factor is the sum of one and the straight three-year average of the ratios, limited by a minimum of 1.05 and a maximum of 1.30.

EXHIBIT THREE

Exhibit Three shows the "development triangles" of Case Incurred Loss and ALAE for each coverage.

For each Part 2, any development factor that results in a division by zero shall instead not be considered in the calculation of loss development factors.

Part 1

Evaluations are at 15, 27, 39, 51, 63, 75, 87 and 99 months for BI and PIP coverages and at 15, 27, 39 and 51 months for PD and Phys Dam coverages.

This part is derived from Exhibit 2, Col (18).

- AY Year -1 @ 15 months = Sheet 1, AY Year -1.
- AY Year -2 @ 15 months = Sheet 2, AY Year -2.
- AY Year -2 @ 27 months = Sheet 1, AY Year -2.
- AY Year -3 @ 15 months = Sheet 3, AY Year -3.
- AY Year -3 @ 27 months = Sheet 2, AY Year -3.
- AY Year -3 @ 39 months = Sheet 1, AY Year -3.
- And so on through AY Year -8 @ 99 months for BI and PIP coverages and through AY Year -8 @ 51 months for PD and Phys Dam coverages.

Part 2

Development factors are through 87-99 months for BI and PIP coverages and through 39-51 months for PD and Phys Dam coverages.

See: 25 N.J.R. 1829(a), 26 N.J.R. 241(a).
 Amended by R.1996 d.58, effective February 5, 1996.
 See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
 Repeal and New Rule, R.1996 d.312, effective July 15, 1996.
 See: 28 N.J.R. 1616(a), 28 N.J.R. 3627(b).
 Administrative correction.
 See: 28 N.J.R. 3798(b).
 Amended by R.2002 d.386, effective December 2, 2002.
 See: 34 N.J.R. 1093(a), 34 N.J.R. 4053(a).
 Appendix deleted and replaced with new appendix.
 Amended by R.2004 d.97, effective March 15, 2004.
 See: 35 N.J.R. 3098(a), 36 N.J.R. 1426(a).
 Appendix deleted and replaced with new appendix.
 Amended by R.2004 d.338, effective September 7, 2004.
 See: 36 N.J.R. 1279(a), 36 N.J.R. 4147(a).
 Amended Exhibits One, Seven, Eight, and Nine.

SUBCHAPTER 20A. (RESERVED)

SUBCHAPTER 21. PERSONAL INJURY PROTECTION COVERAGE REDUCED PIP PREMIUM CHARGE FOR ADDITIONAL AUTOS IN ONE-DRIVER HOUSEHOLDS

11:3-21.1 Purpose

The purpose of this rule is to implement N.J.S.A. 39:6A-4.1, which provides for reduced personal injury protection premiums for additional automobiles in one-driver households.

11:3-21.2 Reduction of PIP premium

(a) In any instance where a named insured is the owner, the only designated operator of two or more automobiles insured by the same insurer under one or more policies, and the only licensed driver residing in the household, the full basic PIP rate shall be charged on one automobile, and a percentage discount shall be given on the PIP premium charge on each additional auto. For the three-year period commencing with the operative date of this rule, the premium reduction shall be at least 50 percent of the approved charge for the applicable territory of garaging for the additional automobile(s), exclusive of expense fees and policy constants or residual market equalization charges.

11:3-21.3 Automobiles eligible for premium reduction

(a) Except as provided in paragraph 1 below, the reduced premiums shall only apply to a private passenger automobile of a private passenger or station wagon type that is owned or hired by an individual or by husband and wife who are

residents of the same household and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; and a motor vehicle with a pick-up body, a delivery sedan, a van, or a panel truck or a camper type vehicle used for recreational purposes owned by an individual or by husband and wife who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching. An automobile owned by a farm family copartnership or corporation which is principally garaged on a farm or ranch and otherwise meets the definitions contained in this section, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.

1. The reduced premium shall not apply to automobiles for which the basic PIP premium charge is less than \$25.00, exclusive of expense fees and policy constants or residual market equalization charges, and which are of the following types:

- i. Automobiles 10 years or older and maintained primarily for use in exhibitions, parades and club activities, or
- ii. A self-propelled vehicle with a living area that is an integral part of the chassis or a pick-up with a permanently attached camper body.

(b) A reduced premium charge for PIP coverage as specified in (a) above shall apply to all policies which are in force, issued or renewed on or after the operative date of this rule.

1. With respect to in force policies, the insurer shall calculate the reduce premium charge in (a) above, and shall issue a refund check in this amount to the insured or apply a credit in this amount to the insured's renewal policy.

- i. In the event a policy is nonrenewed or otherwise terminated prior to renewal, the insurer shall calculate a return premium in accordance with the operative date of this rule and the effective termination date of the policy. The insurer shall issue a refund check in this amount to the insured.

11:3-21.4 Filing and statistical requirements

(a) Each automobile filer shall, within 60 days of the effective date of this rule, submit to the Commissioner for approval filings of rates and manual rules for implementing the reduced PIP premium charges for additional automobiles required by this rule.

(b) Insurers shall complete and file the information in Appendix B by January 1 of each year.

(c) Completed copies of Appendix B shall be submitted to:

Department of Banking and Insurance
Director of Public Affairs
PO Box 325
Trenton, New Jersey 08625-0325

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

11:3-25.10 Compliance

For treatments rendered between January 6, 1997 and July 6, 1997, all eligible charge reductions set forth in N.J.A.C. 11:3-25.5(b) shall be reduced by 50 percent (for example, a 10 percent reduction shall be five percent, a 25 percent reduction shall be 12.5 percent, etc.).

APPENDIX A

**Notification of Commencement of Medical Treatment
(to be filed with insurer)**

Name, address and phone number of Treating Health Care Provider:

Fax Number (optional) _____

Name and address of patient: _____

Name and address of insured: (if different)

Insurer Name: _____
Insurer Address: _____

Policy No. _____
Date of accident/injury: _____
Date of first treatment: _____

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).
Substituted a reference to Treating Health Care Providers for a reference to Treating Medical Providers

APPENDIX B

**Address for Notification of Commencement
of Medical Treatment**

Insurance Co. Name: _____
NAIC Group #: _____ NAIC Company #: _____
Address established by insurer for the filing of the notification of the commencement of PIP treatment by Treating Health Care Providers

Address: _____

Facsimile Number: _____
E-mail: _____
Contact Person: _____
Phone: _____

To be filed with:

Department of Banking and Insurance
Division of Public Affairs
PO Box 325
Trenton, NJ 08625-0325
Attn: Notification of Treatment List

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).
Substituted a reference to Treating Health Care Providers for a reference to Treating Medical Providers.

**SUBCHAPTER 26. UNSATISFIED CLAIM AND
JUDGMENT FUND: NOTICE OF INTENT**

11:3-26.1 Claim information

(a) Notice of intention to make a claim under N.J.S.A. 39:6-65 shall contain the following information:

1. The claimant's name, address, date of birth and social security number;
2. The time, date, location, municipality and county in which the loss occurred;
3. The identity of the operators and vehicles involved in the accident, including the name and address of the owner and operator and the license plate number of the vehicle;
4. Such witnesses to said accident as are then known;
5. A short description of the accident, including the claimant's role or position therein;
6. A description of the injuries then known, and attached thereto a medical certificate if then available. In any event the medical certificate shall be filed as soon as available;
7. A description of the damage sustained to property, and attached thereto an estimate of the cost of repairs if then available; and
8. The policy number of any insurance applicable to the accident, including the name and address of all insurance companies involved.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

In (a)1-5: added text to contents of claim information notice.
Added new (a)8.
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

11:3-26.2 Claim filing; form

(a) A Notice of Intention to make Claim under N.J.S.A. 39:6-65 may be filed on form UCJF #72 of the Unsatisfied Claim and Judgment Fund Board designated as a "Notice of Intention to Make Claim", incorporated herein by reference as Appendix A.

(b) A written notice to the Board in any other form that contains the information required by this section shall be acceptable.

(c) A notice of intention to make a claim that does not contain the items identified in N.J.A.C. 11:3-26.1(a) 1 through 8 shall be returned to the sender and deemed to be not filed with the Unsatisfied Claim and Judgment Fund (UCJF) for the purpose of complying with N.J.S.A. 39:6-65 and shall not toll the statute of limitations.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Added new subsection (c).

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1997 d.85, effective February 18, 1997.

See: 28 N.J.R. 5030(a), 29 N.J.R. 551(a).

In (a), inserted form number and reference to Appendix A.

4—QUESTIONS

- 1. Is the claim payable under an uninsured motorist endorsement? Yes ____ No ____
N.J.S.A. 17:28-1.1
(See check list, Section 5 below, before answering)
- 2. Were you covered by any Workers' Compensation Law for injuries received? Yes ____ No ____
N.J.S.A. 39:6-70
- 3. Were you the spouse, parent or child of the uninsured motorist against whom the claim was made? Yes ____ No ____
N.J.S.A. 39:6-70
- 4. Were you the owner or registrant of an uninsured motor vehicle? Yes ____ No ____
N.J.S.A. 39:6-70
- 5. Were you operating or riding in a motor vehicle without the permission of the owner? Yes ____ No ____
N.J.S.A. 39:6-70
- 6. Were you operating a motor vehicle in violation of an order of suspension or revocation of your license? Yes ____ No ____
N.J.S.A. 39:6-70
- 7. Are your medical bills payable under any medical payment plan? Blue Cross, HMO, private, etc. Yes ____ No ____
N.J.S.A. 39:6-86.2

ANY PERSON WHO PROVIDES ANY FALSE OR MISLEADING INFORMATION TO THE UCJF IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

I CERTIFY THAT ALL STATEMENTS MADE BY ME ARE TRUE.

I AM AWARE THAT IF ANY STATEMENTS MADE HEREIN ARE FALSE, I AM SUBJECT TO PUNISHMENT.

Signature _____ Date _____
CLAIMANT

Signature _____ I.D. No. or S.S. No. _____
PERSONAL REPRESENTATIVE

5—CHECK LIST

Please attach the following (where applicable) to this Notice of Intention.

- 1. A copy of the police report.
- 2. A certification by a physician of the injuries sustained, treatment provided and prognosis thus far.
- 3. Estimates of a repairman or an itemized repair bill for property damage other than to your vehicle.
- 4. Such information as is known to you as to liability insurance in effect with respect to the motor vehicles involved in the accident.
- 5. Have you checked as to the availability of uninsured motorist coverage? The liability insurance policy of the motor vehicles involved must provide uninsured motorist coverage to all persons in an insured vehicle. Uninsured motorist coverage is also available to the named insured and members of his household when he or she is a pedestrian or passenger in another vehicle.

6—LITIGATION

IF YOU HAVE COMMENCED A LAWSUIT, ATTACH A COPY OF THE COMPLAINT. IF YOU COMMENCE A SUIT AFTER FILING THIS NOTICE, YOU MUST NOTIFY THE UNSATISFIED CLAIM AND JUDGMENT FUND BOARD WITHIN 15 DAYS BY GIVING IT A COPY OF YOUR COMPLAINT. N.J.S.A. 39:6-65

7—YOU CANNOT COLLECT FROM THE FUND IF:

- 1. You fail to notify the Board of your intention to make a claim within ninety days of the date of the accident. N.J.S.A. 39:6-65
- 2. Claimant's injuries or death are covered by Workers' Compensation. N.J.S.A. 39:6-70
- 3. You are the spouse, parent or child of the judgment debtor (person against whom claim is made). N.J.S.A. 39:6-70
- 4. You were at the time of the accident operating or riding in a motor vehicle which you had stolen or helped to steal or were operating or riding in a motor vehicle without the owner's permission. N.J.S.A. 39:6-70
- 5. You were the owner or registrant of an uninsured vehicle. N.J.S.A. 39:6-70
- 6. The judgment debtor was insured at the time of the accident and the insurance company is liable to pay part or all of the judgment. N.J.S.A. 39:6-70
- 7. The claim is covered by uninsured motorist coverage, collision insurance, extended fire or other insurance. N.J.S.A. 17:28-1.1
- 8. The damage to your vehicle or property is covered by an insurance policy. N.J.S.A. 39:6-70
- 9. Your claim is for property damage of \$500.00 or less. N.J.S.A. 39:6-73
- 10. The claim is for property damage caused by a hit and run motor vehicle. N.J.S.A. 39:6-78
- 11. You were operating a motor vehicle in violation of an order of suspension or revocation. N.J.S.A. 39:6-70
- 12. The accident occurred out of State. N.J.S.A. 39:6-65

If you are a driver involved in an accident resulting in injury to or death of any person or damage to property of any one person in excess of five hundred dollars (\$500), you must report this accident to the Security Responsibility Accident Reporting Section, Division of Motor Vehicles, CN 050, Trenton NJ 08666-0050. N.J.S.A. 39:4-130

New Rule, R.1997 d.85, effective February 18, 1997.
See: 28 N.J.R. 5030(a), 29 N.J.R. 551(a).

SUBCHAPTER 27. UNSATISFIED CLAIM AND JUDGMENT FUND BOARD

11:3-27.1 Uninsured's current financial status

(a) Upon review of a case by the Unsatisfied Claim and Judgment Fund Board, if the Board does not have sufficient current information to determine whether or not the uninsured's installment payment is reasonable, a request will be addressed to the uninsured asking for a statement of current financial status.

(b) If the uninsured fails to furnish a completed statement of current financial status within a time period to be established by the executive director, the Unsatisfied Claim and Judgment Fund Board will request the Director of Motor Vehicles to suspend the license and all registrations of the uninsured pursuant to N.J.S.A. 39:5-30 and 39:5-87, for failure to furnish this information.

SUBCHAPTER 28. UNSATISFIED CLAIM AND JUDGMENT FUND'S REIMBURSEMENT OF EXCESS MEDICAL EXPENSE BENEFITS PAID BY INSURERS

11:3-28.1 Purpose and scope

(a) The purpose of this subchapter is to establish procedures to ensure that only appropriate, reimburseable claims are submitted to the Fund by insurers by requiring investigation of the medical necessity for certain claims; requiring the audit of claims of \$10,000 or more submitted by licensed providers of health care services or claims of \$25,000 or more by health care facilities; and requiring prior approval of claims for alterations to vehicles and residences. This subchapter also requires insurers to pursue the proper, alternative sources for reimbursement where such other sources of funds are available.

(b) This subchapter applies to all insurers authorized in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17-1. In accordance with N.J.S.A. 39:6-73.1, reimbursement for medical expense benefits may be sought from the Fund on account of personal injury to any one person in any one accident occurring on or after February 19, 1978.

(c) N.J.A.C. 11:3-28.13 establishes standards for insurers to demonstrate diligent pursuit of any potentially responsible tortfeasor for the purpose of recovering PIP medical expense benefits paid on behalf of the injured party by the Fund. Insurers shall obtain reimbursement from the Fund for excess medical expense benefit payments once they comply with the standards established herein. The purpose of these provisions are to contain costs for automobile insurance in this State. Accordingly, consistent with this purpose and N.J.S.A. 39:6A-9.1, for accidents occurring outside this State, insurers are expected to assert appropriate legal remedies to pursue recovery actions against potentially responsible tortfeasors, consistent with the legal rights and remedies asserted by the injured party.

Repeal and New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Section was "Notification of potential for payment of excess medical expense benefits".

Amended by R.2001 d.151, effective May 7, 2001.

See: 32 N.J.R. 3714(a), 33 N.J.R. 1389(a).

In (b), added the second sentence; added (c).

11:3-28.2 Definitions

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

"Board" means the Unsatisfied Claim and Judgment Fund Board created in accordance with N.J.S.A. 39:6-64.

"Diagnosis related groups" or "DRG" means a patient classification scheme in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (for example, length of stay or dollars).

"Excess medical expenses benefits" means medical expense benefits paid in accordance with N.J.S.A. 39:6A-4a, 39:6A-4.3, or 39:6A-3.1 that are in excess of \$75,000 resulting from personal injury to any one person in any one accident.

"Fund" means the Unsatisfied Claim and Judgment Fund established pursuant to N.J.S.A. 39:6-61 et seq.

"Health care facility" means a health care provider that is a facility or institution, whether public or private, engaged principally in providing services for diagnosis of treatment of pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, outpatient clinic, dispensary or residential health care facility.

“Health care provider” or “provider” means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to:

1. A hospital or health care facility which is maintained by a state or any of its political subdivisions;
2. A hospital or health care facility licensed by the Department of Health and Senior Services;
3. Other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiology and diagnostic testing, freestanding emergency clinics or offices, and private treatment centers;

4. A nonprofit voluntary visiting nurse organization providing health care services other than in a hospital;
5. Hospitals or other health care facilities or treatment centers located in other states or nations;
6. Physicians licensed to practice medicine and surgery;
7. Licensed chiropractors;
8. Licensed dentists;
9. Licensed optometrists;
10. Licensed pharmacists;
11. Licensed chiropodists (podiatrists);

12. Registered bio-analytical laboratories;
13. Licensed psychologists;
14. Licensed physical therapists;
15. Certified nurse-midwives;
16. Certified nurse-practitioners/clinical nurse-specialists;
17. Licensed health maintenance organizations;
18. Licensed orthotists and prosthetists;
19. Licensed professional nurses;
20. Licensed occupational therapists;
21. Licensed speech-language pathologists;
22. Licensed audiologists;
23. Licensed physician assistants;
24. Licensed physical therapists assistants;
25. Licensed occupational therapy assistants; and
26. Providers of other health care services or supplies, including durable medical goods.

“Health care service” means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of diagnosis or treatment of pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

“Insurer” means any person authorized or admitted in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17-1, pursuant to N.J.S.A. 17:17-1 et seq. or 17:32-1 et seq., as applicable. “Insurer” shall not include a surplus lines insurer eligible to write business pursuant to N.J.S.A. 17:22-6.40 et seq.

“Licensed nursing personnel” or “licensed nurse” means a nurse licensed by the New Jersey State Board of Nursing or the equivalent from another jurisdiction.

“Medical expense benefits” means medical expense benefits paid in accordance with N.J.S.A. 39:6A-4a or 39:6A-3.1 and N.J.A.C. 11:3-4.

“Medically necessary” is as defined in N.J.A.C. 11:3-4.2.

“Per diem” means a daily fixed charge which includes room and board and other fees for services and supplies.

“PIP coverage” means personal injury protection coverage as described in N.J.S.A. 39:6A-4 or 39:6A-3.1.

“Person” means any individual, association, company, corporation, insurer, joint stock company, organization, partnership, society, syndicate, trust, any combination of the foregoing acting in concert or any other entity.

“Pre-screen” means an off-site review of the billings from a health care facility to determine whether the care given and amounts charged are appropriate.

“Provider” means any person that furnishes services or equipment for medical expense benefits for which payment is required to be made under PIP coverage in automobile insurance policies, but does not include health care facilities.

“Reimbursement” refers to reimbursement to insurers by the Fund as provided at N.J.S.A. 39:6-73.1.

“Uninsured motorist claims” means claims submitted against operators of uninsured vehicles and hit and run claims submitted pursuant to N.J.S.A. 39:6-61.

New Rule, R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Amended by R.1994 d.597, effective December 5, 1994.

See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

Amended by R.1997 d.535, effective December 15, 1997.

See: 29 N.J.R. 4246(a), 29 N.J.R. 5309(a).

Amended “Insurer”.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

In “Excess medical expenses benefits”, inserted a reference to N.J.S.A. 39:6A-4.3 and 39:6A-3.1; in “Health care facility”, inserted “health care provider that is a” following “means a”; inserted “Health care provider” or “provider”; in “Medical expense benefits”, added a reference to N.J.S.A. 39:6A-3.1 and N.J.A.C. 11:3-4; rewrote “Medically necessary”; in “PIP coverage”, added a reference to N.J.S.A. 39:6A-3.1; and deleted “Provider”.

11:3-28.3 Report of claims when the carrier has paid at least \$50,000 for medical expense benefits

In cases where the potential exposure to the automobile liability insurer exceeds \$75,000, the insurer shall report on UCJF Form 1(321) (incorporated herein by reference as Form 1 in Appendix A) whenever medical expense benefits in a total amount of \$50,000 have been paid on account of personal injury to any one person in any one accident.

Recodified from 11:3-28.2 and amended by R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Amended by R.1997 d.85, effective February 18, 1997.

See: 28 N.J.R. 5030(a), 29 N.J.R. 551(a).

Amended form references.

11:3-28.4 Notice of change in the amount of reserves

Whenever an automobile liability insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount of \$50,000, said insurer shall notify the Fund of any changes in the

amount of reserves established for payment of the claim or closing of the file.

Recodified from 11:3-28.3 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.5 Supplemental forms to be submitted to the Fund

(a) UCJF Form 2(RR) (incorporated herein by reference as Form 2 in Appendix A), shall be filed with the Fund within 90 days after an automobile insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount in excess of \$75,000. Such form together with UCJF Form 3(323) (incorporated herein by reference as Form 3 in Appendix A) shall be filed each quarter thereafter that the insurer seeks reimbursement.

(b) Any office of an insurer seeking reimbursement of funds from the UCJF for personal injury protection medical expense must also complete and file with the UCJF a New Jersey Information Questionnaire, UCJF Form 4(W-9) (incorporated herein by reference as Form 4 in Appendix A).

Recodified from 11:3-28.4 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Amended by R.1997 d.85, effective February 18, 1997.
See: 28 N.J.R. 5030(a), 29 N.J.R. 551(a).
In (a), amended form references; and added (b).

11:3-28.6 Insurer's continuing obligation to investigate claims

(a) An automobile liability insurer shall be required to discharge its duty of investigating claims where the potential exposure to the insurer exceeds \$75,000. Said insurer's duty and obligation with regard to claim handling shall exist and continue to exist notwithstanding this rule. The Executive Director may direct such investigations as often as he or she deems necessary. All expenses relating to the investigation of claims, including expenses for medical examinations, file maintenance and cost containment measures, are the responsibility of the automobile liability insurer.

(b) The failure to properly discharge the duty of investigating a claim may result in the imposition of a penalty, to be determined by the UCJF Board of Directors, against the insurer's request for reimbursement.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Added new subsection (b) to text, therein creating subsection (a) to existing text.
Recodified from 11:3-28.5 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Case Notes

Insurer may request claimant to undergo physical or mental examination after cessation of benefits. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

Insurer may seek examination under oath of claimant after termination of benefits or demand of arbitration. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D. 1992).

Insurer's denial of benefits to claimant who refused examination under oath was not warranted. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

11:3-28.7 Reimbursement of excess medical expense benefits paid by insurers

(a) Insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefit claim payments as soon as practicable after the close of the quarter for which reimbursement is sought. The Fund shall reimburse automobile liability insurers for excess medical expense benefits on a quarterly basis. Insurers shall not be reimbursed for interest, attorney fees or punitive damages.

1. For a period of one year from the date of payment of a claim for excess medical expense benefits by an insurer, the insurer may submit to the Fund a request for reimbursement of a claim which was not included in the insurer's quarterly submission. The insurer shall include with its request, specific documentation to identify the subject payment.

2. Failure to comply with the requirements set forth in (a)1 above shall result in a denial by the Fund of the reimbursement request which was omitted from the quarterly submission.

(b) The Fund shall not reimburse an insurer for excess medical expense benefits if it is determined that there are multiple insurance policies applicable to a claim unless an insurer has expended medical benefits in an amount exceeding \$75,000 on account of personal injury to any one person in any one accident. Where there are two or more different primary insurers liable, the Fund shall not reimburse such an insurer for excess medical expense benefits unless each primary insurer has expended medical benefits in an amount exceeding \$75,000 on account of personal injury to any one person in any one accident.

(c) Where the Fund has reimbursed an insurer for excess medical expense benefits and thereafter determines that there were or are multiple insurance policies applicable to the underlying claim, the insurer shall return all moneys paid from the Fund. The insurer(s) shall apportion the medical benefits payment and make individual application to the Fund where the potential exposure to the insurer(s) exceeds \$75,000 on account of personal injury to any one person in any one accident.

(d) Whenever an insurer recovers amounts expended by it for medical benefits, it shall not be reimbursed for excess medical expense benefits unless it has fully repaid the amount previously reimbursed by the Fund.

Recodified from 11:3-28.6 and amended by R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Case Notes

Unsatisfied Claim and Judgment Fund not required to reimburse insurers of out-of-state vehicles for PIP benefits in excess of \$75,000. *Martin v. Home Ins. Co.*, 141 N.J. 279, 661 A.2d 808 (1995).

11:3-28.8 Audits

Upon request of the Fund, the insurer(s) shall present for audit at the direction of the Executive Director at a New Jersey location all policy and claim records on which notice of potential for payment of excess medical expense benefits have been submitted.

Recodified from 11:3-28.7 and amended by R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.9 Reporting of losses for personal injury protection payments in excess of \$75,000

(a) For purposes of completing page 14, Exhibit of Premiums and Losses, of the annual statement filed pursuant to N.J.S.A. 17:23-1, the insurer shall include the total amount of losses for private passenger automobile and commercial automobile personal injury protection payments (lines 19.1 and 19.3), including those in excess of \$75,000. Insurers shall also provide a footnote on page 14 that indicates the amount of losses reported, excluding losses from payments of private passenger automobile and commercial automobile personal injury protection payments in excess of \$75,000.

(b) For purposes of completing Schedule F of the annual statement, insurers shall consider the assumption and reimbursement by the Fund of private passenger automobile and commercial automobile personal injury protection payments in excess of \$75,000 as a reinsurance transaction. Insurers shall consider assessments paid to the UCJF pursuant to N.J.S.A. 39:6-63 based on the insurer's premiums for private passenger automobile liability insurance (including PIP) and commercial automobile liability insurance (including PIP) as ceded premium, pro rated for the appropriate line of business on which the assessment was based.

(c) Insurers shall comply with the provisions of this section beginning with the annual statement due March 1, 1994 (covering the calendar year ended December 31, 1993). For purposes of completing the annual statement due March 1, 1993 (covering the calendar year ended December 31, 1992), insurers shall file by no later than July 1, 1993 a supplemental page 14 and schedule F of the annual statement in accordance with the provisions of this section.

New Rule, R.1993 d.178, effective April 19, 1993.

See: 24 N.J.R. 3215(a), 24 N.J.R. 1769(a).

Recodified from 11:3-28.8 and amended by R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.10 Insurers' obligations to investigate and audit bills for medical benefits

(a) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by health care facilities where such claims are equal to or in excess of \$25,000.

1. Failure of an insurer to complete an audit in accordance with these rules shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

2. Per diem billings for health care facilities are not subject to the audit requirements set forth in this subchapter.

3. An insurer shall conduct an initial on-site audit for charges by health care facilities to determine whether the level of care, need and charges are appropriate.

4. An insurer may pay 80 percent of the provider's bill prior to completion of the initial on-site audit. The remaining amount due, if any, shall be paid following completion of the insurer's audit.

5. Annual on-site audits shall be completed in 12-month intervals, from the initial on-site audit and shall be filed with the Fund within 90 days of completion of the audit; and

6. Whenever a change in services occurs such as, but not limited to, the level of care, the daily room rate or additional charges, an insurer shall conduct an on-site audit and shall provide the audit and auditor's statement to the Fund with the next reimbursement request.

7. All other audits shall be conducted prior to payment to the health care facility and may be performed on a pre-screen basis as set forth in (e) below.

(b) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by providers other than health care facilities where such claims are equal to or in excess of \$10,000.

1. Failure of an insurer to complete an audit in accordance with this subchapter shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

(c) The thresholds in (a) and (b) above are cumulative for each confinement associated with damages resulting from bodily injuries arising out of the ownership, maintenance or use of a motor vehicle in this State and shall incorporate all claims submitted per confinement by the provider.

(d) To be eligible for reimbursement by the Fund, insurers shall audit, prior to payment, bills submitted for continuous treatment from any provider which exceed or may exceed the applicable threshold.

(e) Audits of all providers conducted pursuant to this subchapter, including the audit of DRG bills and successor pricing, shall be performed by:

1. Licensed nursing personnel with two years experience or training in required auditing and hospital practices; or
2. An outside auditing firm retained by the insurer for such purposes.

(f) Audits performed shall include, but not be limited to, confirmation of compliance with the medical fee schedule set forth at N.J.A.C. 11:3-29 including those situations where the insurer does not provide the primary coverage to the claimant.

(g) An insurer is not required to conduct a separate, independent audit, if it has obtained a true copy of an audit conducted by the primary insurer or health insurer.

(h) Insurers shall append copies of audits conducted, including those conducted by the primary insurer or health insurer, and the auditor's statements with the reimbursement request filed with the Fund in accordance with N.J.A.C. 11:3-28.7.

New Rule, R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

In (b), inserted "other than health care facilities" following "providers" in the introductory paragraph; in (c), deleted "health care facility or by each individual" preceding "provider"; and in (d) and (e), deleted references to health care facilities.

11:3-28.11 Modifications to vehicles

(a) An insurer shall obtain prior approval from the Fund for modifications to a claimant's vehicle, or vehicle to be used for the benefit of the claimant, the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, seeking approval of modifications which are equal to or in excess of \$1,000, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:
 - i. Where the claimant is the operator of the vehicle, current findings on the claimant's physical ability to drive and a copy of the claimant's current driver's license;
 - ii. A brief analysis of the medical necessity and medical purpose for the requested modifications;
 - iii. A description of the purpose for which the vehicle will be used; and

iv. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. A cost benefit analysis, supported by appropriate documentation, comparing the cost of modifying the claimant's vehicle to the cost of alternate methods of transporting the claimant. This analysis shall incorporate an evaluation of the anticipated miles to be driven per year for medically necessary health care services, including a breakdown reflecting the number of miles to be driven to obtain health care service and the frequency of such services, the cost per mile of alternate means of such transportation, as well as the useful life of the vehicle;

3. An agreement between the insurer and the claimant setting forth, but not limited to:

- i. The claimant's responsibility to maintain insurance on the vehicle; and
- ii. The claimant's responsibility to repair and maintain the vehicle; and

4. Any additional information specifically requested by the Fund with regard to a particular application for approval.

(d) The insurer may independently evaluate, or be required by the Fund to evaluate, the claimant by a physician chosen by the insurer and approved by the Fund, at the insurer's cost, to determine whether a medical necessity and medical purpose exist for modifications to the vehicle. The evaluation shall include a review of the elements considered in the primary evaluation as set forth at (c) above.

(e) The Fund shall not approve modifications to a vehicle unless it is demonstrated that the modifications are required for purposes of medical necessity resulting from injuries sustained by the claimant in the subject accident, are required for a medical purpose and the modifications are shown to be cost effective or as the Fund may otherwise determine.

(f) A request for modifications may be denied for failure to fulfill any of the above conditions.

New Rule, R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.12 Modifications to a claimant's residence

(a) An insurer shall obtain prior approval from the Fund for any modifications to a claimant's primary residence the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, seeking approval of modifications which are equal to or in excess of \$10,000, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:

i. A brief analysis of the medical necessity for the requested modifications; and

ii. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. Medical documentation estimating the claimant's life expectancy;

3. A cost benefit analysis, supported by appropriate documentation, which establishes that the proposed modifications are more cost effective than long term residential care services. The analysis shall include, in accordance with Appendix B incorporated herein by reference, an evaluation based on the life expectancy of the claimant and a comparison between the costs of the modifications and home care to be provided, to the costs of other residential care alternatives;

4. An evaluation prepared by an independent consultant experienced in barrier free designs that sets forth the type of modifications required and the costs of such modifications;

5. An agreement setting forth the responsibilities regarding the obligations of the claimant, the owner of the property or both and the insurer for, but not limited to:

i. The claimant's or property owner's responsibility for:

(1) The expenses for upkeep of the residence;

(2) Maintenance of insurance on the property; and

(3) Repayment to the insurer in the event of the claimant's relocation, death or upon the sale of the modified premises; and

ii. The insurer's obligation to remove nonessential equipment;

6. A repayment agreement with an amortization provision which provides an amortization term and amount, once a modification is determined to be cost effective, calculated in accordance with the formula provided in Appendix B to this subchapter; and

7. Any other additional information specifically requested by the Fund with regard to a particular application for approval.

(d) The insurer may independently evaluate, or be required by the Fund to evaluate, the claimant by a physician chosen by the insurer and approved by the Fund, at the insurer's cost, to determine whether a medical necessity for the modifications exist. The evaluation shall include a

review of the elements considered in the primary evaluation as set forth at (c) above.

(e) The Fund shall not approve modifications to a residence unless it is demonstrated that the modifications are required for purposes of medical necessity resulting from injuries sustained by the claimant in the subject accident and the modifications are shown to be cost effective or as the Fund may otherwise determine.

(f) A request for modification may be denied for failure to fulfill any of the above requirements.

(g) Where a request for modifications is approved, the insurer shall record a lien against the modified property in the county in which the property is located and shall file a copy of the recorded lien with the Fund within 30 days.

1. This provision shall not apply to rental property.

(h) Where a claimant seeks to modify rental property, the insurer shall obtain:

1. A written consent from the owner of the property which permits the modifications and indemnifies the insurer and the Fund from any other liabilities relating thereto; and

2. A written agreement between the claimant and the insurer, in which the claimant agrees to reimburse the insurer for the unamortized costs of the improvements in the event of the claimant's relocation or death.

(i) Upon the claimant's relocation or death, the claimant, the claimant's estate or the owner of the property against which the lien is recorded, shall reimburse the insurer for the unamortized cost of the modifications to the claimant's residence.

(j) The claimant, the claimant's estate or the owner of the property against which the lien was recorded, shall have a reasonable period in which to reimburse the insurer.

(k) Where repayment by the claimant or the claimant's estate is required pursuant to this section, interest shall accrue at the prevailing rate of post judgment interest as set forth in the rules governing civil practice in the New Jersey Court Rules in effect at the time of execution of the repayment agreement, until the amount owed is paid in full.

(l) Within 30 days from the date of the claimant's relocation or death, the insurer shall so notify the Fund in writing and shall include the terms of repayment by the claimant to the insurer. The insurer shall repay the Fund for such reimbursement.

1. The insurer shall be required to repay the Fund within 60 days from receipt of any and all partial payments or from the receipt of a payment made in full by the claimant.

(m) A warrant discharging the lien shall be filed by the insurer when the full amount owed to the insurer, in accordance with the amortization agreement, is satisfied.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.13 Insurer's obligation to obtain recovery of payments for paid medical expense benefit claims

(a) The Fund shall reimburse insurers for paid medical expense benefit claims if an insurer demonstrates that it has diligently pursued all potentially responsible tortfeasors within the time prescribed at N.J.S.A. 39:6A-9.1, or any other applicable limitation period.

1. An insurer shall demonstrate, in accordance with (c) below, that it has diligently pursued any potentially responsible tortfeasor to obtain reimbursement of PIP medical expense benefit claim payments made by the insurer from the Fund.

2. Where the insurer has failed to diligently pursue any potentially responsible tortfeasor as set forth in (c) below, the Fund shall be entitled to discontinue reimbursements on that claim. The Fund shall also be entitled to recover from the insurer any reimbursement payments already made to the insurer on that claim, after notice and opportunity for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

3. An insurer shall obtain prior approval from the Fund before settling or compromising a claim against a potentially responsible tortfeasor or a tortfeasor.

(b) Any and all expenses and fees incurred by the insurer as a result of the pursuit of a potentially responsible tortfeasor, shall be borne by the insurer.

(c) For purposes of this section, "diligently pursue" means that the insurer has either prosecuted or is prosecuting an action, including by agreement or arbitration, in matters subject to N.J.S.A. 39:6A-9.1, against all potentially responsible tortfeasors, or determined not to do so after:

1. Examining or reviewing the following documents, where applicable:
 - i. Police accident reports, including fatal accident reports and supplemental reports;
 - ii. Statements of the parties involved;
 - iii. Witness statements;
 - iv. Central Index Bureau return results;
 - v. Information about the assets of uninsured tortfeasors;
 - vi. Scene photographs and diagrams;

vii. Reports of blood alcohol content;

viii. Relevant court records and information on any related suits, arbitrations, settlements or judgments, either within or outside the State, including, but not limited to:

(1) Pleadings;

(2) Transcripts of depositions and other related discovery materials; and

(3) Amounts of settlements or judgments; and

ix. Information about the amount of any potentially responsible tortfeasor's insurance liability limits, including, but not limited to, umbrella and excess insurance policies; and

2. Considering the following factors in determining whether to prosecute an action against potentially responsible tortfeasors:

i. The liability of the parties involved;

ii. Relevant law regarding right of recovery actions; and

iii. The basis for denial of coverage by the insurer of the potentially responsible tortfeasor.

(d) Insurers shall file a certification, in the form of Appendix C incorporated herein by reference, that they have diligently pursued recovery of medical expense benefits, and that the insurer has not received from any source reimbursement, contribution, or indemnification of the excess medical benefits paid by the insurer for which reimbursement from the Fund is sought. This certification shall be signed by an officer of the insurer or other person authorized to sign the certification on behalf of the insurer, and shall be filed no later than two years from the date of the accident, prior to expiration of any applicable statute of limitations, or at the time filing for reimbursement is made, whichever occurs first. Failure to file the certification shall result in denial of reimbursement to the insurer by the Fund.

New Rule, R.1993 d.583, effective November 15, 1993.

See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Amended by R.2001 d.151, effective May 7, 2001.

See: 32 N.J.R. 3714(a), 33 N.J.R. 1389(a).

Rewrote (a); in (b), deleted "right of recovery against a" and inserted "potentially responsible" preceding "tortfeasor"; added (c) and (d).

11:3-28.14 Insurer's responsibility upon assignment of an uninsured motorist claim

(a) An insurer shall, within 10 business days of receipt of a claim assignment and accompanying instruction sheet (see Appendix B, Item 1, incorporated herein by reference) from the Fund, submit a letter to the Fund which:

1. Acknowledges receipt of the assignment and the accompanying instruction sheet; and

2. Provides the names and telephone numbers of the case handler or manager, the claim investigator and the claim adjuster.

(b) An insurer shall, within 10 business days from the date it assigns the claim to defense counsel, provide the Fund with the name, address and telephone number of defense counsel.

(c) An insurer shall, within 10 business days, provide written notice to the Fund of any changes, substitutions or replacements which occur with respect to any of the persons identified pursuant to (a)2 or (b) above.

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

11:3-28.15 Procedures for handling as assigned uninsured motorist claim

(a) Each insurer shall:

1. Perform an investigation in accordance with the procedures set forth in the instruction sheet and obtain the following:

- i. Confirmation that there is no insurance available for the claim;
- ii. Confirmation of the claimant's eligibility based on N.J.S.A. 39:6-70 or 39:6-78;
- iii. A police report;
- iv. Witness statements;
- v. Copies of medical reports, bills and hospital records; and
- vi. A central index bureau ("C.I.B.") report;

2. Forward to assigned defense counsel a copy of the instruction sheet for reference; and

3. Forward to the Fund's claim adjuster for certification responses to interrogatories propounded upon the Commissioner in hit and run cases.

(b) An insurer or assigned defense counsel shall obtain and file with the Fund, within five business days of receipt, all documents which relate to the claim including, but not limited to:

1. Documents relating to the discovery of information including, but not limited to:

- i. Interrogatories propounded by the claimant and any responses thereto;
- ii. Responses to interrogatories propounded by the insurer;
- iii. Deposition notices; and
- iv. Deposition transcripts;

2. Documents filed with the court including, but not limited to:

- i. Motion papers;
- ii. Briefs; and
- iii. Settlement or consent agreements; and
- iv. Orders entered by the Court; and

3. Scheduling notices, notices of arbitration and any results thereof; other correspondence from the courts; and any judgments or court decisions which affect the claim in whole or in part and copies of trial or hearing transcripts upon the request of the Fund.

(c) Within 60 days of receipt of a claim assignment, an insurer shall file with the Fund a completed 60-day Report as set forth in Appendix B, Item 2, incorporated herein by reference, and the following information:

1. The results of the investigation conducted in accordance with (a)1 above;
2. An estimate of the amount of damages involved;
3. A brief synopsis of the status of the case;
4. All answers to interrogatories not previously filed, which have been propounded on the Fund, the Commissioner or any known defendants;
5. Answers to interrogatories propounded by the insurer; and
6. Any other pertinent documents filed with the court in connection with the matter which were not previously forwarded to the Fund.

(d) At six-month intervals, the following initial receipt of a case assignment, an insurer shall file with the Fund an updated, detailed Six Month Summary Report as set forth at Appendix B, Item 3. Incorporated herein by reference, and the following information:

1. An update of the information set forth in (b) and (c) above;
2. A brief summary which describes the status of the case, outlines the action taken to date, sets forth anticipated future action and/or strategy; and the anticipated outcome;
3. The discovery of any evidence of a fraudulent claim. Such information shall be referred to an insurer's special investigation unit. The unit shall, thereafter forward its findings to the Office of the Insurance Fraud Prosecutor with a copy to the Fund; and
4. All other relevant information discovered during the pendency of the claim.

(e) An insurer shall provide notice to the Fund of any and all hearings, motions, arbitration and trial dates in a manner which provides sufficient notice to facilitate the

Fund's review of the file prior thereto. An insurer shall provide notice to the Fund's claim adjuster either by telephone and confirming letter, facsimile transmission or mail.

(f) An insurer shall consult with the Fund and obtain prior approval from the Board before:

1. Entering into a settlement or judgment by consent in accordance with N.J.S.A. 39:6-72 or 6-82;
2. Proceeding to trial; or
3. Filing a motion for reconsideration.

(g) An insurer shall consult with the Fund and obtain prior approval from the Board before filing an appeal from an order or judgment adverse to the Fund.

(h) Prior approval from the Board shall be obtained by telephoning the Fund at (609) 292-3100 or by writing to:

Fund Adjuster
Unsatisfied Claim and Judgment Fund
PO Box 325
Trenton, NJ 08625-0325

(i) For each assigned claim, an insurer shall review all medical bills submitted by claimants to ensure compliance with the medical fee schedule set forth at N.J.A.C. 11:3-29. Where a medical bill is not in compliance with N.J.A.C. 11:3-29, the insurer shall immediately notify the Fund of the discrepancy.

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-28.16 (Reserved)

11:3-28.17 Penalties

Failure of an assigned insurer to comply with these rules shall result in the imposition of penalties prescribed by law.

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

(b) Within 10 working days of a determination to deny automobile insurance in the voluntary market (from either a written application or from the date that an oral request is made for a written determination), an insurer or agent shall notify an applicant, in writing, of each specific reason for the denial. The reasons provided by an insurer or insurance agent shall be comprehensive and written in plain language. The reasons shall identify the specific basis for which the applicant fails to qualify as an "eligible person."

(c) An insurer or agent who has issued a written denial shall notify an applicant of his or her right to appeal the denial to the Department, pursuant to the provisions of this subchapter. That insurer or agent shall also advise the applicant of his or her obligation to obtain insurance coverage as a condition of operation of the vehicle. As part of this notification, an insurer or agent shall provide an applicant with the letter and appeal form which comprise Appendices A and B to this subchapter set forth and incorporated as part of this rule. For nonrenewals, the insurer shall provide the notice set forth in N.J.A.C. 11:3-8.3 together with the letter and appeal form when nonrenewing an applicant pursuant to N.J.A.C. 11:3-8.4.

11:3-33.5 Procedure for filing an appeal

(a) Appeals from a denial of automobile insurance in the voluntary market shall be submitted to the Department, on a form prescribed by the Department (Appendix B to this subchapter, which is incorporated herein by reference as part of this rule), within 90 days of the date of a written denial from an insurer or insurance agent. Notwithstanding an insurer's or agent's obligation to provide a person with this form upon a denial of initial coverage (see N.J.A.C. 11:3-33.4(c)), copies can also be obtained by contacting the Department by telephone (609) 984-2426 or by mail at the address below:

Department of Banking and Insurance
 Division of Enforcement and Consumer Protection
 Attn: Auto Insurance Denial
 20 West State Street
 PO Box 329
 Trenton, New Jersey 08625-0329

(b) The form prescribed by the Department shall be completed and submitted to the address above and shall include, at a minimum, the following information:

1. A copy of the written denial obtained from the insurer or agent pursuant to N.J.S.A. 17:33B-16 and N.J.A.C. 11:3-33.4. When an applicant receives an oral denial, he or she shall request a written denial as provided by N.J.A.C. 11:3-33.4; and
2. A statement from the applicant who has received a denial of coverage, including supporting documentation, if any, indicating the reasons why the denial is improper.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-33.6 Processing appeals

(a) Upon receipt of an appeal submitted in accordance with N.J.A.C. 11:3-33.5, the Department shall send to the insurer or insurance agent (the "respondent") who provided the written denial, a copy of all pertinent documents which have been submitted by applicant (the "appellant"), and shall require a final written reply from the respondent within 30 days of the receipt of these documents.

(b) Upon the Department's receipt of the respondent's reply to the appeal, and upon a review of the papers, the Department shall render its decision on the appeal. The decision shall be in writing and shall set forth the reasons why the denial was appropriate or inappropriate under law. Copies of the Department's decision shall be mailed by certified mail to the appellant and the respondent. The Department's decision shall also include a written notice explaining the procedures to appeal the decision pursuant to N.J.A.C. 11:3-33.7.

(c) A respondent's failure to timely reply pursuant to (a) above shall result in a decision by the Department based solely upon the papers submitted by the appellant, together with any other information available to the Department at that time, pursuant to this subchapter. A respondent's failure to timely reply pursuant to (a) above shall be deemed a violation of this subchapter and may result in the assessment of penalties provided in N.J.A.C. 11:3-33.8.

(d) Upon a determination by the Department that a denial was improper, the insurer shall be required to offer the applicant the requested coverage effective as of the date of the declination. The Department may, however, determine to require the insurer to offer coverage effective on a later date upon a finding that the applicant failed to maintain insurance on an automobile as required by N.J.S.A. 39:6B-1.

11:3-33.7 Contested case hearings; pleadings

(a) An appeal from a decision of the Department made pursuant to N.J.A.C. 11:3-33.6 shall be heard as a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., as implemented by the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) The procedure for filing an appeal from the Department's decision pursuant to N.J.A.C. 11:3-33.6(c) shall be as follows:

1. Upon receipt of the Department's decision, the insurer or agent denying coverage or the applicant denied automobile insurance coverage shall, within 20 calendar days of receipt of the decision, file with the Department a written request that the matter be heard as a contested case. Failure to file an appeal within the time required by this section shall result in the Department's decision becoming the final agency action. The written request

for a hearing as a contested case shall contain the following information.

- i. The name and address of the appellant;
- ii. The Department's case or file number;
- iii. If the appellant is the person denied insurance, the name and address of the insurance company and/or insurance agent which issued the denial of automobile insurance. If the appellant is the insurance company, the name and address of the insurance agent who issued the denial of coverage, if any, and the name and address of the person to whom automobile insurance was denied;
- iv. A detailed statement explaining the reasons why the Department's determination is improper together with supporting documentation, if any; and
- v. A statement as to whether the appellant is represented by legal counsel, or another person pursuant to N.J.A.C. 1:1-5.1, and the name, address and telephone number of said person.

(c) Upon the Department's timely receipt of the items set forth in (b) above, it shall simultaneously send a copy of the documents to the opposing party and shall transmit the matter to the Office of Administrative Law for hearing as a contested case.

11:3-33.8 Penalties

Any insurer or insurance producer who violates any provision of this subchapter shall be subject to the penalties provided by law, including, but not limited to, the suspension or revocation of a certificate of authority or licensure and a civil penalty in an amount of up to \$2,000 for the first violation and up to \$5,000 for the second and each subsequent violation, pursuant to N.J.S.A. 17:33B-15 and 21.

11:3-33.9 Compliance

(a) Pursuant to N.J.S.A. 39:6A-3 and 17:33B-15, compliance with the provisions of this subchapter shall be effected in the following manner:

1. Appeals from denials concerning new policies on or after April 1, 1992 may be filed in the manner prescribed by this subchapter; and
2. Appeals from denials concerning policy renewals which take effect on or after April 1, 1992, may be filed in the manner prescribed by this subchapter.

APPENDIX A

Dear Applicant,

The "Fair Automobile Insurance Reform Act of 1990" (Act) provides that on or after April 1, 1992, every insurer, either by one or more separate rating plans, shall provide automobile insurance for eligible persons.

Therefore, an insurer may deny coverage only to those applicants who are not eligible. New Jersey law provides that any person who owns or has registered an automobile in New Jersey or a person who has a valid New Jersey drivers license is eligible except a person:

1. Who, in the last three years, has been convicted of driving under the influence or refusing a chemical test in New Jersey or elsewhere;
2. Who, in the last three years, has been convicted of a crime involving an automobile;
3. Whose driving license is suspended or revoked by a court;
4. Who, in the last five years, has been convicted of fraud or intent to defraud involving an insurance claim or application;
5. Who, in the last five years, has been denied payment of an insurance claim in excess of \$1,000, if there was evidence of fraud or intent to defraud;
6. Whose automobile insurance policy, in the last two years, was cancelled because of nonpayment of premium or financed premium (unless the entire annual premium for the new coverage is paid in full before issuance or renewal);
7. Who fails to maintain membership in a club, group or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance;
8. Whose driving record, for the last three years, has an accumulation of seven or more eligibility points. (Eligibility points are accumulated as a result of convictions, suspensions, revocations and determination of responsibility for civil infractions in accordance with schedules adopted by the New Jersey Department of Banking and Insurance. For example, one at-fault accident has been assigned five eligibility points.);
9. Who, during the three-year period immediately preceding application for, or renewal of, an automobile insurance policy, has knowingly provided materially false or misleading information in connection with an application for insurance, or renewal of insurance or claim for benefits under an insurance policy; or
10. Who is a named insured or who is insured under the same policy as a person whose driver's license is suspended or revoked and either:
 - i. The suspended or revoked driver has been convicted of a violation of N.J.S.A. 39:6B-2 within the previous three years; or
 - ii. Other evidence exists indicating that the suspended or revoked driver has been operating a vehicle during the period of suspension.

11:3-34.4 Eligible person qualifications

(a) An "eligible person" is a person who is an owner or registrant of an automobile registered and principally garaged in this State or who is a resident and holds a valid New Jersey driver's license to operate an automobile, but does not include any person:

1. Who, during the three-year period immediately preceding application for, or renewal of, an automobile insurance policy has been convicted pursuant to N.J.S.A. 39:4-50 or N.J.S.A. 39:4-50.4a or for an offense of a substantially similar nature committed in another jurisdiction;

2. Who has been convicted of a crime of the first, second or third degree resulting from the use of a motor vehicle; or has been convicted of theft of a motor vehicle;

3. Whose driver's license to operate an automobile is under suspension or revocation;

4. Who has been convicted, within the five-year period immediately preceding application for or renewal of a policy of automobile insurance, of fraud or intent to defraud involving an insurance claim or an application for insurance;

5. Who has been successfully denied, with the immediately preceding five years' payment by an insurer of a claim in excess of \$1,000 under an automobile insurance policy, if there was evidence of fraud or intent to defraud involving the automobile insurance claim or application. For the purpose of this section:

i. If the claim has been subject to litigation between the insurer and the insured in which the insurer defended against payment of the claim in whole or in part on grounds of fraud, it shall be conclusively presumed that the claim was successfully denied if judgment was entered for the insurer in the litigation; and conclusively presumed that the claim was not successfully denied if judgment was entered for the insured;

ii. If the claim has not been subject to litigation between the insurer and the insured, but the insurer denied the claim without payment by reason of fraud, it shall be presumed that the claim was successfully denied. This presumption may be overcome in an administrative proceeding pursuant to N.J.A.C. 11:3-33;

iii. If the incident was not reported to the New Jersey Office of Insurance Fraud Prosecutor pursuant to N.J.S.A. 17:33A-9 it shall be presumed that there was no evidence of fraud or intent to defraud;

6. Whose automobile insurance policy has been cancelled for nonpayment of premiums or financed premium with a lapse of coverage of at least 30 days, within the immediately preceding two-year period, unless the premium due on a policy for which application has been made is paid in full before issuance or renewal of the policy. For the purpose of this section, "paid in full" shall not

include any transaction in which a lender obtains authority from an insured to cancel the policy and receive a refund from the insurer in the event the insured defaults on a loan used to pay the premium;

7. Who fails to obtain or maintain membership or qualification for membership in a club, group, or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance, and if the dues or charges, if any, or other conditions for membership or qualifications for membership are applied uniformly throughout this State, are not expressed as a percentage of the insurance premium, and do not vary with respect to the rating classification of the member or potential member except for the purpose of offering a membership fee to family units. Membership fees, if applicable, may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees;

8. Whose driving record for the three year period immediately preceding the application for or renewal of a policy of automobile insurance has an accumulation of seven or more automobile insurance eligibility points as determined in N.J.A.C. 11:3-34.5;

9. Who, during the three-year period immediately preceding application for, or renewal of, an automobile insurance policy, has knowingly provided materially false or misleading information in connection with an application for insurance, renewal of insurance or claim for benefits under an insurance policy; or

10. Who is a named insured or who is insured under the same policy as a person whose driver's license is suspended or revoked and either:

i. The suspended or revoked driver has been convicted of a violation of N.J.S.A. 39:6B-2 within the previous three years; or

ii. Other evidence exists indicating that the suspended or revoked driver has been operating a vehicle during the period of suspension.

(b) An "eligible person" includes a person who is an owner or registrant of an automobile registered in this State or who holds a valid New Jersey driver's license to operate an automobile and is domiciled in this State who is temporarily residing out-of-State and whose car may be principally garaged in another state while the person either is a full time student or is in the military service and is stationed out-of-State.

Emergency Amendment, R.1992 d.380, effective September 4, 1992 (expires November 3, 1992).

See: 24 N.J.R. 3420(a).

Text added to (a)6 to specify a lapse of at least 30 days.

Adopted Concurrent Proposal, R.1992 d.481, effective November 2, 1992.

See: 24 N.J.R. 3420(a), 24 N.J.R. 4396(a).

Provisions of Emergency Amendment R.1992 d.380 readopted with changes effective December 7, 1992.

Emergency Amendment R.1993 d.135, effective March 1, 1993. (Operative March 8, 1993) (expires April 30, 1993.)

See: 25 N.J.R. 1290(a).

Definition of eligible person added at (b).

Adopted Concurrent Proposal, R.1993 d.238, effective April 30, 1993.

See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

Amended by R.1996 d.246, effective June 3, 1996.

See: 27 N.J.R. 2048(a), 28 N.J.R. 3002(b).

Added (a)9.

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Amended by R.2003 d.469, effective December 1, 2003.

See: 35 N.J.R. 3260(a), 35 N.J.R. 5423(a).

In (a), substituted "seven" for "nine" following "accumulation of" in 8, added a new 9 and recodified former 9 as 10.

Case Notes

Insured's nine ineligibility points justifies insured's nonrenewal of automobile policy. *Lawrence v. USAA Casualty Insurance Company*, 97 N.J.A.R.2d (INS) 3.

Nonrenewal of automobile insurance policy was upheld where insured motorist exceeded maximum number of automobile insurance eligibility points. *Woo v. State Farm Insurance Company*, 96 N.J.A.R.2d (INS) 99.

Insurer's nonrenewal of automobile policy justified when insured accumulates 10 eligibility points from two accidents for which insured is at fault. *Premi v. New Jersey Manufacturers Ins. Co.*, 96 N.J.A.R.2d (INS) 9.

Renewal of automobile policy for one period despite accumulation of points did not preclude nonrenewal in next period for same points. *Liberty Mutual v. Lee*, 95 N.J.A.R.2d (INS) 38.

Accident in which insured was at fault, when combined with two other accidents in period of coverage, justified nonrenewal for accumulation of too many points. *New Jersey Manufacturers v. Sandor*, 95 N.J.A.R.2d (INS) 36.

Accumulation of nine or more points by member of insured's household justified nonrenewal of auto policy, *Pandola v. State Farm*, 95 N.J.A.R.2d (INS) 32.

Insured who was otherwise eligible for automobile insurance in voluntary market could obtain coverage for vehicles registered to her notwithstanding her husband's license suspension. *Kwok v. First Trenton*, 95 N.J.A.R.2d (INS) 29.

Decision not to renew automobile insurance policy was improper. *Capasso v. State Farm Indemnity Company*, 94 N.J.A.R.2d (INS) 59.

Eligibility points for accident prior to effective date of regulation not ex post facto violation. *Selective Insurance Company v. Diana*, 93 N.J.A.R.2d (INS) 58.

11:3-34.5 Automobile insurance eligibility points

(a) Automobile insurance eligibility points shall be accumulated as a result of convictions, suspensions, revocations and determinations of responsibility for civil infractions in accordance with the schedule set forth in the Appendix to this subchapter herein incorporated by reference.

(b) Automobile eligibility points are cumulative and accrue for all violations and occurrences set forth on Schedules 1 and 2. Automobile insurance eligibility points shall be deemed to accrue as follows:

1. Points for an at-fault accident shall accrue on the date that total payment by the insurer equals or exceeds \$1,000 or such other amount as may be prescribed by Order of the Commissioner issued pursuant to N.J.S.A. 17:33B-14. The amount under such Order shall be reflected in this paragraph through a notice of administrative change published in the *New Jersey Register*. An insurer may, at its option, use the date of the accident or date of first payment provided, however, that the insurer shall not underwrite or rate any policy based on the accident until total payment by the insurer equals or exceeds \$1,000, and further provided that the insurer shall use the optional date consistently in all cases.

2. Points for conviction of motor vehicle violations and other events that are set forth on an abstract of drivers license records available from the New Jersey Division of Motor Vehicles, or comparable agency of another state, shall accrue when the event is recorded in the agency's records as evidenced by an abstract.

3. When an eligible person has not accrued eligibility points during the preceding three-year period, and is subsequently involved in an at-fault accident, no eligibility points for a two-or three-point violation, as set forth in Schedule 2 of the Appendix, shall accrue along with the points assessed in accordance with Schedule 1 for the at-fault accident, when the violation arises out of the same incident which results in the assessment of points for the at-fault accident. However, violations that arise out of the same incident may be considered by insurers for purposes of tier placement pursuant to N.J.A.C. 11:3-19A.

4. Points for each full year of court-imposed driver's license suspension within the preceding three years and points for each full year within the immediately preceding three years that a person has not held a driver's license shall accrue on the date of application for insurance. However, in accordance with Schedule 1, eligibility points assessed for failure to hold a drivers' license in the previous three years are not cumulative to points assessed for the suspension of a drivers license.

(c) Automobile insurance eligibility points set forth on Schedule 2 of the Appendix represent motor vehicle points established by the New Jersey Division of Motor Vehicles by rule, N.J.A.C. 13:19-10.1, which is hereby incorporated by reference. Any additions, deletions or modifications to N.J.A.C. 13:19-10.1 shall likewise be incorporated as of the effective date of amendment. Schedule 2 is included in the Appendix for convenience.

(d) The reference in Appendix Schedule 1 and Schedule 2 to provisions of the *New Jersey Statutes Annotated* is meant for convenience to assist in the quick identification of the nature of the event. If the event takes place in a state or province other than New Jersey, Schedule 1 and 2 should be consulted for identification of the specific misconduct committed and the assessment of the appropriate number of insurance eligibility points to be assessed.

(e) In addition to the motor vehicle violation and insurance eligibility points specifically enumerated on Schedule 2 of the Appendix pertaining to the New Jersey Turnpike, Atlantic City Expressway, and the Garden State Parkway, for any other motor vehicle violations that occur on the New Jersey Turnpike (N.J.A.C. 19:9), the Atlantic City Expressway (N.J.A.C. 19:2-2.1), the Garden State Parkway (N.J.A.C. 19:8) or for any other moving violation at any location, Schedules 1 and 2 shall be consulted for identification of the specific misconduct committed and the determination of the appropriate number of insurance eligibility points to be assessed.

Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Added (e).
Amended by R.2002 d.330, effective October 7, 2002.
See: 34 N.J.R. 368(a), 34 N.J.R. 3525(a).

Added (f).
Amended by R.2003 d.469, effective December 1, 2003.
See: 35 N.J.R. 3260(a), 35 N.J.R. 5423(a).

Rewrote (b); deleted (c) and recodified former (d) through (f) as (c) through (e).

Case Notes

Police report established five-point at fault accident which, when combined with six-point speeding violations, justified insurer in declining to renew automobile policy. *Fichera v. Liberty Mutual*, 95 N.J.A.R.2d (INS) 41.

Renewal of automobile policy for one period despite accumulation of points did not preclude nonrenewal in next period for same points. *Liberty Mutual v. Lee*, 95 N.J.A.R.2d (INS) 38.

Accident in which insured was at fault, when combined with two other accidents in period of coverage, justified nonrenewal for accumulation of too many points. *New Jersey Manufacturers v. Sandor*, 95 N.J.A.R.2d (INS) 36.

Accumulation of nine or more points by member of insured's household justified nonrenewal of auto policy, *Pandola v. State Farm*, 95 N.J.A.R.2d (INS) 32.

Accident resulting in payment of \$500 or more not recouped from another tort-feasor and not specifically excepted, and driver not excused under proportionate responsibility standard, was "at-fault accident" warranting eligibility points. *Amica Mutual Insurance Co. v. Kern*, 93 N.J.A.R.2d (INS) 55.

Insured at-fault for automobile accident; insured could decline to renew insurance. *AMICA Mutual Insurance Co. v. Farley*, 93 N.J.A.R.2d (INS) 51.

APPENDIX

Schedule of Automobile Insurance Eligibility Points

Schedule 1

N.J.S.A. Section Number If applicable	Event Description	DMV Event Identifier(s) If applicable	Points
39:4-50	Operating a motor vehicle under the influence of alcohol or drugs	0450; 3261	9
39:4-50.4	Refusal to submit to a chemical test	4504	9
2C:11-2	Vehicular homicide	C115	9
39:3-40	Operating a motor vehicle while driving privilege is suspended	0340	9
39:6B-2	Operating a motor vehicle without liability insurance	06B2	9

N.J.S.A. Section Number If applicable	Event Description	DMV Event Identifier(s) If applicable	Points
39:6A-15	Misrepresentation of insurance coverage	6A15	9
	Each at fault accident		5
	* For each full year of a court imposed driver's license suspension within the preceding 3 years		3
	* For each full year within the immediately preceding 3 years that a person has not held a driver's license		1
	Involved in a fatal accident	EFTL; NFTL	4
39:3-37		0337; 0312; 05D5; 1312; MSNJ; MSOS	2
39:3-38	Obtaining a driver's license or registration through deception		5
39:3-38	Make or use counterfeit plate or plates other than issued	0338	5
39:3-38.1	Make, alter or counterfeit driver's license or registration	3381	5
	Failure to verify insurance involved in an automobile accident	FVIA	2

*Points for failure to hold a driver's license in the previous three years are not cumulative to points for driver's license suspension.

Schedule 2

N.J.S.A. Section Number	Offense	Points
27:23-29	Moving against traffic—New Jersey Turnpike, Garden State Parkway, and Atlantic City Expressway	2
27:23-29	Improper passing—New Jersey Turnpike, Garden State Parkway, and Atlantic City Expressway	4
27:23-29	Unlawful use of median strip—New Jersey Turnpike, Garden State Parkway, and Atlantic City Expressway	2
39:3-20	Operating constructor vehicle in excess of 30 mph	3
39:4-14.3	Operating motorized bicycle on a restricted highway	2
39:4-14.3d	More than one person on a motorized bike	2
39:4-35	Failure to yield to pedestrian in crosswalk	2
39:4-36	Failure to yield to pedestrian in crosswalk; passing a vehicle yielding to pedestrian in crosswalk	2
39:4-41	Driving through a safety zone	2
39:4-52 & 39:5C-1	Racing on highway	5
39:4-55	Improper action or omission on grades and curves	2
39:4-57	Failure to observe direction of officer	2
39:4-66	Failure to stop vehicle before crossing sidewalk	2
39:4-66.1	Failure to yield to pedestrians or vehicles while entering or leaving highway	2
39:4-71	Operating a motor vehicle on a sidewalk	2
39:4-80	Failure to obey direction of officer	2
39:4-81	Failure to observe traffic signals	2
39:4-82	Failure to keep right	2
39:4-82.1	Improper operating of vehicle on divided highway or divider	2
39:4-83	Failure to keep right at intersection	2
39:4-84	Failure to pass to right of vehicle proceeding in opposite direction	5
39:4-85	Improper passing on right or off roadway	4
39:4-85.1	Wrong way on a one-way street	2
39:4-86	Improper passing in no passing zone	4
39:4-87	Failure to yield to overtaking vehicle	2
39:4-88	Failure to observe traffic lanes	2

N.J.S.A. Section Number	Offense	Points
39:4-89	Tailgating	5
39:4-90	Failure to yield at intersection	2
39:4-90.1	Failure to use proper entrances to limited access highways	2
39:4-91 & 39:4-92	Failure to yield to emergency vehicles	2
39:4-96	Reckless driving	5
39:4-97	Careless driving	2
39:4-97a	Destruction of agricultural or recreational property	2
39:4-97.1	Slow speed blocking traffic	2
39:4-98 & 39:4-99	Exceeding maximum speed 1-14 mph over limit	2
	Exceeding maximum speed 15-29 mph over limit	4
	Exceeding maximum speed 30 mph or more over limit	5
39:4-105	Failure to stop for traffic light	2
39:4-115	Improper turn at traffic light	3
39:4-119	Failure to stop at flashing red signal	2
39:4-122	Failure to stop for police whistle	2
39:4-123	Improper right or left turn	3
39:4-124	Improper turn from approved turning course	3
39:4-125	Improper "U" turn	3
39:4-126	Failure to give proper signal	2
39:4-127	Improper backing or turning in street	2
39:4-127.1	Improper crossing of railroad grade crossing	2
39:4-127.2	Improper crossing of bridge	2
39:4-128	Improper crossing of railroad grade crossing by certain vehicles	2
39:4-128.1	Improper passing of school bus	5
39:4-128.4	Improper passing of a frozen dessert truck	4
39:4-129	Leaving the scene of an accident	
	No personal injury	2
	Personal injury	8
39:4-144	Failure to observe "stop" or "yield" signs	2
39:5D-4	Moving violation out-of-state	2

Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

**SUBCHAPTER 35. PRIVATE PASSENGER
AUTOMOBILE INSURANCE UNDERWRITING
RULES**

11:3-35.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17:29A-46 which requires that personal private passenger automobile insurers file for approval their underwriting rules used to accept or reject new or renewal business or to assign risks to the standard or non-standard rate levels. Approval of underwriting rules shall serve to confirm that each insurer's business practices are consistent with law regarding the acceptance of new business, the renewal of current business and the assignment of a risk to an insurer's standard or non-standard rate level.

(b) This subchapter applies to all insurers that are licensed and authorized to transact personal private passenger automobile insurance in the voluntary market. It applies to affiliated companies which insure risks through different individual insurance companies.

(c) No private passenger automobile insurer shall make any filing pursuant to this subchapter after March 1, 1998.

Amended by R.1998 d.129, effective March 2, 1998.
See: 29 N.J.R. 5253(a), 30 N.J.R. 839(a).
Added a new (c).

11:3-35.2 Definitions

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

"Affiliated companies" means two or more individual insurance companies that are authorized to transact private passenger automobile insurance business in New Jersey and that are under both common ownership and common management.

"Automobile insurance eligibility points" means points accrued as provided in accordance with the schedule set forth in N.J.A.C. 11:3-34.

"Commissioner" means the Commissioner of Banking and Insurance of the State of New Jersey.

"Department" means the New Jersey Department of Banking and Insurance.

"Individual insurance company" means an insurance company licensed and authorized to transact private passenger automobile insurance business in New Jersey, regardless of whether it is one of a group of affiliated companies.

"Insurer" includes a group of affiliated companies.

"Renew" means to issue and deliver at the end of the policy period a policy superseding a policy previously issued and delivered, or to issue and deliver a certificate or notice extending the term of a policy beyond its policy period or term, by the same individual insurance company, or by another of a group of affiliated companies pursuant to a standard/non-standard rating plan filed and approved in accordance with N.J.A.C. 11:3-19.

Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-35.3 General requirements and filing format

(a) All insurers that write personal private passenger automobile insurance in New Jersey shall file for approval their underwriting rules used to accept or reject new business, to renew or nonrenew current business and to assign business to a tier in a tier rating plan in accordance with N.J.S.A. 17:29A-46.1 and 46.2 and this subchapter. No insurer shall use or implement any underwriting rule not filed and approved as set forth herein. Insurers may also utilize alternate underwriting rules pursuant to N.J.A.C. 11:3-35A.

**SUBCHAPTER 35A. PRIVATE PASSENGER
AUTOMOBILE INSURANCE—USE OF
ALTERNATE UNDERWRITING RULES**

Subchapter Historical Note

Subchapter 35A, Private Passenger Automobile Insurance—Use of Alternate Underwriting Rules, was adopted by R.2004 d.165, effective April 19, 2004. See: 35 N.J.R. 4429(a), 36 N.J.R. 1929(a).

11:3-35A.1 Scope and purpose

(a) This subchapter implements N.J.S.A. 17:33B-15, as amended by P.L. 2003, c. 89, which permits insurers that have met the requirements of the subchapter to have underwriting rules that are used to refuse to issue or limit coverage for new business.

(b) This subchapter applies to all insurers that are licensed and authorized to transact personal lines private passenger automobile insurance in the voluntary market.

Amended by R.2005 d.345, effective October 17, 2005. See: 36 N.J.R. 4364(a), 37 N.J.R. 4030(a).

In (a), substituted “N.J.S.A. 17:33B-15, as amended by P.L. 2003, c.89,” for “N.J.S.A. 17:29A-46.2”.

11:3-35A.2 Definitions

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

“Affiliated companies” means two or more individual insurance companies that are authorized to transact personal lines private passenger automobile insurance business in New Jersey and that are under common ownership and common management.

“Alternate underwriting rules” means a set of underwriting rules that an insurer may use in accordance with the provisions of this subchapter and instead of the underwriting rules filed and approved pursuant to N.J.A.C. 11:3-35.3.

“Automobile” or “private passenger automobile” means a vehicle that meets the definition of “automobile” set forth at N.J.S.A. 39:6A-2.

“Automobile insurance” means personal lines private passenger automobile insurance.

“Automobile insurer” or “insurer” means an insurer or group of affiliated insurers authorized or admitted to transact the business of personal lines private passenger insurance in this State.

“Commissioner” means the Commissioner of Banking and Insurance of the State of New Jersey.

“Consolidated report” means the report required to be filed by insurers pursuant to N.J.A.C. 11:3-3A.3.

“Declination,” “denied” or “denial” means:

1. Refusal by an insurance producer to submit an application on behalf of an applicant to the insurers represented by the producer;

2. Refusal by an insurer to issue an automobile insurance policy to an applicant upon receipt of an application for automobile insurance;

3. The offer of automobile insurance coverage with less favorable terms or conditions than those requested by an applicant;

4. The refusal by an insurer or producer to provide, upon the request of an applicant, an application form or other means of making an application or request for automobile insurance coverage; or

5. Failure of an insurer to either bind coverage or issue a written denial of coverage to an applicant or, if requested, to notify the applicant whether coverage will be provided or denied within five business days of the date a completed written application is received that includes the information in N.J.A.C. 11:3-44.3(a).

“Department” means the New Jersey Department of Banking and Insurance.

“Eligible person” means an eligible person as defined in N.J.S.A. 17:33B-13.

“New business” means an automobile not currently insured by the automobile insurer or its affiliates that is other than:

1. A replacement automobile;

2. An added automobile; or

3. An automobile whose coverage is reinstated by the automobile insurer after a grace period with or without time out of force.

“PAIP” means the New Jersey Personal Automobile Insurance Plan established pursuant to N.J.S.A. 17:29D-1 and N.J.A.C. 11:3-2.

11:3-35A.3 General requirements

(a) Notwithstanding the provisions of N.J.A.C. 11:3-35, an insurer may use alternate underwriting rules for new business or may cease writing new business in any rating territory where the insurer has met the growth requirements specified in N.J.A.C. 11:3-35A.4 and made the filing required by N.J.A.C. 11:3-35A.6.

1. Nothing in this subchapter shall reduce an insurer’s obligation to renew policies pursuant to N.J.S.A. 17:29C-7.1 and N.J.A.C. 11:3-8.3.

2. Nothing in this subchapter shall reduce an insurer’s obligation to meet its Urban Enterprise Zone share pursuant to N.J.A.C. 11:3-46.

(b) The insurer’s alternate underwriting rules must meet the requirements of N.J.A.C. 11:3-35A.5 and must be applied uniformly in all exempt territories.

(c) Alternate underwriting rules shall be filed with the Department as follows:

1. An insurer's initial set of alternate underwriting rules shall be included in the filing made pursuant to N.J.A.C. 11:3-35A.6.

2. Revisions to an insurer's alternate underwriting rules shall include the certification as set forth in N.J.A.C. 11:3-35A.6(b) and the date on which they become effective.

Amended by R.2005 d.345, effective October 17, 2005.

See: 36 N.J.R. 4364(a), 37 N.J.R. 4030(a).

Rewrote (c)2.

11:3-35A.4 Growth requirements

(a) An insurer may make a filing in accordance with N.J.A.C. 11:3-35A.6(d) to use its alternate underwriting rules in each territory where its in-force exposures as of:

1. December 31, 2003, as filed in the consolidated report due on or before January 31, 2004, exceed its in-force exposures as of December 31, 2002 by five percent or more;

2. June 30, 2004, as filed in the consolidated report due on or before July 31, 2004, exceed its in-force exposures as of June 30, 2003 by five percent or more;

3. December 31, 2004, as filed in the consolidated report due on or before January 31, 2005, exceed its in-force exposures as of December 31, 2003 by four percent or more;

4. June 30, 2005, as filed in the consolidated report due on or before July 31, 2005, exceed its in-force exposures as of June 30, 2004 by four percent or more;

5. December 31, 2005, as filed in the consolidated report due on or before January 31, 2006, exceed its in-force exposures as of December 31, 2004 by three percent or more;

6. June 30, 2006, as filed in the consolidated report due on or before July 31, 2006, exceed its in-force exposures as of June 30, 2005 by three percent or more;

7. December 31, 2006, as filed in the consolidated report due on or before January 31, 2007, exceed its in-force exposures as of December 31, 2005 by two percent or more;

8. June 30, 2007, as filed in the consolidated report due on or before July 31, 2007, exceed its in-force exposures as of June 30, 2006 by two percent or more;

9. December 31, 2007, as filed in the consolidated report due on or before January 31, 2008, exceed its in-force exposures as of December 31, 2006 by one percent or more; or

10. June 30, 2008, as filed in the consolidated report due on or before July 31, 2008, exceed its in-force exposures as of June 30, 2007 by one percent or more.

(b) The growth requirements for an insurer newly authorized to transact automobile insurance in this State and that

had no in-force exposures on December 31, 2002 shall be as follows:

1. The insurer's baseline for growth shall be the consolidated report in (a)1 through 10 above in which the insurer's total number of in-force exposures exceeds 1,000.

(c) An insurer may file a request with the Commissioner to use a lower percentage growth standard than those listed in (a)1 through 10 above and the Commissioner may approve such a filing upon a finding that meeting the growth standard in this subchapter would result in the insurer qualifying for relief from its obligations pursuant to N.J.A.C. 11:2-35 or being in hazardous financial condition pursuant to N.J.A.C. 11:2-27.

Amended by R.2005 d.345, effective October 17, 2005.

See: 36 N.J.R. 4364(a), 37 N.J.R. 4030(a).

Rewrote the section.

11:3-35A.5 Alternate underwriting rules

(a) Alternate underwriting rules shall meet the following standards:

1. An underwriting rule shall be based on specific and verifiable standards. No underwriting rule shall be based on subjective judgments such as "pride of ownership evident," "poor attitude," "unsatisfactory environment to conduct business," etc.

2. No underwriting rule shall be based on race, color, creed, national origin or ancestry.

3. No underwriting rule shall be based on the lawful occupation or profession of an insured, except that this provision shall not apply to any insurer which limits all its insureds to one lawful occupation or profession, or to several related lawful occupations or professions.

4. No underwriting rule shall be based on whether the insured is impaired by physical or mental disabilities except those disabilities that impair the ability to operate an automobile safely.

11:3-35A.6 Activation of alternate underwriting rules

(a) An insurer shall initiate the process to use its alternate underwriting rules by making a filing with the Commissioner. The filing shall include the proposed effective date of the filing and the information set forth in (a)1 and 2 below for the territory(ies) where the insurer has met the growth standard established in N.J.A.C. 11:3-35A.4.

1. The in-force exposures in the territory, showing the required growth percentage over the year ending June 30 or December 31, or shorter period pursuant to (e) below. For example, Territory 1—June 30, 2004, 1,000 in-force exposures; June 30, 2005, 1,040 exposures = four percent growth; and

2. Whether the insurer will:

i. Continue to use its underwriting guidelines filed and approved pursuant to N.J.A.C. 11:3-35;

(d) When a health benefits plan provides hospital expense or service benefits only, or medical expense or service benefits only, and is not otherwise a part of a basic health benefits package, all allowable expenses remaining uncovered shall be considered by that health benefits plan for the provision of benefits, without regard as to whether the expenses are hospital-related or medical-related expenses. Actual benefits paid by that health benefits plan for the allowable expenses remaining uncovered shall not exceed the total actual benefits which would have been payable had the health benefits plan been providing coverage primary to the PIP plan.

(e) When there is one health benefits plan providing insureds hospital expense or service benefits and another health benefits plan providing insureds medical expense or service benefits as two separate parts of one basic health benefits plan package, the hospital benefits plan and the medical benefits plan shall both consider all allowable expenses remaining uncovered and shall apportion such allowable expenses between the two plans on a pro-rata basis without regard as to whether the expenses are hospital-related or medical-related expenses. Actual benefits paid by each plan of the health benefits plan package shall not exceed the total actual benefits which would have been payable by each plan had the health benefits plan package been providing primary coverage.

(f) No insured shall be liable to a health care provider for any fees for services or supplies which exceed the dollar or percentage amounts recognized for those services or supplies on the medical fee schedules.

(g) No health benefits plan shall seek repayment from or withhold payment to an insured for amounts paid to the insured in consideration of charges which were in excess of the amounts set forth in the medical fee schedules.

(h) If there is more than one group health benefits plan providing secondary coverage to an insured, these plans may coordinate their benefits with one another in accordance with N.J.A.C. 11:4-28.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).
Rewrote (b).

Case Notes

Costs of home renovations and specialized equipment for quadriplegic insured were "allowable expenses" within meaning of regulation mandating that actual benefits payable by health benefits plan. *Bailey v. Garden State Hospitalization Plan*, 280 N.J.Super. 206, 654 A.2d 1043 (L.1994), affirmed 290 N.J.Super. 277, 675 A.2d 696.

Hospitalization insurer could be held responsible for hospital bills without regard to when they were incurred, and personal injury protection benefits could be used for specialized equipment and home modifications. *Bailey v. Garden State Hospitalization Plan*, 280 N.J.Super. 206, 654 A.2d 1043 (L.1994), affirmed 290 N.J.Super. 277, 675 A.2d 696.

"Primary carrier" is carrier first required to pay personal injury protection benefits preserving its right of contribution from other insurers also liable for such payments. *Bailey v. Garden State Hospitalization Plan*, 280 N.J.Super. 206, 654 A.2d 1043 (L.1994), affirmed 290 N.J.Super. 277, 675 A.2d 696.

11:3-37.10 Explanation of benefits

(a) Automobile insurers shall develop and utilize an explanation of benefits form to be provided with the payment of benefits for expenses incurred for treatment of injuries which clearly identifies and explains the following:

1. Each procedure for which a claim has been made;
2. Eligible expense related to each procedure with an indication of whether the eligible expense is based on the medical fee schedules or is the reasonable charge as determined by the automobile insurer;
3. Actual benefits paid;
4. Any deductible or copayment applied;
5. A concise explanation why any item of expense is considered an ineligible expense, when this occurs; and
6. A statement to insureds that no health care provider may demand or request any payment from any person in excess of those permitted by N.J.A.C. 11:3-29, and that no person is liable to any health care provider for any amount of money which results from the charging of fees in excess of those permitted by N.J.A.C. 11:3-29 pursuant to N.J.S.A. 39:6A-4.6.

Amended by R.1994 d.564, effective November 21, 1994 (operative January 1, 1995).
See: 25 N.J.R. 4706(a), 26 N.J.R. 4616(b).

Case Notes

Former patient failed to establish that charges reflected in bill were not usual, customary, and reasonable; hospital's witness testified that charges were in accord with other teaching institutions in area and were approved by state insurance commission, and patient's insurance company paid its full share of all charges and did not reject any by claiming that they were not usual, customary, reasonable, and/or necessary. *Hahnemann University Hosp. v. Dudnick*, 292 N.J.Super. 11, 678 A.2d 266 (A.D.1996).

11:3-37.11 Dispute as to primacy of coverage

(a) If, subsequent to the selection of the PIP-as-secondary coverage option by the named insured, injuries are sustained by an insured eligible for health benefits plan coverage, but a dispute exists between the health benefits provider and the automobile insurer, then the health benefits provider shall provide benefit as if it were the primary coverage provider and no PIP benefits were available to the insured. In no event shall the provision of benefits be unreasonably delayed by either a health benefits provider or an automobile insurer.

(b) If the health benefits provider asserts that it is not subject to N.J.A.C. 11:3-37.3, and thus, will not act as the primary coverage provider then the automobile insurer shall assume the role of primary coverage provider, and provide

its benefits in accordance with N.J.A.C. 11:3-37.8. The automobile insurer shall be entitled to recover premium reductions in accordance with N.J.A.C. 11:3-37.8(c).

11:3-37.12 Eligibility under two or more automobile policies

(a) If an insured is eligible for coverage of medical expenses under more than one automobile policy, the determination as to which automobile policy will assume coverage responsibility for that insured shall be as follows:

1. A named insured shall receive benefits for medical expenses under the terms of the automobile policy on which he or she, or his or her spouse, is identified as the named insured.

2. A family member who is a child of a named insured or the named insured's spouse shall receive benefits for medical expenses under the automobile policy of the named insured, subject to the following:

i. If the child is a child of more than one named insured or of more than one spouse of a named insured, the child shall receive benefits under the terms of the automobile policy of the named insured who has legal custody of that child or whose spouse has legal custody of that child.

ii. If the child is a child of more than one named insured or of more than one named insured's spouse, and legal custody of that child has either never been awarded, or has been awarded jointly, then the child shall receive benefits under the terms of the automobile policy of the named insured whose birthday occurs earliest in the calendar year.

iii. If the child is a named insured or the spouse of a named insured, (a)1 above shall apply.

3. If neither (a)1 nor (a)2 above apply to an adult or child family member, then that family member shall receive benefits for medical expenses under the terms of the automobile policy of the named insured whose birthday occurs earliest in the calendar year.

4. If an automobile policy identifies more than one person as a named insured on the automobile policy, the birthday of the named insured whose birthday occurs earliest in the calendar year shall be considered the determinant birthday on that automobile policy.

(b) An insured shall not receive benefits for medical expenses under more than one automobile policy.

(c) If an automobile policy PIP plan provides benefits for medical expenses for an insured who is eligible for medical expense benefits under more than one automobile policy PIP plan, the automobile insurer of the paying PIP plan may seek equitable pro rata contributions from the other automobile policy PIP plan(s) for the benefits actually paid by the paying PIP plan.

Case Notes

"Follow-the-family" exclusionary clause, under which policy did not provide personal injury protection benefits to those outside named insured's family if they were entitled to coverage under another policy, did not violate provision of No-Fault Act setting forth permissible exclusions from coverage. *Rutgers Cas. Ins. Co. v. Ohio Cas. Ins. Co.*, 299 N.J.Super. 249, 690 A.2d 1074 (A.D.1997).

Primary carrier must pay PIP benefits and may seek contribution from other carriers. *U.S. Fidelity & Guar. Co. v. Industrial Indem. Co.*, 264 N.J.Super. 379, 624 A.2d 1014 (A.D.1993), certification denied 134 N.J. 484, 634 A.2d 530.

Double recovery of PIP benefits is prohibited. *Martin v. Prudential Ins. Co.*, 255 N.J.Super. 524, 605 A.2d 762 (A.D.1992).

Passenger could recover PIP benefits under both driver's policy and own policy. *Martin v. Prudential Ins. Co.*, 255 N.J.Super. 524, 605 A.2d 762 (A.D.1992).

11:3-37.13 Penalties

Each automobile policy or health benefits plan subject to the terms of this subchapter which fails to comply with the terms herein shall be in violation of this subchapter. Failure to comply with the terms of this subchapter may result in the assessment of any and all penalties in accordance with the laws of this State.

11:3-37.14 Severability

If any provision of this subchapter or 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 38. (RESERVED)

Subchapter 38, Towing and Storage Fee Schedule, was repealed by R.1999 d.1, effective January 4, 1999. See: 30 N.J.R. 2813(a), 31 N.J.R. 54(c).

SUBCHAPTER 39. REDUCTIONS IN PREMIUM CHARGES FOR PRIVATE PASSENGER AUTOMOBILES EQUIPPED WITH ANTI-THEFT, VEHICLE RECOVERY AND SAFETY FEATURES

11:3-39.1 Purpose

The purpose of this subchapter is to encourage consumers to invest in and use anti-theft and vehicle recovery devices and safety features in private passenger automobiles by providing that there shall be a reduction in the base rates applicable to automobile physical damage coverage, in accordance with N.J.S.A. 17:33B-44, for those private passenger automobiles equipped with anti-theft and vehicle recovery devices and safety features.

<u>Zip Code</u>	<u>UEZ</u>	<u>Voluntary In-Force Exposures</u>	<u>UZAR Assigned In-Force Exposures</u>	<u>Total In-Force Exposures</u>
07107	Newark			
07108	Newark			
07109	Belleville			
07111	Irvington			
07112	Newark			
07114	Newark			
07201	Elizabeth			
07202	Elizabeth			
07206	Elizabeth			
07207	Elizabeth			
07208	Elizabeth			
07302	Jersey City			
07303	Jersey City			
07304	Jersey City			
07305	Jersey City			
07306	Jersey City			
07307	Jersey City			
07309	Jersey City			
07310	Jersey City			
07311	Jersey City			
07424	Little Falls/W. Paterson			
07501	Paterson			
07502	Paterson			
07503	Paterson			
07504	Paterson			
07505	Paterson			
07506	Hawthorne			
07507	Hawthorne			
07509	Paterson			
07510	Paterson			
07513	Paterson			
07514	Paterson			
07522	Paterson			
07524	Paterson			
07533	Paterson			
07543	Paterson			
07544	Paterson			
08030	Gloucester			
08101	Camden			
08102	Camden			
08103	Camden			
08104	Camden			
08105	Camden			
08401	Atlantic City			
08601	Trenton			
08602	Trenton			
08603	Trenton			
08605	Trenton			
08607	Trenton			
08608	Trenton			
08609	Trenton			
08611	Trenton			
08618	Trenton			
08629	Trenton			
08638	Trenton			
08861	Perth Amboy			
08862	Perth Amboy			
08901	New Brunswick			
08903	New Brunswick			
08906	New Brunswick			
	Total			

Amended by R.1999 d.218, effective July 19, 1999.
See: 31 N.J.R. 920(a), 31 N.J.R. 1927(a).

In Exhibit A, inserted references to the towns of Perth Amboy and Plainfield; and added Exhibit C.

SUBCHAPTER 47. INSURANCE SCENARIOS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e 17:29A-52.

Source and Effective Date
R.2004 d.118, effective March 15, 2004.
See: 35 N.J.R. 4434(a), 36 N.J.R. 1587(a).

11:3-47.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the requirements for the provision by private passenger automobile insurers and insurance producers of insurance scenarios to new applicants and insureds pursuant to N.J.S.A. 17:29A-52.

(b) This subchapter shall apply to all insurers transacting personal private passenger automobile insurance in this State and licensed insurance producers.

(c) The requirements of this subchapter shall not apply to transactions where a new applicant for insurance specifically requests to purchase a basic policy as provided in N.J.S.A. 39:6A-3.1 or a special policy as provided in N.J.S.A. 39:6A-3.3.

(d) This subchapter shall apply to all applications and requests made on or after May 14, 2004.

11:3-47.2 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 Banking and Insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“Insurer” means an entity authorized or admitted to transact insurance business in this State pursuant to N.J.S.A. 17:17-1 et seq., or 17:32-1 et seq., as applicable. “Insurer” includes the Personal Automobile Insurance Plan established pursuant to N.J.S.A. 17:29D-1 et seq. and N.J.A.C. 11:3-2.

“Insurance producer” means a person licensed under the laws of this State to sell, solicit or negotiate insurance.

“Personal private passenger automobile insurance” means direct insurance on automobiles as defined in N.J.S.A. 39:6A-2.

11:3-47.3 Insurance scenarios

(a) Pursuant to N.J.S.A. 17:29A-52, insurers and insurance producers shall provide insurance scenarios in accordance with this subchapter.

1. Every insurer writing private passenger automobile insurance in this State as a direct writer or through insurance producers employed by that insurer or retained to represent that insurer exclusively shall provide each new applicant seeking automobile insurance, and each

insured upon request, with a document or documents that describe at least three insurance scenarios demonstrating the effect of different coverage choices. For new applicants, the insurance scenarios shall be provided in connection with a premium quotation or application and prior to execution of the Coverage Selection Form required by N.J.A.C. 11:3-15. For existing insureds, the insurance scenarios shall be provided upon request. The types of coverage to be utilized in providing the scenarios shall be as set forth in this section.

2. Every insurance producer that is not employed by an insurer or retained to represent one insurer exclusively (that is, an independent insurance producer) shall provide each new applicant seeking automobile insurance, and each insured upon request, with a document or documents that describe at least three insurance scenarios as set forth in (a)1 above. An independent insurance producer shall provide a minimum of three insurance scenarios under this rule irrespective of the number of insurers it may represent. Nothing in this subchapter is intended to affect or modify the duties of an independent insurance producer with respect to any obligations he or she may owe to one or more insurers as a result of any agency relationship or contract with an insurer.

3. For purposes of this rule, "new applicant" shall not include a person who is replacing a vehicle already insured under the policy; adding a vehicle to the policy; or whose policy is being replaced by the insurer or an affiliated insurer to cover the existing insured vehicles, replacement vehicles or added vehicles, provided that the rating system of the affiliated insurer is identical to that of the insurer which originally issued the policy.

4. Where application for an insurance policy is made via the Internet, compliance with (a)1 above shall be satisfied by having the insurance scenarios readily available to the applicant on the insurer's website. In addition to being readily available on the insurer's website, this information also may be placed on the producer's website.

5. Where application for an insurance policy is made via the telephone and coverage is bound during the telephonic transaction, compliance with (a)1 above shall be satisfied if the insurer, with the agreement of the applicant, sends the applicant the insurance scenarios within five business days after the telephonic transaction is completed. Insureds may alter coverages based on their review of the insurance scenarios by returning a signed Coverage Selection Form with the changes noted therein, or electronically, if such process is made available by the insurer. Such alterations shall be effective in accordance with N.J.A.C. 11:3-15.7(d)2.

(b) Coverage limits included in each insurance scenario shall meet the minimum limits of coverage as required by law, and may be modified as required to satisfy coverage requirements for leased or financed vehicles for which coverage is sought. Insurance scenarios shall reflect the approximate cost of purchasing such limits of coverage, and shall not be deemed to be binding quotes.

(c) The three insurance scenarios shall be as follows:

1. Scenario 1 shall reflect choices of Bodily Injury Liability coverage under N.J.S.A. 39:6A-3, for example, the basic policy established by N.J.S.A. 39:6A-3.1; the limitation on lawsuit and no limitation on lawsuit options pursuant to N.J.S.A. 39:6A-8; and policy limits options, including options on uninsured and underinsured motorist coverage;

2. Scenario 2 shall reflect choices related to the Personal Injury Protection coverage under N.J.S.A. 39:6A-4, for example, the medical coverage only option; the health-care primary options; and policy limits options; and

3. Scenario 3 shall reflect choices related to Physical Damage coverage options, for example, the option not to purchase Physical Damage coverage; various deductible options; and the named driver exclusion option.

(d) The insurance scenarios provided may contain the following statement: "Insurance scenarios are intended to further educate consumers about the choices available to them, are not binding quotes, and do not necessarily represent the recommendations of the producer or insurer."

(e) An insurer or producer shall satisfy the requirements of this subchapter by either:

1. Providing the applicant or insured with three applicable generic insurance scenarios, as set forth in (c) above, from among a selection of scenarios. The scenarios provided shall reflect coverage choices that correspond to the general circumstances of certain kinds of applicants, for example, three that are applicable to families; three that are applicable to single drivers; or three that are applicable to senior citizens, or three that are applicable to households with one, two or three or more drivers, or with one, two or three or more vehicles to be insured. The premium amounts associated with each scenario may be expressed either in an approximate dollar amount or as a percentage difference;

2. Providing the applicant or insured with three insurance scenarios, as set forth in (c) above, which are produced by an electronic data system based upon the individual characteristics and circumstances of the applicant or insured as indicated in information they provide to the insurer or producer. The premium amounts associated with each scenario may be expressed either in an approximate dollar amount or as a percentage difference; or

3. Providing the applicant or insured with three insurance scenarios, as set forth in (c) above, on a document developed by the Department and available on the Department's website, www.njdobi.org, and entering appropriate premium amounts where indicated.