REPORT OF THE
VIRGINIA CODE COMMISSION
ON

The Revision of Title 38.1 of the Code of Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
1986

Report of the
Virginia Code Commission
on
The Revision of Title 38.1
of the Code of Virginia
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1986

To: Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

House Joint Resolution No. 1 of the 1984 Acts of Assembly directed the Virginia Code Commission to make a careful study of Title 38.1 of the Code of Virginia and report to the Governor and the General Assembly its findings in the form of a revision of the Title. Pursuant to this mandate, the study has been completed and the revision is appended to this report.

The study resolution was initially brought to the attention of the 1984 General Assembly by Delegate Theodore V. Morrison, Jr. and Speaker of the House A. L. Philpott both of whom were interested in making consistent the style and substance of the insurance laws of the Commonwealth. Subsequent to the last revision of these laws in 1952 numerous changes have been made in the statutes. Many inconsistencies in style and substance have resulted from over thirty years of amendments and the need arose to organize the laws in a more logical manner; to delete obsolete provisions; to improve the grammar, clarity and purpose of the insurance laws and to make substantive changes in order to recognize new developments in the insurance industry.

Due to the size of Title 38.1 and the multitude of statutes which had to be reviewed and rewritten, the Code Commission continued its study through 1984 into 1985. This allowed the Commission and interested parties sufficient opportunity to complete a careful review of the title.

The State Corporation Commission's Bureau of Insurance, headed by Commissioner James M. Thomson drafted the bulk of the changes made and adopted. A team of staff individuals from the Bureau, headed by Stephen J. Kaufmann, Deputy Commissioner, were responsible for the drafting and presentation of the suggested revisions. C. William Cramme', III, Esquire, Senior Attorney with the Division of Legislative Services, provided staff support for this project and assisted the Bureau in its drafting. Joan W. Smith, of the Division provided administrative and technical support.

Those responsible for preparing the drafts were assisted by representatives of the following: the American Insurance Association, James C. Roberts, Esquire; Aetna Insurance, J. Maurice Miller, Esquire; the Independent Insurance Agents of Virginia, Ted L. Smith; the Virginia Hospital Association, Laurens Sartoris, Esquire; State Farm Insurance, Philip B. Morris, Esquire; Nationwide Mutual, J. Christopher LaGow, Esquire; Blue Cross/Blue Shield of Northern Virginia, D. Patrick Lacy, Esquire; Blue Cross/Blue Shield of Virginia, Thomas & Fiske; Life of Virginia, Frank Sutherland, George H. Parsons and Peggy Parker; Alliance of American Insurers, C. William Waechter, Jr., Esquire; National Association of Independent Insurers, Henry H. McVey, III, Esquire; Virginia Consumer Finance Association, Jeff D. Smith, III; and the Professional Insurance Agents Association of Virginia and the District of Columbia, Elsie Reamy. These representatives and others regularly attended Commission meetings, spoke to the substantive changes and continually advised the Commission. Copies of the proposed drafts of the title were liberally distributed to and comments requested from each of the groups and individuals having a substantial interest in the insurance laws of the Commonwealth.

The revision of Title 38.1 of the Code of Virginia follows this text as Appendix 1. While the revision represents a complete rewrite of the title, the principal changes include:

Subtitle I - General Provisions

1. § 38.2-218 (§38.1-40). Penalties and Restitution payments.

The proposed change to this section is intended to: 1) extend coverage to violations of regulations (as in existing § 38.1-279.56); 2) drop the minimum penalties and introduce a minimum penalty cap for negligent violations; 3) increase the maximum allowable penalty; 4) provide a greater maximum allowable penalty for knowing or willful violations and violations where a reasonable person should have known he was committing a violation; 5) provide restitution payments; 6) exempt from penalty violations those resulting from solely electronic or mechanical malfunctions; and 7) turn this section into a general as contrasted to a residual penalty section.

2. § 38.2-225 (§ 38.1-42). Disposition of fines and penalties.

Subsection A is devoted exclusively to the payment of fines for criminal violations of this title. Subsection B, which is devoted to civil violations, provides the Commission authority to direct payment of penalties to either the Literary Fund or to one of the Guaranty Associations if needed.

Appropriate changes were also made in the Property and Casualty Insurance and Life, Accident and Sickness Insurance Guaranty Association chapters.

3. § 38.2-508 (§ 38.1-50.7). Unfair discrimination.

As a compromise between the Bureau, industry and the National Federation for the Blind, refusal to insure or limit the amount, extent or kind of coverage available to an individual, or charging different rates solely because of blindness, or mental or physical impairments can occur only if the decision is based on sound actuarial principals. Actual or reasonably anticipated experience has been deleted.

Subtitle II - Financial Regulations.

4. § 38.2-1304 (§ 38.1-163). False statements, reports, etc. deemed perjury.

Surplus lines brokers were added to those subject to penalty for violation of this section.

5. Chapter 16 - Virginia Property and Casualty Insurance Guaranty Association

A new article has been developed that outlines the procedures to administer the new provisions of § 38.2-225 (Disposition of fines and penalties) for the Property and Casualty Guaranty Association.

6. Chapter 17 - Virginia Life, Accident and Sickness Insurance Guaranty Association

A new article has been developed that outlines the procedures to administer the new provisions of § 38.2-225 (Disposition of fines and penalties) for the Life, Accident and Sickness Guaranty Association.

Subtitle III - Insurance Agents.

7. § 38.2-1815 (new section). License required of resident life and health insurance agent and health agents.

Salesman for proposed chapters 42 (Health Services Plans) and 43 (Health Maintenance Origanizations) are now considered health agents and subject to health license requirements which includes passing a 25-hour study course.

Subtitle V - Life and Accident and Sickness Insurance.

8. Chapter 35 - Accident and Sickness Insurance Policies.

A new aritcle was developed for group accident and sickness insurance policies. The current Virginia Code has no standard policy provision requirements for group accident and sickness insurance. This new article essentially adopts the NAIC Health Insurance Standard Provisions Model Act.

Subtitle VII - Other.

9. § 38.2-4809 (§ 38.1-327.54. Licensees to pay assessments and license taxes on insurers.

Amendments have been proposed tht would broaden the Bureau's scope of authority with surplus lines brokers who are delinquent in paying the assessment or premium tax. In addition, all surplus lines brokers will be required to make the estimated tax payments required of regular insurance companies and will be responsible for the taxes and assessments in a fiduciary relationship with the Commonwealth of Virginia. The failure or refusal to pay the license tax or assessment will be deemed a Class 1 misdemeanor.

Cross-reference tables follow the draft, appearing as Appendix 2 to this report, and indicate the equivalent sections in the proposed new Title 38.2 equivalent to those in the present Title 38.1 and vice versa.

The Virginia Code Commission recommends that the General Assembly enact legislation at the 1986 Session to effect this revision.

Respectfully submitted,

Theodore V. Morrison, Jr., Chairman
Dudley J. Emick, Jr., Vice-Chairman
John A. Banks, Jr., Secretary
William G. Broaddus
Russell M. Carneal
James P. Jones
John Wingo Knowles
A. L. Philpott

CONCURRING AND DISSENTING OPINION OF
SENATOR DUDLEY J. EMICK, JR.

I concur with the report as to the majority of changes made; however, it is necessary that I dissent from some of the changes made as reflected in the minutes of the Commission.

CONCURRING OPINION OF
DELEGATE THEODORE V. MORRISON, JR.

This recodification study was conducted during a period of more than two years and involved one of the largest titles in the Code of Virginia. There were occasions during this time that I and other Commission members, in addition to Senator Emick, expressed dissents; this has historically been the case in other major title revisions. However, in spite of the relatively minor differences, I strongly concur in this report and feel that it represents a substantial improvement in the laws of the Commonwealth dealing with Insurance.

Title 38.2

CHAPTER 1.

General Provisions.

ARTICLE 1.

Definitions.

Definitions having a title-wide application have been moved to this section.

ARTICLE 2.

Insurance Classified and Defined.

1. Several new classes of insurance have been added to this chapter. These additions conform to classes of insurance currently provided by insurers.

2. The phrase "kind or class of insurance" has been revised to read "class of insurance".

CHAPTER 1.

GENERAL PROVISIONS.

Article 1.

Definitions.

§ 38.2-100. Definitions.—As used in this title:

"Alien company" means a company incorporated or organized under the laws of any country other than the United States.

"Commission" means the State Corporation Commission.

"Commissioner" or "Commissioner of Insurance" means the administrative or executive officer of the division or bureau of the Commission established to administer the insurance laws of this Commonwealth.

"Company" means any association, aggregate of individuals, business, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Domestic company" means a company incorporated or organized under the laws of this Commonwealth.

"Foreign company" means a company incorporated or organized under the laws of the United States, or of any state other than this Commonwealth.
Drafting Note: Fraternal benefit society is now defined in proposed § 38.2-4100.

"Health services plan" means any arrangement for offering or administering health services or similar or related services by a corporation licensed under Chapter 42 of this title.
Drafting Note: The phrase "health services plan" is used throughout proposed Title 38.2; therefore, it is being defined here.

"Insurance company" means any company engaged in the business of making contracts of insurance.
Drafting Note: Fidelity and surety is included in the definition of "insurance."

"Insurance transaction," "insurance business," and "business of insurance" include solicitation, negotiations preliminary to execution, execution of an insurance contract, and the transaction of matters subsequent to execution of the contract and arising out of it.
Drafting Note: The phrase "business of insurance" is used throughout proposed Title 38.2; therefore, it is being included here.

"Insurer" means an insurance company.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendment of 1965, as amended.
Drafting Note: This definition has been transferred from existing § 38.1-362.12.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Rate" or "rates" means any rate of premium, policy fee, membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance. The terms "rate" or "rates" shall not include a membership fee paid to become a member of an organization or association, one of the benefits of which is the purchasing of insurance coverage.
Drafting Note: This definition has been transferred from existing §§ 38.1-219 and 38.1-279.30. This change merges the two existing definitions, which are essentially identical, and renders the definition effective title-wide.

"Rate service organization" means any organization or person, other than a joint underwriting association under § 38.2-1915 or any employee of an insurer including those insurers under common control or management, who assists insurers in ratemaking or filing by:

(a) Collecting, compiling, and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.
Drafting Note: Proposed § 38.2-1915 is existing § 38.1-279.43. This definition has been transferred from existing § 38.1-279.30.

"State" means any commonwealth, state, territory, district or insular possession of the United States.

"Surplus to policyholders" means the excess of total admitted assets over the liabilities of an insurer, and shall be the sum of all capital and surplus accounts, including any voluntary reserves, minus any impairment of all capital and surplus accounts.

Without otherwise limiting the meaning of or defining the following terms, "insurance" shall include fidelity and suretyship, and "insurance contracts" or "insurance policies" shall include contracts of fidelity, indemnity, guaranty and suretyship.

Article 2.

Insurance Classified and Defined.

§ 38.2-101. Classification of insurance.—Insurance is classified and defined as set out in subsequent sections of this article.

38.2-102. Life.—"Life insurance" means insurance upon the lives of human beings. "Life insurance" includes policies that also provide (i) endowment benefits; (ii) additional benefits in the event of death, dismemberment, or loss of sight by accident or accidental means; (iii) additional benefits to safeguard the contract from lapse or to provide a special surrender value, a special benefit or an annuity, in the event of total and permanent disability of the insured; and (iv) optional modes of settlement of proceeds. As used in this title, unless the context requires otherwise, "life insurance" shall be deemed to include "credit life insurance", "industrial life insurance", and "variable life insurance."

§ 38.2-103. Credit life.—"Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.
Drafting Note: This is taken from existing § 38.1-482.2(a).

§ 38.2-104. Industrial life.—"Industrial life insurance" means life insurance provided by an individual insurance contract (i) under which premiums are payable at least monthly and (ii) that has the words "industrial policy" printed upon the policy as a part of the descriptive matter.

Drafting Note: This is taken from existing § 38.1-409.

§ 38.2-105. Variable life.—"Variable life insurance" means any policy or contract of life insurance in which the amount or duration of benefits may vary according to the investment experience of any separate account maintained by the insurer for the policy or contract, as provided for in § 38.2-3113.
Drafting Note: Proposed § 38.2-3113 is existing § 38.1-443. This definition and the definition of variable annuity are both based on the definition of a variable contract in Regulation 3 of the Virginia Insurance Regulations and the NAIC definition of variable life.

§ 38.2-106 Annuities.—"Annuities" means all agreements to make periodic payments in fixed dollar amounts pursuant to the terms of a contract for a stated period of time or for the life of the person or persons specified in the contract. "Annuities" does not include contracts defined in § 38.2-102.

As used in this title, unless the context requires otherwise, "annuity" shall be deemed to include "variable annuity."
Drafting Note: Proposed § 38.2-102 is existing § 38.1-3. Since variable annuity is defined in § 38.2-107, any reference to benefits varying according to investment experience has been deleted. 1985 legislative action added "for a stated period of time."

§ 38.2-107. Variable Annuity.—"Variable annuity" means any agreement or contract for an annuity in which the amount or duration of benefits may vary according to the investment experience of any separate account maintained by the insurer for the policy or contract as provided for in § 38.2-3113. Pursuant to the terms of the contract, payments may be made for a stated period of time or for the life of the person or persons specified in the contract.
Drafting Note: Proposed § 38.2-3113 is existing § 38.1-443. This new classification is added to bring the Code up to date with the products being sold in today's market.

§ 38.2-108. Credit accident and sickness.—"Credit accident and sickness insurance" means insurance on a debtor to provide for payments on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.
Drafting Note: This is taken from existing § 38.1-482.2(b).

§ 38.2-109. Accident and sickness.—"Accident and sickness insurance" means insurance against loss resulting from sickness, or from bodily injury or death by accident or accidental means, or from a combination of any or all of these perils. As used in this title, unless the context requires otherwise, the term "accident and sickness insurance" shall be deemed to include "credit accident and sickness insurance."

§ 38.2-110. Fire.—"Fire insurance" means insurance against loss of or damage to any property resulting from fire, including loss or damage incident (i) to extinguishing a fire, or (ii) to the salvaging of property in connection with a fire.

§ 38.2-111. Miscellaneous property.–" Miscellaneous property insurance " means insurance against loss of or damage to property resulting from:

1. Lightning, smoke or smudge, windstorm, tornado, cyclone, earthquake, volcanic eruption, rain, hail, frost and freeze, weather or climatic conditions, excess or deficiency of moisture, flood, the rising of the waters of the ocean or its tributaries; or

2. Insects, blights, or disease of such property other than animals; or

3. Electrical disturbance causing or concomitant with a fire or an explosion; or
Drafting Note: Number 4 has been moved from existing § 38.1-12 as it comes within the concept of miscellaneous property insurance.

4. The ownership, maintenance or use of elevators, except loss or damage by fire. This class of insurance includes the incidental power to make inspections of and to issue certificates of inspection upon any such elevator; or

5. Bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe, vandalism or malicious mischief, strike or lockout, collapse from any cause, or explosion; but not including any kind of insurance specified in § 38.2-115, except insurance against loss or damage to property resulting from:

a. Explosion of pressure vessels, except steam boilers of more than fifteen pounds pressure, in buildings designed and used solely for residential purposes by not more than four families;

b. Explosion of any kind originating outside of the insured building or outside of the building containing the insured property;

c. Explosion of pressure vessels not containing steam; or

d. Electrical disturbance causing or concomitant with an explosion; or

6. Any other cause or hazard which may result in a loss or damage to property, if the insurance is not contrary to law or public policy.

§ 38.2-112. Water damage.–"Water damage insurance" means insurance against loss or damage to any property by water or other fluid or substance resulting from (i) the breakage or leakage of sprinklers, pumps or other apparatus erected for extinguishing fires or of water pipes or other conduits or containers, or (ii) casual water entering through leaks or openings in buildings or by seepage through building walls, but not including loss or damage resulting from flood or the rising of the waters of the ocean or its tributaries. This class of insurance includes insurance against accidental injury of such sprinklers, pumps, fire apparatus, conduits or containers.

§ 38.2-113. Burglary and theft.–"Burglary and theft insurance" means insurance against:

1. Loss of or damage to any property resulting from actual or attempted burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, wrongful confiscation or wrongful conversion, disposal or concealment by any person or persons ;

2. Loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers or documents, resulting from any cause, except while in the custody or possession of and being transported by any carrier for hire or in the mail; or
Drafting Note: This provision is deleted as it is included in the marine definition.

3. The loss of property actually surrendered due to extortion, threat, or demand, involving the actual, alleged or threatened kidnapping of any individual or the threat to do bodily injury to or damage to property of or to wrongfully abduct or detain any individual.
Drafting Note: Proposed paragraph 3 clarifies the authority for what is now being written under paragraph 1 of this section.

§ 38.2-114. Glass insurance.–"Glass insurance " means insurance against loss of or damage to glass and its appurtenances resulting from any cause.

§ 38.2-115. Boiler and machinery. –"Boiler and machinery insurance" means insurance against any liability of the insured and against loss of or damage to any property of the insured resulting from the explosion of or injury to (i) any boiler, heater or other fired pressure vessel; (ii) any unfired pressure vessel; (iii) any pipes or containers connected with any of the boilers or vessels; (iv) any engine, turbine, compressor, pump or wheel; (v) any apparatus generating, transmitting or using electricity; or (vi) any other machinery or apparatus connected with or operated by any of the previously named boilers, vessels or machines. Boiler and machinery insurance includes the incidental power to inspect and to issue certificates of inspection upon any such boilers, pressure vessels, apparatus, and machinery.
Drafting Note: This has been moved to proposed § 38.2-111(4)

§ 38.2-116. Animal.–"Animal insurance " means insurance against loss of or damage to any animal resulting from any cause.

Drafting Note: This section is unnecessary since motor vehicle insurance is defined under proposed § 38.2-124 and aircraft insurance is defined under proposed § 38.2-125.

§ 38.2-117. Personal injury liability. –"Personal injury liability insurance" means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability, arising out of the death or injury of any person, or arising out of injury to the economic interests of any person as the result of negligence in rendering expert, fiduciary or professional service, but not including any class of insurance specified in § 38.2-119.

Any policy of personal injury liability insurance may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death or injury of any person, regardless of any legal liability of the insured.

§ 38.2-118. Property damage liability.–"Property damage liability insurance" means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability, arising out of the loss or destruction of, or damage to, the property of any other person, but not including any class of insurance specified in § 38.2-117 or § 38.2-119.

§ 38.2-119. Workers' compensation and employers' liability.–"Workers' compensation and employers' liability insurance" means insurance against the legal liability of any employer for the death or disablement of, or injury to, his or its employee whether imposed by common law or by statute, or assumed by contract.

Employers' liability insurance may include appropriate provisions obligating the insurer to pay medical, chiropractic, hospital, surgical, and funeral expenses arising out of the death or injury of an employee, regardless of any legal liability of the insured.

Drafting Note: The word "chiropractic" has been added to accord with changes in the Virginia Workers' Compensation Act.

§ 38.2-120. Fidelity.–"Fidelity insurance" means:

1. Indemnifying any person against loss through counterfeit, forgery or alteration of, on, or in any security obligation or other written instrument; or

2. Indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss resulting from any cause, of personal property, including fixtures, equipment, safes and vaults on the insured's premises.

§ 38.2-121. Surety.–"Surety insurance" means:

1. Becoming surety or guarantor for any person, in any public or private position or place of trust, whether the guarantee is in an individual, schedule or blanket form; or

2. Becoming surety on or guaranteeing the performance of any lawful obligation, undertaking, agreement, or contract, including reinsurance contracts connected therewith, except policies of insurance; or

3. Becoming surety on or guaranteeing the performance of bonds and undertakings required or permitted in all judicial proceedings or otherwise allowed by law, including surety bonds accepted by state and municipal authorities in lieu of deposits as security for the performance of insurance contracts.

Drafting Note: The definitions of "fidelity" and "surety" remain the same but each has been given a separate section number to accord with the way companies are licensed and financial figures are reported.

§ 38.2-122. Credit.–"Credit insurance" means indemnifying merchants or other persons extending credit against loss or damage resulting from the nonpayment of debts owed to them. "Credit insurance" includes the incidental power to acquire and dispose of debts so insured and to collect any debts owed to the insurer or to any persons so insured by the insurer. "Credit insurance" does not include any insurance defined in §§ 38.2-103, 38.2-108, or 38.2-128.

Drafting Note: This last sentence has been added to keep credit insurance and mortgage guaranty insurance distinct and to distinguish credit insurance from credit life and credit accident and sickness.

§ 38.2-123. Title.–"Title insurance " means insurance against loss by reason of liens and encumbrances upon property, defects in the title to property, and other matters affecting the title to property or the right to the use and enjoyment of property. "Title insurance" includes insurance of the condition of the title to property and the status of any lien on property.

§ 38.2-124. Motor vehicle .–A. "Motor vehicle and insurance " means insurance against:

1. Loss of or damage to motor vehicles, including trailers, semitrailers or other attachments designed for use in connection with motor vehicles, resulting from any cause, and against legal liability of the insured for loss or damage to the property of another resulting from the ownership, maintenance or use of motor vehicles and against loss, damage or expense incident to a claim of such liability; or

2. Legal liability of the insured, and liability arising under subsection A of § 38.2-2206 and against loss, damage, or expense incident to a claim of such liability, arising out of the death or injury of any person resulting from the ownership, maintenance or use of motor vehicles. Motor vehicle insurance does not include any class of insurance specified in § 38.2-119.

B.1. Any policy of "motor vehicle insurance" covering legal liability of the insured under paragraph 2 of subsection A and covering liability arising under subsection A of § 38.2-2206 may include appropriate provisions obligating the insurer to pay medical, chiropractic, hospital, surgical, and funeral expenses arising out of the death or injury of any person. Any policy of motor vehicle insurance may include appropriate provisions obligating the insurer to pay weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, if the injury or death is caused by accident and sustained while in or upon, entering or alighting from, or through being struck by a motor vehicle. These provisions shall obligate the insurer to make payment regardless of any legal liability of the insured or any other person.

2. In any policy of personal automobile insurance in which the insured has purchased coverage mentioned in paragraph 1 of this subsection obligating the insurer to pay medical, chiropractic, hospital, surgical, and funeral expenses arising out of the death or injury of any person, every insurer providing such coverage arising from the ownership, maintenance or use of not more than four motor vehicles shall be liable to pay up to the maximum policy limit available on every motor vehicle insured under such coverage where the medical, chiropractic, hospital, surgical or funeral expenses and costs mentioned in paragraph 1 of this subsection exceed the limits of coverage for any one motor vehicle so insured.

§ 38.2-125. Aircraft.–"Aircraft insurance" means insurance against:

1. Loss of or damage to aircraft and its equipment, resulting from any cause, and against legal liability of the insured for loss of or damage to the property of another resulting from the ownership, maintenance or use of aircraft and against loss, damage or expense incident to a claim of liability; or

2. Legal liability of the insured, and against loss, damage, or expense incident to a claim of liability, arising out of the death or injury of any person resulting from the ownership, maintenance or use of aircraft.

Any policy of "aircraft insurance" covering legal liability of the insured under paragraph 2 of this section may include appropriate provisions obligating the insurer to pay medical, chiropractic, hospital, surgical, and funeral expenses arising out of the death or injury of any person.

Drafting Note: Since motor vehicle insurance and aircraft insurance apply to two separate entities, their definitions have been separated. No substantive changes were made.

§ 38.2-126. Marine.–A. "Marine insurance" means insurance against any kind of loss or damage to:

1. Vessels, craft, aircraft, vehicles of every kind, excluding vehicles operating under their own power or while in storage not incidental to transportation, as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein in respect to any risks or perils of navigation, transit or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting shipment, or during any delays, storage, transshipment, or reshipment incident to shipment, including marine builders' risks and all personal property floater risks;

2. Persons or property in connection with or appertaining to marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of the insurance. This class of insurance shall not include life insurance, surety bonds or insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles;

3. Precious stones, jewels, jewelry, gold, silver and other precious metals used in business, trade, or otherwise and whether or not in transit. This class of insurance shall include jewelers' block insurance;

4.(i) Bridges, tunnels, and other instrumentalities of transportation and communication, excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage, unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, and civil commotion are the only hazards to be covered; (ii) to piers, wharves, docks, and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion; and (iii) to other aids to navigation and transportation, including dry docks and marine railways, against all risks.

B. Marine insurance shall also include "marine protection and indemnity insurance," meaning insurance against loss, damage, or expense or against legal liability of the insured for loss, damage, or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

C. Any policy of "marine insurance" as defined in this section providing protection against bodily injury, sickness or death of another person may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death or injury of any person, regardless of any legal liability of the insured.

Drafting Note: Proposed subsection C is designed to allow medical payments coverage under marine policies.

§ 38.2-127. Legal services insurance. –"Legal services insurance " means the assumption of a

contractual obligation to reimburse the insured against, or pay on behalf of the insured, all or a portion of his fees, costs, and expenses related to services performed by or under the supervision of an attorney licensed to practice in the jurisdiction where the services are performed.

§ 38.2-128. Mortgage guaranty insurance.–"Mortgage guaranty insurance" means indemnifying lenders against financial loss arising from nonpayment of principal, interest, or other sums due under the terms of any evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real property.

Drafting Note: This definition is similar to the California definition of mortgage guaranty insurance (IC §119).

§ 38.2-129. Home protection insurance.–"Home protection insurance" means any contract or agreement whereby a person undertakes for a specified period of time and for a predetermined fee to furnish, arrange for, or indemnify for service, repair, or replacement of any or all of the structural components, parts, appliances, or systems of any covered residential dwelling caused by wear and tear, deterioration, inherent defect, or by the failure of any inspection to detect the likelihood of failure.

Drafting Note: This definition is substantially similar to existing § 38.1-932 (proposed § 38.2-2600).

§ 38.2-130. Homeowners insurance.–"Homeowners insurance" is a combination multi-peril policy written under the provisions of § 38.2-1921 containing fire, miscellaneous property, and liability coverages, insuring primarily (i) owner-occupied residential real property pursuant to § 38.2-2108, (ii) personal property located in residential units, or (iii) any combination thereof.

Drafting Note: Proposed § 38.2-2108 is existing § 38.1-367.2. Proposed § 38.2-1921 is existing § 38.1-279.49. The classes in §§ 38.2-130, 38.2-131 and 38.2-132 have been added to conform with current industry practice.

§ 38.2-131. Farmowners insurance.–"Farmowners insurance" is a combination multi-peril policy written under the provisions of § 38.2-1921 containing fire, miscellaneous property, and liability coverages, insuring primarily (i) farm and related residential property and improvements to real property owned, leased, or operated as a farm, (ii) personal property located in residential units, (iii) other real or personal property usual or incidental to the operation of a farm, or (iv) any combination thereof.

Drafting Note: Proposed § 38.2-1921 is existing § 38.1-279.49.

§ 38.2-132. Commercial multi-peril insurance.– "Commercial multi-peril insurance" is a combination multi-peril policy written under the provisions of § 38.2-1921 insuring risks incident to a commercial enterprise containing any combination of the classes of insurance set forth in subsection A of § 38.2-1902, except insurance on or with respect to operating properties of railroads.

Drafting Note: Proposed § 38.2-1921 is existing § 38.1-279.49. Proposed § 38.2-1902 is existing § 38.1-279.31.

§ 38.2-133. Contingent and consequential losses. –The definition of any class of insurance against loss of or damage to property enumerated in this article may include insurance against contingent, consequential and indirect losses resulting from any of the causes set out in this article. Coverage for these losses shall be included in the specific grouping of the class of insurance where the cause is specified. Insurance against loss of or damage to property may include insurance against loss or damage to all lawful interests in the property, and against loss of use and occupancy, rents, and profits resulting from the loss or damage.

§ 38.2-134. Definitions to include other insurance of same general kind.–The definition of any class of insurance enumerated in this article shall include insurance against other loss, damage or liability of the same general nature or character, or of a similar kind, if the insurance may reasonably and properly be included in the definition and is not specifically included in the definition of some other class of insurance.

Article 3.

Classes of Insurance Companies May Write; Reinsurance.

§ 38.2-135. Classes of insurance companies may be licensed to write.– Except as otherwise provided in this title and subject to any conditions and restrictions imposed therein, any insurer licensed to transact the business of insurance in this Commonwealth, other than life insurers and title insurers, may be licensed to write one or more of the classes of insurance enumerated in Article 2 (§ 38.2-101 et seq.) of this chapter that it is authorized under its charter to write, except life insurance, industrial life insurance, credit life insurance, variable life insurance, annuities, variable annuities and title insurance. An insurer licensed to write life insurance shall not be licensed to write any additional class of insurance except variable life insurance, annuities, variable annunities, credit life insurance, credit accident and sickness insurance, accident and sickness insurance, industrial life insurance, and legal services insurance. An insurer licensed to write title insurance shall not be licensed to write any additional class of insurance. However, any life insurer that has been licensed to write and has been actively engaged in writing life insurance and any additional class of insurance set out in Article 2 (§ 38.2-101 et seq.) of this chapter continuously during a period of twenty years immediately preceding July 1, 1952, may continue to be licensed to write those classes of insurance. No company shall write any class of insurance unless it has a current annual license from the Commission to do so.

Drafting Note: 1. Because variable life insurance, variable annuities, industrial life, credit life and credit accident and sickness have been set out as distinct kinds of insurance, they have been specifically noted in this section.

2. The phrase "kind or class of insurance" has been revised to read "class of insurance."

§ 38.2-136. Reinsurance.--Except as otherwise provided in this title, any insurer licensed to transact the business of insurance in this Commonwealth may, by policy, treaty or other agreement, cede to or accept from any insurer reinsurance upon the whole or any part of any risk, with or without contingent liability or participation, and, if a mutual insurer, with or without membership therein.

Title 38.2

CHAPTER 2.

Provisions of a General Nature.

1. Existing § 38.1-29.1 (proposed § 38.2-203) dealing with management and exclusive agency contracts, has been expanded to give the Commission the authority to withdraw approval of these contracts. The section also has been expanded to include contracts for legal services plans and home protection companies since they are already subject to this provision by their respective chapters.

2. Portions of existing § 38.1-327.10 have been moved to this chapter to create a new section (§ 38.2-205). A new subsection was added at the request of the banking and savings and loan industry clarifying that grandfathered agencies may have newly-licensed agents without losing their grandfathered status.

3. Existing sections 38.1-33 and 38.1-34 (proposed §§ 38.2-210 and 38.2-211) have been expanded to cover health, dental and optometric services plans, health maintenance organizations and home protection companies.

4. The proposed change to existing § 38.1-40 (§ 38.2-218) is intended to: 1) extend coverage to violations of regulations (as in existing § 38.1-279.56); 2) drop the minimum penalties and introduce a minimum penalty cap for negligent violations; 3) increase the maximum allowable penalty; 4) provide a greater maximum allowable penalty for knowing or willful violations; 5) provide restitution payments; 6) exempt from penalty violations resulting from solely electronic or mechanical malfunctions; and 7) turn this section into a general as contrasted to a residual penalty section.

5. A new section, § 38.2-219, has been added providing for title-wide authority for cease and desist orders. This section represents a synthesis based on existing §§ 38.1-178.7, 38.1-61, and 38.1-62, as well as of existing §§ 38.1-54, 38.1-55, 38.1-60, 38.1-178.17, and 38.1-482.14:1 to provide a general title-wide cease and desist order provision. All of these sections will be deleted. Existing § 38.1-224 (proposed 38.2-2002) contains a provision somewhat similar to a cease and desist provision, but that provision will be left unchanged because it is a special case.

6. A new section, proposed § 38.2-220 has been added providing title-wide authority for issuing injunctions. This section is based on existing §§ 38.1-806, 38.1-830, 38.1-884, 38.1-911, and 38.1-946 being made applicable title-wide. All of these sections, along with § 38.1-279.44:3 and part of §38.1-98.1, will be deleted. Existing § 38.1-132 (proposed 38.2-1507) is a special case dealing with delinquency proceedings and will not be deleted. The authority of the Commission to issue injunctions is already contained in § 12.1-13. However, new § 38.2-220 is more detailed and provides a ready reference for those subject to Title 38.2.

7. The appeal provision in Title 12.1 applying to all orders, judgments, etc., of the Commission has been incorporated by reference in a new section, proposed § 38.2-222. The various appeal sections currently appearing throughout the title will be deleted.

8. A new section, § 38.2-223, has been added providing on a title-wide basis for authority to issue rules and regulations and also to enter orders. It will replace a number of existing similar sections.

9. A new section, § 38.2-224, has been added providing on a title-wide basis for the application of the procedures of Chapter 5 (Procedure Before the Commission and Appeals) of Title 12.1 to proceedings under proposed Title 38.2. While Chapter 5 of Title 12.1 would apply to Title 38.1 and proposed Title 38.2 even without § 38.2-224, this section was added for ready reference.

10. Existing § 38.1-42 (§ 38.2-225) has been expanded to provide the Commission with authority to direct payment of penalties to either the Literary Fund or to one of the Guaranty Associations if needed.

11. A new section, § 38.2-228, has been added to provide the Commission the authority to enforce the filing of proof of financial responsibility as required by Title 46.1 of the Virginia Code.

CHAPTER 2.

PROVISIONS OF A GENERAL NATURE.

§ 38.2-200. General powers of the Commission relative to insurance.—A. The Commission is charged with the execution of all laws relating to insurance and insurers. All companies, domestic, foreign, and alien, transacting or licensed to transact the business of insurance in this Commonwealth are subject to inspection, supervision and regulation by the Commission.

B. All licenses granting the authority to transact the business of insurance in this Commonwealth shall be granted and issued by the Commission under its seal. The licenses shall be in addition to the certificates of authority required of foreign corporations under §§ 13.1-757 and 13.1-919.

Drafting Note: The outdated citation to Title 13 has been updated.

Drafting Note: Existing § 38.1-29.1 has been moved and renumbered as § 38.2-203.

§ 38.2-201. Recommendations by Commission to General Assembly.—The Commission shall make any recommendations to the General Assembly necessary for legislation governing and regulating the classes of companies placed under its supervision by this title.

§ 38.2-202. Regulation of solicitation of proxies, consents and authorizations.—The Commission may adopt any rules and regulations regarding the voting equity securities of any domestic stock insurer. These rules and regulations shall cover (i) the solicitation of proxies, (ii) consents, (iii) authorizations, and (iv) any related financial reports. However, these rules and regulations shall not apply to any domestic stock insurer whose equity securities are registered, or required to be registered, pursuant to § 12 of the Securities Exchange Act of 1934, as amended.

Drafting Note: The authority to issue rules and regulations will be granted in one general section (proposed § 38.2-223) for all of the title, so proposed § 38.2-202 has been changed to merely continue its restrictions on that authority as to proxies, etc.

§ 38.2-203. Management and exclusive agency contracts subject to approval by Commission.—A. For the purpose of this section, an insurer shall mean a stock or mutual insurer, cooperative nonprofit life benefit company, mutual assessment life, accident and sickness insurer, burial society, fraternal benefit society, mutual assessment property and casualty insurers, legal services plan or home protection company, incorporated or organized under the laws of this Commonwealth.

B. No insurer shall make or enter into any contract that provides for the control and management of the insurer, or the controlling or preemptive right to produce substantially all insurance business for the insurer, unless the contract has been filed with and approved by the Commission and approval has not been withdrawn by the Commission. Any approval, disapproval, or withdrawal of approval shall be delivered to the insurer in writing. The notice of disapproval or withdrawal of approval shall state the grounds of such action and shall be delivered to the insurer at least fifteen days before the effective date.

C. The Commission may disapprove or withdraw approval of any contract referred to in this section that:

1. Subjects the insurer to excessive charges for expenses or commissions;

2. Does not contain fair and adequate standards of performance;

3. Extends for an unreasonable length of time; or

4. Contains other inequitable provisions or provisions that may jeopardize the security of policyholders.

D. The provisions of this section shall not affect contracts made before June 30, 1954, but shall apply to all renewals of those contracts made after that date.

E. Any insurer aggrieved by a disapproval or withdrawal of approval under this section may proceed under the provisions of § 38.2-222.

Drafting Note: 1. Proposed § 38.2-222 incorporates parts of§ 38.1-41.

2. This section (existing § 38.1-29.1) has been renumbered as § 38.2-203 to put it in a more appropriate place.

3. Legal services plans and home protection companies are subject to this provision by their respective chapters and have been added here only for consistency.

4. The authority to disapprove management and exclusive agency contracts has been expanded to include the authority to withdraw approval.

§ 38.2-204. Insurance companies not to engage in banking. —Except as otherwise expressly provided by law, no insurer shall engage in the banking business.

§ 38.2-205. Prohibited insurance activities of lending institutions and bank holding companies.—

A. No lending institution, bank holding company as defined in § 38.2-1811, or any subsidiaries or affiliates of any of the foregoing, doing business in this Commonwealth, or any officer or employee, excluding the director of any of these institutions, shall be directly or indirectly licensed to sell insurance

if located in any county, city or town in this Commonwealth that has a population exceeding 5,000 persons according to the latest decennial census, except as permitted in § 38.2-1811. No such institution shall have ownership in any insurance agency in which any profit, income, or renewal rights to such insurance inures to the benefit of the lending institution, bank holding company, or its subsidiary or affiliate.

B. No lending institution, bank holding company or subsidiary or affiliate thereof doing business in this Commonwealth shall make or grant a loan contingent upon the purchase of insurance from a particular person or organization.

C. Nothing in this section shall apply to (i) any lending institution, bank holding company, savings institution holding company or to any institution, corporation, partnership, company or organization which was a subsidiary or affiliate of the lending institution, bank holding company, or savings institution holding company as of January 1, 1977, or (ii) to any officer or employee of the foregoing, if, on January 1, 1977, the lending institution, bank holding company, savings institution holding company, their subsidiaries or affiliates, and their officers or employees were licensed to sell insurance in this Commonwealth and were conducting business in conformity with all applicable federal and state laws and regulations. However, the license shall not be expanded to include additional classes of insurance for which the lending institution, bank holding company, subsidiaries or affiliates, and their officers or employees were not licensed on January 1, 1977. This does not prohibit the writing of (a) similar or new policies of insurance comparable to and within the classes of insurance for which an agent or agency is licensed on January 1, 1977, or (b) new classes of insurance not written or available in this Commonwealth on January 1, 1977. Nothing in this section shall prohibit a lending institution, bank holding company, savings institution holding company, or their subsidiaries or affiliates, which, on January 1, 1977, were licensed to sell insurance in this Commonwealth, from employing persons to sell insurance who were licensed after January 1, 1977.

D. If the lending institution, bank holding company, subsidiary or affiliate had an application relating to insurance filed and pending before a state or federal regulatory body on January 1, 1977, such persons and their officers or employees in each case shall be exempt as in subsection C of this section.

Drafting Note: 1) Proposed § 38.2-1811 is existing § 38.1-327.10. 2) Portions of existing § 38.1-327.10 have been moved here to create a new section. The addition to subsection C was added at the request of the banking and savings and loan industry and clarifies that grandfathered agencies may hire newly-licensed agents without losing their grandfathered status.

§ 38.2-206. Corporations as members of mutual insurers.—Any public or private corporation in this Commonwealth or elsewhere may apply and enter into agreements for, hold policies in, and be a member of any mutual insurer.

§ 38.2-207. Enforcement of right of subrogation in name of insured.— Except for contracts or plans subject to §§ 38.2-3405 or 38.2-2209, when any insurer pays an insured under a contract of insurance which provides that the insurer becomes subrogated to the rights of the insured against any other party the insurer may enforce the legal liability of the other party. This action may be brought in its own name or in the name of the insured or the insured's personal representative.

Drafting Note: Existing § 38.1-381.2 (proposed § 38.2-2209) prohibits subrogation and is therefore being added to the exception in § 38.2-207.

Drafting Note: Existing § 38.1-31.3 is being merged into paragraph 3 of subsection A of proposed § 38.2-513.

§ 38.2-208. Limitation of risks generally.—A. Except as otherwise provided in this title, no insurer transacting business in this Commonwealth shall expose itself to any loss on any one risk or hazard in an amount exceeding ten percent of its surplus to policyholders. Any risk or portion of any risk reinsured by an insurer meeting standards of solvency equal to those set forth in § 38.2-1316 shall be deducted in determining the limitation of risk prescribed in this section.

B. For the purpose of this section, the surplus to policyholders shall be determined from (i) the insurer's last sworn statement filed with the Commission or (ii) the Commission's last report of examination, whichever is more recent at the time the risk is assumed.

Drafting Note: Proposed § 38.2-1316 is existing § 38.1-171.1. The definition of surplus to policyholders set forth in proposed § 38.2-100 already includes voluntary reserves, so the reference to voluntary reserves has been deleted here.

C. The limitation of risk prescribed in this section for any alien insurer shall apply only to the exposure to risk and the trusteed surplus of the alien insurer's policyholders.

D. This section shall not apply to (i) life insurance, (ii) annuities, (iii) accident and sickness insurance, (iv) insurance of marine risks or marine protection and indemnity risks, (v) workers' compensation or employers' liability risks, or (vi) risks covered by title insurance.

§ 38.2-209. Award of insured's attorney fees in certain cases.—A. Notwithstanding any provision of law to the contrary, in any civil case in which an insured individual sues his insurer to determine what coverage, if any, exists under his present policy or the extent to which his insurer is liable for compensating a covered loss, the individual insured shall be entitled to recover from the insurer costs and such reasonable attorney fees as the court may award. However, these costs and attorney's fees shall not be awarded unless the court determines that the insurer, not acting in good faith, has either denied coverage or failed or refused to make payment to the insured under the policy.

B. Nothing in this section shall be deemed to grant a right to bring an action against an insurer by an

insured who would otherwise lack standing to bring an action.

C. As used in this section, "insurer" shall include "self insurer".

§ 38.2-210. Loans to officers, directors, etc., prohibited.—A. Except as provided in § 38.2-212, no insurer, legal services plan, health services plan, dental or optometric services plan, health maintenance organization, or home protection company, transacting business in this Commonwealth shall make a loan, either directly or indirectly, to any of its officers or directors. No such company shall make a loan to any other corporation or business unit in which any of its officers or directors has a substantial interest. No such officer or director shall accept or receive any such loan directly or indirectly.

B. For the purposes of this section and of § 38.2-211, "a substantial interest " in any corporation or business unit means an interest equivalent to ownership or control of at least ten percent of its stock or its equivalent by an officer or director, or the aggregate ownership or control by all officers and directors of the same company.

Drafting Note 1. ..... Proposed § 38.2-212 is existing § 38.1-35. Proposed § 38.2-211 is existing § 38.1-34.

2. The expanded coverage in subsection A is intended to provide similar treatment for officers and directors of companies providing insurance-related products. The definition of "a substantial interest" has been broadened by referring not only to ownership of stock, but also to "its equivalent."

§ 38.2-211. Other interests and payments to officers, directors, etc., prohibited.— Except as provided in § 38.2-212, no officer or director of any company listed in § 38.2-210 and transacting business in this Commonwealth shall receive, directly, indirectly or through any substantial interest in any other corporation, any compensation for negotiating, procuring, recommending, or aiding in the purchase or sale of property by such company, or in obtaining any loan from the company. No such officer or director shall be pecuniarily interested, either as principal, agent, or beneficiary, in any such purchase, sale or loan. No financial obligation of any such officer or director shall be guaranteed by the company.

Drafting Note: Proposed § 38.2-212 is existing § 38.1-35. Proposed § 38.2-210 is existing § 38.1-33.

§ 38.2-212. Certain compensation not prohibited.—A. Nothing contained in §§ 38.2-210 and 38.2-211 shall prohibit any officer or director of any company listed in § 38.2-210 from receiving usual compensation for services rendered in the ordinary course of his duties as an officer or director, if the compensation is authorized by vote of the board of directors or other governing body of the company. Nor shall the provisions of §§ 38.2-210 and 38.2-211 prohibit the payment to an officer or director of any such company who is a licensed attorney-at-law of a fee in connection with loans made by the company if and when those fees are paid by the borrower and do not constitute a charge against the company.

B. Nothing contained in this chapter shall prohibit a life insurer from making a loan upon a policy of insurance issued by it and held by the borrower. This loan shall not exceed the net cash value of the policy. Nothing contained in this chapter shall prohibit any company from (i) making a loan on real property owned by the officer and improved with a dwelling that is to serve as his residence if the loan qualifies under paragraph 1 of § 38.2-1434 and under § 38.2-1437 or (ii) acquiring the residence of the officer in conformance with subsection B of § 38.2-1441 if the transaction is in connection with the relocation of the place of employment of an officer who is neither a director nor a trustee of the company.

Drafting Note: The ninety percent requirement for loans on the residences of officers is being deleted in subsection B because proposed § 38.2-1437 (existing § 38.1-217.40) already has that requirement. The fair market value requirement for acquiring the residence of an officer is deleted in subsection B because proposed § 38.2-1441 (existing § 38.1-217.44) already has that requirement.

C. Nothing contained in § 38.2-211 shall prohibit a director of any such company from receiving compensation that is usual and customary in the director's business with respect to transactions in the ordinary course of business of the company and of the director. Prior to payment of the compensation, written request for the Commission's approval shall be made. This written request shall set forth under oath complete details concerning the transactions that the company intends to conduct with a director. Any approval given by the Commission shall be in writing. No approval granted under this subsection shall imply that the Commission approves any investment of any company.

Drafting Note: The last sentence is unnecessary as it is covered in the proposed general regulation authority section.

§ 38.2-213. Violation of § 38.2-210 or § 38.2-211.—Any company, officer or director violating any provision of § 38.2-210 or § 38.2-211 shall be guilty upon conviction of a Class 1 misdemeanor. Any funds of any company invested or used in violation of either of § 38.2-210 or § 38.2-211 may not be allowed as admitted assets of the company.

Drafting Note: The rewording of existing § 38.1-36 (proposed § 38.2-213) is based on § 18.2-11 in the Criminal Code. May has been substituted for shall to give the Commission discretion in nonadmitting certain assets.

§ 38.2-214. Restrictions upon purchase and sale of equity securities of domestic stock insurers.—A. Each person who is directly or indirectly the beneficial owner of more than ten percent of a class of any equity security of a domestic insurer, or who is a director or an officer of a domestic stock insurer, shall file a statement with the Commission within ten days after becoming a beneficial owner, director or officer. This statement shall be in a form prescribed by the Commission and shall show the amount of all the domestic insurer's equity securities of which he is the beneficial owner. Within ten days after the close of each calendar month, if there has been a change in his ownership during such month, the person shall file with

the Commission a statement prescribed by the Commission indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

Drafting Note: The July 1, 1966 date is no longer needed.

B. To prevent the unfair use of information obtained by any beneficial owner, director or officer any profit realized by such person within six months from the purchase and sale, or any sale and purchase, of any of the insurer's equity securities shall inure to and be recoverable by the insurer. This provision shall apply regardless of any intention of the beneficial owner, director or officer to hold the equity security purchased or not to repurchase any sold equity security for a period exceeding six months. However, this provision shall not apply if the security was acquired in good faith in connection with a debt previously contracted. The insurer may sue at law or in equity to recover the profit in any court of competent jurisdiction. The owner of any equity security of the insurer may sue in the name and in behalf of the insurer if the insurer fails or refuses to bring suit within sixty days after request or if the insurer fails to diligently prosecute after bringing suit. No suit under this subsection shall be brought more than two years after the date the profit was realized. This subsection shall not be construed to cover any transaction where the person was not the beneficial owner at the time of either the purchase or sale of the equity security involved. The Commission may by rules and regulations exempt from the provisions of this subsection any transaction that is not comprehended within the purpose of this subsection.

C. No beneficial owner, director or officer shall directly or indirectly sell any equity security of the insurer if the person selling the security or his principal (i) does not own the security sold, or (ii) owns the equity security but does not deliver it within twenty days after the sale or does not mail it within five days after the sale. No person shall be deemed to have violated this subsection if he proves that , notwithstanding the exercise of good faith, he was unable to deliver or mail the security within the required time, or that to do so would cause undue inconvenience or expense. Any person violating this subsection shall be guilty upon conviction of a Class 1 misdemeanor.

D. Subsections B and C of this section shall not apply to the transactions of a dealer in an investment account that are conducted in the ordinary course of a dealer's business and incident to the establishment or maintenance of an equity security's primary or secondary market, other than on an exchange defined in the Securities Exchange Act of 1934. The Commission may, by rules and regulations, define and prescribe terms and conditions with respect to equity securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

E. Subsections A, B, and C of this section shall not apply to foreign or domestic arbitrage transactions unless made in contravention of rules and regulations adopted by the Commission to carry out the purposes of this section.

F. The term "equity security" when used in this section means (i) any stock or similar security, (ii) any security that is convertible, with or without consideration, into another security, (iii) any security that carries any warrant or right to subscribe to or purchase a security, or (iv) any warrant, right or other security that the Commission, by rules and regulations, deems to be similar in nature to an equity security and considers the classification necessary or appropriate for protecting the public or an investor's interest.

G. Subsections A, B, and C of this section shall not apply to equity securities of a domestic stock insurer if (i) those equity securities are registered or are required to be registered pursuant to § 12 of the Securities Exchange Act of 1934, as amended; or (ii) the domestic stock insurer does not have any class of its equity securities held of record by 100 or more persons on the last business day of the year immediately preceding the year in which equity securities of the insurer would be subject to subsections A, B, and C of this section.

H. The Commission may adopt rules and regulations pursuant to § 38.2-223 for the execution of the functions vested in it by subsections A through G of this section. The Commission may classify for that purpose any domestic stock insurers, equity securities, and other persons or matters within its jurisdiction. The Commission may exempt from the provisions of this section any officer, director or beneficial owner of equity securities of any domestic stock insurer under the terms and conditions, and for the period of time the Commission considers necessary or appropriate if the Commission finds that the action is consistent with the public interest or the protection of investors. Any such exemption may be accomplished by (i) rules and regulations issued pursuant to § 38.2-223 or (ii) by order, upon application of any interested person, after due notice and an opportunity for hearing has been given. No provision of subsections A, B, and C of this section imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Commission. Notwithstanding the provisions of this subsection, such rule or regulation may be amended, rescinded or determined by judicial or other authority to be invalid for any reason after the act or omission has occurred.

§ 38.2-215. Liability of president, chief executive officer or directors if insurance issued when insurer insolvent.—If any insurer is insolvent, and the president, chief executive officer or directors with knowledge of insolvency make or agree to further insurance, they shall be personally liable for any loss under that insurance.

Drafting Note: "Chief executive officer" is added to parallel titles used in organizational structures.

§ 38.2-216. Restrictions on removal or transfer of property and on reinsurance; penalty.—A. No domestic insurer shall remove from this Commonwealth either all or substantially all of its property or business without the written approval of the Commission.

B. No domestic insurer shall transfer or attempt to transfer substantially its entire property, or enter into any transaction the effect of which is to merge substantially its entire property or business into the property or business of any other company, without prior written approval of the Commission.

C. No domestic insurer shall reinsure with any other insurer all or substantially all of its risks without prior written approval of the Commission of the reinsurance and of the contract under which reinsurance is effected.

D. Any director or officer of the insurer consenting to and participating in any violation of this section shall be guilty of a Class 1 misdemeanor.

Drafting Note: The stricken language in front of proposed subsection D of § 38.2-216 is unnecessary in light of the wording of the proposed general penalty section. The rewording of the latter part of the section is based on § 18.2-11 in the Criminal Code.

§ 38.2-217. When assets may not be distributed among stockholders.—No domestic insurer shall distribute its assets among its stockholders until all risks have expired or have been cancelled, or have been replaced by the policies of another solvent insurer licensed to transact the business of insurance in this Commonwealth, and until all claims against the insurer have been settled. No insurer shall contract to reinsure its risks for the purpose of distributing its assets without first obtaining the written approval of the Commission. However, nothing in this section shall be construed to prohibit the lawful payment of dividends.

Drafting Note: Section 38.1-40 has been replaced with § 38.2-218 which will serve as a title wide centralized penalty section.

§ 38.2-218. Penalties and restitution payments. – A. Any person who knowingly or willfully violates any provision of this title or any regulation issued pursuant to this title shall be punished for each violation by a penalty of not more than $5,000.

B. Any person who violates without knowledge or intent any provision of this title or any rule, regulation, or order issued pursuant to this title may be punished for each violation by a penalty of not more than $1,000. For the purpose of this subsection, a series of similar violations resulting from the same act shall be limited to a penalty in the aggregate of not more than $10,000.

C. Any violation resulting solely from a malfunction of mechanical or electronic equipment shall not be subject to a penalty.

D.1. The Commission may require a person to make restitution in the amount of the direct actual financial loss:

a. For charging a rate in excess of that provided by statute or by the rates filed with the Commission by the insurer;

b. For charging a premium that is determined by the Commission to be unfairly discriminatory, such restitution being limited to a period of one year from the date of determination; and

c. For failing to pay amounts explicitly required by the terms of the insurance contract where no aspect of the claim is disputed by the insurer.

2. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection regarding restitution among insurers, insureds, agents, claimants and beneficiaries.

E. The provisions provided under this section may be imposed in addition to or without imposing any other penalties or actions provided by law.

Drafting Note: The proposed change to this section is intended to: 1) extend coverage to violations of regulations (as in existing § 38.1-279.56); 2) drop the minimum penalties and introduce a minimum penalty cap for negligent violations; 3) increase the maximum allowable penalty; 4) provide a greater maximum allowable penalty for knowing or willful violations; 5) provide restitution payments; 6) exempt from penalty violations resulting from solely electronic or mechanical malfunctions; and 7) turn this section into a general as contrasted to a residual penalty section.

§ 38.2-219. Violations; procedure; cease and desist orders.—A. Whenever the Commission has reason to believe that any person has committed a violation of this title or of any rule, regulation, or order issued by the Commission under this title, it shall issue and serve an order upon that person by certified or registered mail or in any other manner permitted by law. The order shall include a statement of the charges and a notice of a hearing on the charges to be held at a fixed time and place which shall be at least ten days after the date of service of the notice. The order shall require that person to show cause why an order should not be made by the Commission directing the alleged offender to cease and desist from the violation or to show cause why the Commission should not issue any other appropriate order as the nature of the case and the interests of the policyholders, creditors, shareholders, or the public may require. At the hearing, that person shall have an opportunity to be heard in accordance with the Commission's order. In all matters in connection with the charges or hearing, the Commission shall have the jurisdiction, power and authority granted or conferred upon it by Title 12.1 and, except as otherwise provided in this title, the procedure shall conform to and the right of appeal shall be the same as that provided in Title 12.1.

B. If the Commission finds in the hearing that there is about to be or has been a violation of this title,

it may issue and serve upon any person committing the violation by certified or registered mail or in any other manner permitted by law (i) an order reciting its findings and directing the person to cease and desist from the violation or (ii) such other appropriate order as the nature of the case and the interests of the policyholders, creditors, shareholders, or the public requires.

C. Any person who violates any order issued under subsection B of this section may upon conviction be subject to one or both of the following:

1. Punishment as provided in § 38.2-218; or

2. The suspension or revocation of any license issued by the Commission.

Drafting Note: Proposed § 38.2-219 represents a synthesis based on existing §§ 38.1-178.7, 38.1-61, and 38.1-62, as well as of existing §§ 38.1-54, 38.1-55, 38.1-60, 38.1-178.17, and 38.1-482.14:1 to provide a general title-wide cease and desist order provision. All of these sections will be deleted. Existing § 38.1-224 (proposed § 38.2-2002) contains a provision somewhat similar to a cease and desist provision, but that provision will be left unchanged because it is a special case.

§ 38.2-220. Injunctions.—The Commission shall have the jurisdiction and powers of a court of equity to issue temporary and permanent injunctions restraining acts which violate or attempt to violate provisions of this title and to enforce the injunctions by civil penalty or imprisonment.

Drafting Note: Proposed § 38.2-220 is based on existing §§ 38.1-806, 38.1-830, 38.1-884, 38.1-911, and 38.1-946 made applicable title-wide. All of these sections, along with § 38.1-279.44:3 and part of § 38.1-98.1, will be deleted. Existing § 38.1-132 (proposed § 38.2-1507) is a special case dealing with delinquency proceedings and will not be deleted. The authority of the Commission to issue injunctions is already contained in § 12.1-13. However, new § 38.2-220 is more detailed and provides a ready reference for those subject to Title 38.1.

§ 38.2-221. Enforcement of penalties.—The Commission may impose, enter judgment for, and enforce any civil penalty or other penalty pronounced against any person for violating any of the provisions of this title, subject to the hearing provisions of § 12.1-28. The power and authority conferred upon the Commission by this section shall be in addition to and not in substitution for the power and authority conferred upon the courts by general law to impose civil penalties for violations of the laws of this Commonwealth.

Drafting Note: The right of appeal provision has been deleted in proposed § 38.2-221, as new § 38.2-222 is designed to provide a general right of appeal.

§ 38.2-222. Appeals generally.—Except as otherwise specifically provided in this title, § 12.1-39 shall apply to the appeal of any final (i) finding, (ii) decision settling the substantive law, (iii) order, or (iv) judgment of the Commission issued pursuant to this title.

Drafting Note: The appeal provision in Title 12.1 applying to all orders, judgments, etc. of the Commission has been incorporated by reference in proposed § 38.2-222. There is a redundancy between proposed §§ 38.2-222 and 38.2-224 because Chapter 5 (Procedure Before the Commission and Appeals) of Title 12.1 (referred to in § 38.2-224) includes § 12.1-39. However, it is felt that appeals should be dealt with separately, even if redundantly. The various appeal sections currently appearing throughout the title will be deleted.

§ 38.2-223. Rules and regulations; orders.—The Commission, after notice and opportunity for all interested parties to be heard, may issue any rules and regulations necessary or appropriate for the administration and enforcement of this title.

Drafting Note: Proposed § 38.2-223 has been added as a single general section applicable title-wide dealing with the authority of the Commission to issue rules and regulations and to enter orders. The numerous sections throughout the title conferring rulemaking authority for a single chapter, article or section will be deleted.

§ 38.2-224. Procedures.—Except as otherwise specifically provided in this title, Chapter 5 (§ 12.1-25 et seq.) of Title 12.1 shall apply to proceedings under this title.

Drafting Note: While Chapter 5 of Title 12.1 would apply to Title 38.1 and proposed Title 38.2 even without proposed § 38.2-224, this section is being added for easy reference.

§ 38.2-225. Disposition of fines and penalties.—A. All fines recovered for criminal violations of this title or for criminal violations of rules, regulations, or orders issued pursuant to this title shall be paid into the state treasury to the credit of the Literary Fund.

B. All penalties and compromise settlements recovered for civil violations of this title or civil violations of rules, regulations, or orders issued pursuant to this title shall be paid into the state treasury. Pursuant to § 38.2-1718 these funds shall be credited to the Literary Fund or if the Commission determines a need, to either (i) the Virginia Property and Casualty Insurance Guaranty Association established pursuant to Chapter 16 or (ii) the Virginia Life, Accident and Sickness Insurance Guaranty Association established pursuant to Chapter 17.

Drafting Note: Subsection A is devoted exclusively to the payment of fines for criminal violations of this title. Subsection B, which is devoted to civil violations, provides the Commission authority to direct payment of penalties to either the Literary Fund or to one of the Guaranty Associations if needed.

§ 38.2-226. Provisions of title not to apply to certain mutual aid associations.— This title shall not apply to beneficial, relief, or mutual aid societies, or partnerships, plans, associations, or corporations, established prior to 1935 and formed by churches for the purpose of aiding members who sustain property losses by fire, lightning, hail, storm, flood, explosion, power failure, theft, burglary, vandalism, civil commotion,

airplane and vehicular damage, and in which the privileges and memberships in these societies, partnerships, plans, associations, or corporations are confined to members of the churches.

§ 38.2-227. Public policy regarding punitive damages.—It is not against the public policy of the Commonwealth for any person to purchase insurance providing coverage for punitive damages arising out of the death or injury of any person as the result of negligence, including willful and wanton negligence, but excluding intentional acts. This section declares existing policy.

§ 38.2-228. Proof of future financial responsibility.—At the request of a named insured, a licensed property and casualty insurer shall provide without unreasonable delay to the Commissioner of the Department of Motor Vehicles proof of future financial responsibility as required by the provisions of Title 46.1.

Drafting Note: The addition of this section provides the Commission the authority to enforce filings of financial responsibility for certain persons as required by Title 46.1 of the Virginia Code.

§ 38.2-229. Immunity from liability. —A. There shall be no liability on the part of and no cause of action against any person for furnishing in good faith to the Commission information relating to the investigation of any insurance or reinsurance transaction when such information is furnished under the requirements of law or at the request or direction of the Commission.

B. There shall be no liability on the part of and no cause of action against the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents, acting in good faith, for investigating any insurance or reinsurance transaction or for the dissemination of any official report related to an official investigation of any insurance or reinsurance transaction.

Drafting Note: A title-wide immunity section has been added that corresponds to the NAIC model language.

§ 38.2-230. Distributions by nonstock corporation.—No dividend or distribution of income, as used in § 13.1-814, shall be made to a member corporation of a corporation licensed under the provisions of this title unless the corporation has received approval by the Commission prior to the distribution. In approving the distribution, the Commission shall give consideration to the subscribers' or policyholders' best interest.

Drafting Note: This section was adopted by the 1985 session of the General Assembly.

Title 38.2

CHAPTER 3.

Provisions Relating to Insurance Policies and Contracts.

The major substantive changes proposed are:

1. Existing § 38.1-330 (proposed § 38.2-302) has been changed to require that no insurer shall knowingly deliver or issue for delivery an insurance contract upon the person unless the insured applies for the insurance or consents in writing to the insurance with certain exceptions.

2. A new subsection has been added to existing § 38.1-342.1 (proposed § 38.2-316) to provide the Commission with the authority to exempt life and health insurance forms from filing and approval requirements.

3. Existing § 38.1-279.48:1 (proposed §38.2-317) has been moved from existing Chapter 6.2 and revised to provide more detailed standards for disapproval of forms.

CHAPTER 3.

PROVISIONS RELATING TO INSURANCE POLICIES AND CONTRACTS.

§ 38.2-300. Scope of chapter.—This chapter shall apply to all classes of insurance except:

1. Ocean marine insurance;

2. Life insurance policies and accident and sickness insurance policies not delivered or issued for delivery in this Commonwealth;

3. Contracts of reinsurance; or

4. Annuities, except as provided for in §§ 38.2-316 and 38.2-321.

Drafting Note: The exception for annuities has been modified because §§ 38.2-316 and 38.2-321 apply to annuities.

Proposed §§ 38.2-316 and 38.2-321 are existing §§ 38.1-342.1 and 38.1-346.1, respectively.

§ 38.2-301. Insurable interest required; life, accident and sickness insurance.—A. Any individual of lawful age may procure or effect an insurance contract upon himself for the benefit of any person. No person shall knowingly procure or cause to be procured any insurance contract upon another individual unless the benefits under the contract are payable to (i) the insured or his personal representative, (ii) a beneficiary designated by the insured, or (iii) a person having an insurable interest in the insured at the time when the contract was made.

B. As used in this section and § 38.2-302, "insurable interest" means:

1. In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection; and

2. In the case of other persons, a lawful and substantial economic interest in the life, health, and bodily safety of the insured. "Insurable interest" shall not include an interest which arises only or is enhanced by the death, disability or injury of the insured.

§ 38.2-302. Life, accident and sickness insurance; application required.—A. No contract of insurance upon a person shall be made or effectuated unless at the time of the making of the contract the individual insured, being of lawful age and competent to contract for the insurance contract (i) applies for insurance, or (ii) consents in writing to the insurance contract. However:

1. A wife or husband may effect an insurance contract upon each other; or

2. Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effect an insurance contract upon the life of or pertaining to the minor.

B. Nothing in this section shall prohibit a minor from obtaining insurance on his own life as authorized in § 38.2-3105.

C. This section shall not apply to group life insurance or group accident and sickness insurance.

Drafting Note: With the above change, the insured must now apply for the insurance or consent in writing to the insurance with certain exceptions. Knowledge of the application being made will not be sufficient for a legal contract.

§ 38.2-303. Insurable interest required; property insurance.—A. No insurance contract on property or on any interest therein or arising therefrom shall be enforceable except for the benefit of persons having an insurable interest in the property insured.

B. As used in this section, "insurable interest" means any lawful and substantial economic interest in the safety or preservation of the subject of insurance free from loss, destruction or pecuniary damage.

§ 38.2-304. Contracts of temporary insurance; duration; what deemed to include.—A. Oral or written binders or other temporary insurance contracts may be made and used for a period not exceeding sixty days pending the issuance of the policy. Unless otherwise provided, oral or written binders or other temporary insurance contracts shall be deemed to include the usual provisions, stipulations and agreements which are commonly used in this Commonwealth in effecting the class of insurance being written.

B. This section shall not apply to:

1. Binders or other contracts referred to in §§ 38.2-2112 and 38.2-4605;

2. Conditional receipts issued by life insurers; or

3. Group insurance policies.

§ 38.2-305. Contents of policies.— A. Each insurance policy or contract shall specify:

1. The names of the parties to the contract;

2. The subject of the insurance;

3. The risks insured against;

4. The time the insurance takes effect and, except in the case of group insurance, title insurance, and insurance written under perpetual policies, the period during which the insurance is to continue;

5. A statement of the premium, except in the case of group insurance and title insurance; and

6. The conditions pertaining to the insurance.

B. If, under the contract, the exact amount of premiums is determinable only at the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished to any policy-examining bureau having jurisdiction or to the insured upon request.

C. This section shall not apply to fidelity or surety insurance contracts.

§ 38.2-306. Additional contents.--A policy or contract may contain additional provisions that are not substantially in conflict with this title and that:

1. Are required to be inserted by the laws of the insurer's state or country of domicile or of the state or country in which the policy is to be delivered or issued for delivery; or

2. Are necessary to state the rights and obligations of the parties to the contract because of the manner in which the insurer is constituted or operated.

§ 38.2-307. Charter and bylaw provisions in policies.--No policy shall contain any provision purporting to make any portion of the charter, bylaws or other organic law of the insurer, however designated, a part of the contract unless that portion is set out in full in the policy. Any policy provision in violation of this section shall be invalid.

§ 38.2-308. Contingent liability provisions in policies issued by certain mutual insurers.--Except in the case of nonassessable policies , the contingent liability of each member of a mutual insurer, other than a life insurer, shall be clearly stated in the mutual insurer's policies. The contingent liability may be limited, but such limitation shall not be less than one additional annual premium on each policy held by the member.

Drafting Note: With the substitution of "clearly stated" for "prescribed" in the first sentence a separate sentence requiring that the contingent liability provision be "plainly stated" in the policy is unnecessary.

Drafting Note: Section 38.1-335.2 has been moved to the fire insurance policies chapter (proposed Chapter 21, § 38.2-2120).

§ 38.2-309. When answers or statements of applicant do not bar recovery on policy.--All statements, declarations and descriptions in any application for an insurance policy or for the reinstatement of an insurance policy shall be deemed representations and not warranties. No statement in an application or in any affidavit made before or after loss under the policy shall bar a recovery upon a policy of insurance unless it is clearly proved that such answer or statement was material to the risk when assumed and was untrue.

§ 38.2-310. All fees, charges, etc., to be stated in policy.--A. All fees, charges, premiums or other consideration charged for the insurance or for the procurement of insurance shall be stated in the policy except in the case of fidelity, surety, title, and group insurance, and except for consulting services as provided in Article 4 (§ 38.2-1837 et seq.) of Chapter 18 of this title. No insurer or its representative shall charge or receive any fee, compensation, or consideration for insurance that is not included in the premium or stated in the policy.

B. Service charges for installment payments of insurance premiums do not need to be stated in the policy if the charges are provided to the insured in writing.

Drafting Note: This new subsection is intended to facilitate the insurers' ability to make one periodic billing to insureds who have several policies with that insurer.

§ 38.2-311. Type size in which conditions and restrictions to be printed.--Except as otherwise provided in this title, no restriction, condition or provision in or endorsed on any insurance policy shall be valid unless the condition or provision is printed in type as large as eight point type, or is written in ink or typewritten in or on the policy. This section shall not apply to a copy of an application or parts thereof, attached to or made part of an insurance policy.

§ 38.2-312. Provisions limiting jurisdiction, or requiring construction of contracts by law of other states, prohibited.--No insurance contract delivered or issued for delivery in this Commonwealth and covering subjects which are located or residing in this Commonwealth, or which are performed in this Commonwealth shall contain any condition, stipulation or agreement:

1. Requiring the contract to be construed according to the laws of any other state or country, except as may be necessary to meet the requirements of the motor vehicle financial responsibility laws of the other state or country; or

2. Depriving the courts of this Commonwealth of jurisdiction in actions against the insurer.

Any such condition, stipulation or agreement shall be void, but such voiding shall not affect the validity of the remainder of the contract.

§ 38.2-313. Where certain contracts deemed made.—All insurance contracts on or with respect to the ownership, maintenance or use of property in this Commonwealth shall be deemed to have been made in and shall be construed in accordance with the laws of this Commonwealth.

§ 38.2-314. Limitation of action and proof of loss.—No provision in any insurance policy shall be valid if it limits the time within which an action may be brought to less than one year after the loss occurs or the cause of action accrues.

If an insurance policy requires a proof of loss, damage or liability to be filed within a specified time, all time consumed in an effort to adjust the claim shall not be considered part of such time.
Drafting Note: A "suit" was deleted since "action" would be broad enough to include "suit."

§ 38.2-315. Intervening breach.—If any breach of warranty or condition in any insurance contract covering property located in this Commonwealth occurs prior to a loss under the contract, the breach shall not void the contract nor permit the insurer to avoid liability unless the breach existed at the time of the loss.
Drafting Note: The word "void" was substituted for "avoid" as it appears to be the proper term in the context of this section.

§ 38.2-316. Policy forms to be filed with Commission; notice of approval or disapproval; exceptions.—A. No policy of life insurance, industrial life insurance, group life insurance, accident and sickness insurance, group accident and sickness insurance; no annuity, pure endowment, variable annuity, group annuity or group variable annuity contract; no health services plan, legal services plan, dental or optometric services plan, or health maintenance organization contract; or fraternal benefit certificate shall be delivered or issued for delivery in this Commonwealth unless a copy of the form has been filed with the Commission. In addition to the above requirement, no policy of accident and sickness insurance shall be delivered or issued for delivery in this Commonwealth unless the rate manual showing rates, rules, and classification of risks applicable thereto has been filed with the Commission.

B. Except as provided in this section, no application form shall be used with the policy or contract and no rider or endorsement shall be attached to or printed or stamped upon the policy or contract unless the form of such application, rider or endorsement has been filed with the Commission. No individual certificate shall be used in connection with any group life insurance policy, group accident and sickness insurance policy, group annuity contract, or group variable annuity contract unless the form for the certificate has been filed with the Commission.

C. None of the policies, contracts, and certificates specified in subsection A of this section shall be delivered or issued for delivery in this Commonwealth and no applications, riders, and endorsements shall be used in connection with the policies, contracts, and certificates unless the forms thereof have been approved in writing by the Commission as conforming to the requirements of this title and not inconsistent with law.

D. The Commission may disapprove or withdraw approval of the form of any policy, contract or certificate specified in subsection A of this section, or of any application, rider or endorsement, if the form:

1. Does not comply with the laws of this Commonwealth;

2. Has any title, heading, backing or other indication of the contents of any or all of its provisions that is likely to mislead the policyholder, contract holder or certificate holder; or

3. Contains any provisions that encourage misrepresentation or are misleading, deceptive or contrary to the public policy of this Commonwealth.

E. Within thirty days after the filing of any form requiring approval, the Commission shall notify the organization filing the form of its approval or disapproval of the form which has been filed, and, in the event of disapproval, its reason therefor. The Commission, at its discretion, may extend for up to an additional thirty days the period within which it shall approve or disapprove the form. Any form received but neither approved nor disapproved by the Commission shall be deemed approved at the expiration of the thirty days if the period is not extended, or at the expiration of the extended period if any.

F. If the Commission proposes to withdraw approval previously given or deemed given to the form of any policy, contract or certificate, or of any application, rider or endorsement, it shall notify the insurer in writing at least fifteen days prior to the proposed effective date of withdrawal giving its reasons for withdrawal.

G. Any insurer or fraternal benefit society aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

H. This section shall not apply to any special rider or endorsement on any policy, except an accident and sickness insurance policy that relates only to the manner of distribution of benefits or to the reservation of rights and benefits under such policy, and that is used at the request of the individual

policyholder, contract holder or certificate holder.

I. The Commission may exempt any categories of such policies, contracts, and certificates and any applicable rate manuals from (i) the filing requirements, (ii) the approval requirements of this section, or (iii) both such requirements. The Commission may modify such requirements, subject to such limitations and conditions which the Commission finds appropriate. In promulgating an exemption, the Commission may consider the nature of the coverage, the person or persons to be insured or covered, the competence of the buyer or other parties to the contract, and other criteria the Commission considers relevant.

Drafting Note: A new subsection I has been added to give the Commission authority to exempt forms from the filing and approval requirements of this section.

§ 38.2-317. Delivery and use of certain policies and endorsements.—A. An insurance policy or endorsement of the kind to which Chapter 19 of this title applies, other than statutory fire insurance policies and standard automobile policy forms and endorsements, may be delivered or issued for delivery in this Commonwealth only if (i) the policy form or endorsement is filed with the Commission at least thirty days prior to its effective date; and (ii) the Commission has not disapproved the form or endorsement within the thirty days because it:

1. Is in violation of any provision of this title;

2. Contains provisions that are contrary to the public policy of this Commonwealth;

3. Contains or incorporates by reference, even where such incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the policy;

4. Has any title, heading or other indication of its provisions that is misleading;

5. Contains provisions that are so unclear or deceptively worded that they encourage misrepresentation; or

6. Provides coverage of such a limited nature that it is contrary to the public interest of this Commonwealth.

B. The policy and endorsement forms referred to in subsection A of this section in use on October 1, 1976, may continue to be used, subject to disapproval by the Commission.

Drafting Note: This revised version of existing § 38.1-279.48:1, which has been moved from existing Chapter 6.2 (proposed Chapter 19), provides more detailed standards for disapproval. The original section provided for disapproval if the policy or endorsement was misleading or violating public policy. The revised section has the same limits of applicability as the original section.

Drafting Note: Section 38.1-342.2 has been moved to an article dealing with accident and sickness insurance and prepaid health care plans (proposed Chapter 34, § 38.2-3405).

§ 38.2-318. Validity of noncomplying forms.—A. Any insurance policy or form containing any condition or provision that is not in compliance with this title shall be valid, but shall be construed and applied in accordance with the conditions and provisions required by this title.

B. As used in this section, "form" means any contract, rider, endorsement, amendment, certificate, or application or other instrument providing, modifying, or eliminating insurance coverage.

Drafting Note: To broaden the section, "policy, rider or endorsement" was changed to "policy or form" with form being defined as "any contract, rider, endorsement, amendment, certificate, or application or other instrument providing, modifying, or eliminating insurance coverage."

§ 38.2-319. Validity of contracts in violation of law.—Any insurance contract made in violation of the laws of this Commonwealth may be enforced against the insurer.

Drafting Note: The reference to "suretyship" was deleted because under proposed § 38.2-100, insurance includes suretyship.

§ 38.2-320. Insurer to furnish forms for proof of loss.—A. Whenever notice of any loss or damage has been given to the insurer or its agent, the insurer shall, upon written request, deliver to the insured or to the person to whom the benefits are payable the forms for such preliminary proof of loss or damage as may be required under the policy. Such forms shall be delivered within fifteen days after written request has been made or mailed to the insurer by the insured or person to whom benefits are payable. The failure or refusal of an insurer or its agent to deliver such forms within fifteen days of written request shall be deemed a waiver of any condition, stipulation or provision in the policy requiring preliminary proof.

Drafting Note: Section 38.1-346 has been moved to an article dealing with accident and sickness insurance. (proposed Chapter 34, § 38.2-3406)

§ 38.2-321. Payment discharges insurer.— A. An insurer shall be fully discharged from all claims under a life insurance policy, accident and sickness insurance policy, or annuity contract:

1. When the proceeds of or payments under a policy or contract become payable in accordance with (i) the terms of the policy or contract or (ii) the exercise of any right or privilege under the contract; and

2. If the insurer makes payments in accordance with the terms of the policy or contract or any written

assignment to the person designed in the policy or contract or by assignment as being entitled to the proceeds or payments.

B. An insurer may not be fully discharged from all claims under a life insurance policy, accident and sickness insurance policy, or annuity contract before payment is made and if the insurer has received, at its home office, written notice that some other person claims to be entitled to payment or some interest in the policy or contract.

Title 38.2

CHAPTER 4.

Assessment for Administration of Insurance Laws and Declaration of Estimated Assessment by Insurers.

1. Existing Chapter 1, Articles 5 and 5.1 have been combined into this proposed chapter. The definition provisions have been consolidated.

2. Proposed §§ 38.2-403, 38.2-407, 38.2-408, 38.2-409, and 38.2-411 have been changed to make this chapter consistent with the recently amended tax code (Title 58.1).

   A. The penalty rate in existing § 38.1-45 (proposed § 38.2-403) for failure to pay an assessment when due has been increased from 5% to 10%. This is consistent with § 58.1-2507. Interest will also be charged on the overdue assessment.

   B. The interest in subsection H of existing § 38.1-48.4 (proposed § 38.2-409) has been increased from .5 to .75 percent (with an extension) and one percent per month without an extension.

   C. The penalty rate under subsection A of existing § 38.1-48.6 (proposed § 38.2-411) for failure to pay an estimated assessment will be changed to the interest rate established pursuant to § 6621 of the Internal Revenue Code. This is consistent with § 58.1-2527.

   D. In existing §§ 38.1-48.6 B and 38.1-48.6 D 3 (proposed §§ 38.2-411 B and proposed 38.2-411 D) the percentage of the portion of installments which must be paid without subjection to penalty is increased from 80% to 90% of the estimated assessment. This is consistent with the change in § 58.1-2527.

3. In proposed § 38.2-402 the definition of direct gross premium income in § 58.1-2500 is referenced.

4. Proposed § 38.2-405 has been clarified to specify that appeals from assessment must be in accordance with the Rules of Court applicable to appeals from the State Corporation Commission.

5. § 38.1-48.8 has been deleted because it is outdated.

6. § 38.1-48.10 has been deleted because it is outdated.

Chapter 4.

ASSESSMENT FOR ADMINISTRATION

OF INSURANCE LAWS AND

DECLARATIONS OF ESTIMATED

ASSESSMENTS BY INSURERS.

§ 38.2-400. Expense of administration of insurance laws borne by licensees; minimum contribution.—The expense of maintaining the Bureau of the Commission responsible for administering the insurance laws of this Commonwealth shall be assessed annually by the Commission against all companies and surplus lines brokers subject to this title except fraternal benefit societies, premium finance companies, and providers of continuing care registered pursuant to Chapter 49 of this title. The assessment shall be in proportion to the direct gross premium income on business done in this Commonwealth. The assessment shall not exceed one-tenth of one percent of the direct gross premium income and shall be levied pursuant to § 38.2-403. For any year a company is subject to an assessment, the assessment shall not be less than $300.

Drafting Note: 1) The language "subject to licensure under this title" is an attempt to include the various single line or insurance-related companies regulated under special chapters of the insurance laws. We think that this approach is preferable to the "laundry list" approach, which would require us to list ten separate types of entities in addition to insurance companies.

2) Providers of continuing care are added to the exception provision for clarity purposes only. The new chapter enacted during the 1985 Session does not impose the maintenance tax on such facilities.

3) Direct gross premium is now defined in proposed § 38.2-402.

§ 38.2-401. Fire Programs Fund.—A. There is hereby established a Fire Programs Fund which shall be administered by the Department of Fire Programs under policies established by the Virginia Fire Commission. In order to maintain the Fund, the Commission shall annually assess against all licensed insurance companies doing business in this Commonwealth by writing any type of insurance as defined in §§ 38.2-110, 38.2-111, 38.2-126, 38.2-130 and 38.2-131 and those combination policies as defined in § 38.2-1921 that contain insurance as defined in §§ 38.2-110, 38.2-111 and 38.2-126, an assessment in the amount of eight-tenths of one percent of the total direct gross premium income for such insurance. Such assessment shall be apportioned, assessed and paid as prescribed by § 38.2-403. In any year in which a company has no direct gross premium income or in which its direct gross premium income is insufficient to produce at the rate of assessment prescribed by law an amount equal to or in excess of $100, there shall be so apportioned and assessed against such company a contribution of $100. The Commission shall be reimbursed from the Fund for all expenses necessary for the administration of this section.

B. Seventy-five percent of the total amount collected annually pursuant to this section shall be allocated to the several counties, cities and towns of the Commonwealth providing fire service operations to be used for the improvement of volunteer and salaried fire services in each of the receiving localities. Funds allocated to the counties, cities and towns pursuant to this subsection shall not be used directly or indirectly to supplant or replace any other funds appropriated by the counties, cities and towns for fire service operations. Such funds shall be used solely for the purposes of fire service training, constructing, improving and expanding regional fire service training facilities, purchasing fire-fighting equipment or purchasing protective clothing and protecting equipment for fire-fighting personnel. Distribution of this seventy-five percent of the Fund shall be made on the basis of population as provided for in § 4-22; however, no county, city or town eligible for such funds shall receive less than $3,000.

C. The remainder of this Fund shall be used for the purposes of underwriting the costs of the operation of the Department of Fire Programs and to construct, improve and expand the regional fire training facilities, consistent with the provisions of § 9-155.1.

Drafting Note: This section is the result of 1985 legislative action. Reference to the new definitions of homeowners and farmowners insurance are added for clarity purposes only.

§ 38.2-402. Definitions.—As used in this chapter:

"Assessable year" means the calendar year upon which the direct gross premium income is computed under this chapter. In the case of direct gross premium income for a fraction of a calendar year, the term includes the period in which that direct gross premium income is received or derived from business in this Commonwealth.

"Direct gross premium income" means direct gross premium as defined in § 58.1-2500.

"Estimated assessment" means the company's estimate of the amount imposed by this chapter for the license year.

"License year" means the twelve-month period beginning on July 1 next succeeding the assessable year and ending on June 30 of the subsequent year. This shall also be the year in which annual reports of direct gross premium income are required to be filed under § 38.2-405 and the annual assessment paid under the provisions of this chapter.

Drafting Note: The definitions for "assessable year" and "license year" are from existing § 38.1-48.1. "Estimated assessment" is from existing § 38.1-48.2(B). The definitions of direct gross premium income codifies current practice.

§ 38.2-403. Assessment for expenses.–The Commission shall assess each company annually for its just share of expenses. The assessment shall be in proportion to direct gross premium income for the year immediately preceding that for which the assessment is made. The Commission shall give the companies notice of the assessment which shall be paid to the Commission on or before March 1 of each year for deposit into the state treasury. Any company that fails to pay the assessment on or before the date herein prescribed shall be subject to a penalty imposed by the Commission. The penalty shall be ten percent of the assessment and interest shall be charged at a rate pursuant to § 58.1-1812 for the period between the due date and the date of full payment. If a payment is made in an amount later found to be in error, the Commission shall, (i) if an additional amount is due, notify the company of the additional amount and the company shall pay the additional amount within fourteen days of the date of the notice or, (ii) if an overpayment is made, order a refund as provided for in subsection B of § 38.2-410.

Drafting Note: The penalty rate in this section has been increased from 5% to 10% of the assessment and interest will be charged pursuant to § 58.1-1812 for consistency with § 58.1-2507.

§ 38.2-404. Recovery of such assessments; revocation or suspension of license.–If an assessment made under § 38.2-403 is not paid to the Commission by the prescribed date, the amount of the assessment, penalty, and interest may be recovered from the defaulting company on motion of the Commission made in the name and for the use of the Commonwealth in the appropriate circuit court after ten days' notice to the company. The license or certificate of authority of any defaulting company to transact business in this Commonwealth may be revoked or suspended by the Commission until it has paid such assessment.

§ 38.2-405. Appeal from assessment.– A company aggrieved by the assessment may appeal to the Supreme Court of Virginia in accordance with the Rules of Court applicable to appeals from the State Corporation Commission. If the court is of the opinion that the assessment is either excessive or insufficient, the court shall by its order request the Commission to make appropriate adjustments. If the appellant fails to pay the assessment when due and the court affirms the action of the Commission, judgment shall be entered against the appellant for damages, which are to be paid to the Commission, equal to legal interest upon the amount of the assessment from the time the assessment was payable. If relief is granted in whole or in part, judgment shall be rendered against the Commonwealth for any excess that may have been paid, with legal interest.

§ 38.2-406. Report of gross premium income and other information.–Each company subject to assessment under this chapter shall report to the Commission by March 1 of each year. The report shall be on forms furnished by the Commission and shall include the company's direct gross premium income, assessments, dues and fees for the preceding calendar year, and any other information the Commission requires.

Drafting Note: Section 38.1-48.1 was moved to proposed § 32.2-402.

§ 38.2-407. Declarations of estimated assessment.–A. Each company subject to licensure under this title that is required to make a declaration of estimated tax as provided in Article 2 (§ 58.1-2520 et seq.) of Chapter 25 of Title 58.1 shall make a declaration of estimated assessment for the assessable year as provided in this chapter. This declaration is required if the assessment imposed by this chapter can reasonably be expected to exceed $3,000.

Drafting Note: The organizations listed in the deleted language are now licensed under existing Title 38.1. An estimated assessment must be made if the amount of the assessment is expected to be more than $3,000. This change is consistent with § 58.1-2520.

–B. The declaration shall contain any pertinent information the Commission may require.

–C. A company may make amendments of a declaration filed during the assessable year, subject to the requirements of the Commission, not exceeding the number specified in subsection B of § 38.2-408.

–D. A company with an assessable year of less than twelve months shall make a declaration in accordance with the requirements of the Commission.

Drafting Note: The definition of estimated assessment was moved to § 38.2-402.

§ 38.2-408. Time for filing declarations of estimated assessment.–A. The declaration of estimated assessment required of companies by § 38.2-407 shall be filed as follows:

If the requirements of § 38.2-403 are first met:

1. Before April 1 of the assessable year, the declaration shall be filed on or before April 15 of the assessable year.

2. After March 31 but before June 1 of the assessable year, the declaration shall be filed on or before June 15 of the assessable year.

3. After May 31 but before September 1 of the assessable year, the declaration shall be filed on or before September 15 of the assessable year.

4. After August 31 but before December 1 of the assessable year, the assessment shall be filed on or before December 15 of the assessable year.

B. –An amendment of a declaration may be filed in any interval between installment dates prescribed for the assessable year, but only one amendment may be filed in each such interval.

C.– The application of this section to assessable years of less than twelve months shall be in accordance with the prescribed requirements of the Commission.

Drafting Note: The previous chart is placed in paragraph format for ease of reading and consistency with § 58.1-2521.

§ 38.2-409. Installment payment of estimated assessment.–A. - The amount of estimated assessment, as defined in subsection B of § 38.2-407 for which a declaration is required under § 38.2-407 shall be paid in instaliments as follows:

1. If the declaration is required to be filed by April 15 of the assessable year, twenty-five percent of the estimated assessment shall be paid on April, June, September and December 15 respectively of the assessable year.

2. If the declaration is required to be filed by June 15 of the assessable year, one-third of the estimated assessment shall be paid on June, September and December 15 respectively of the assessable year.

3. If the declaration is required to be filed by September 15 of the assessable year, one-half of the estimated assessment shall be paid on September and December 15 respectively of the assessable year.

4. If the declaration is required to be filed by December 15 of the assessable year, 100 percent of the estimated assessment shall be paid on the same date the declaration is filed.

Drafting Note: The former chart is placed in paragraph format for ease of reading and consistency with § 58.1-2523.

B. A declaration is timely filed if it is filed on or before the date prescribed by subsection A of § 38.2-408. The timeliness of filing shall be determined without regard to any extension of time for filing the declaration.

C. If the declaration is filed after the time prescribed in subsection A of § 38.2-408, determined without regard to any extension of time for filing the declaration, all estimated assessment installments shall be paid at the time of the filing which would have been payable on or before that time if the declaration had been filed within the prescribed time. The remaining installments shall be paid at the times and in the amounts that would have been payable if the declaration had been filed within the time prescribed.

D. If any amendment of a declaration is filed, the amount of each remaining installment shall be the amount of the last installment due subject to the following adjustment. Each installment shall be increased or decreased by the amount computed by dividing (i) the difference between the current amount of estimated assessment and the amended amount of estimated assessment by (ii) the number of installments remaining to be paid.

E. The Commission shall determine the application of this section to assessable years of less than twelve months.

F. A company may prepay any installment of the estimated assessment.

G. Payment of the estimated assessment or any installment thereof shall be considered payment on account of the assessment imposed by this chapter for the license year.

H. The Commission may grant a reasonable extension of time for (i) payment of estimated assessment, or any installment or (ii) filing any declaration pursuant to this chapter, on condition that interest shall be paid on the amount involved at the rate of three-quarters of one percent per month or fraction thereof from the time the payment was due until the time of payment. Whenever a company, without having been granted an extension, fails to make payment of the estimated assessment or any installment, or fails to file any declaration as required by this chapter, it shall pay interest on the amount involved at the rate of one percent per month or fraction thereof from the time payment was due until the time of payment.

Drafting Note: The interest rates in this subsection have been increased to three-fourths of one percent per month with an extension and one percent per month without an extension.

§ 38.2-410. Where declarations filed and how payments made; refunding overpayments.–A. As required by this chapter, each company shall file a declaration of estimated assessment with and pay the same to the Commission. All such payments shall be deposited by the Commission into the state treasury.

B. If any company overestimates and overpays the assessment, the Commission shall order a refund of the amount of the overpayment to the company. The overpayment shall be refunded out of the state treasury on the order of the Commission upon the Comptroller.

Drafting Note: The amount of time the Commission can retain an overpayment before a refund must be made has been deleted.

§ 38.2-411. Failure to pay estimated assessment.–A. In case of any underpayment of estimated assessment by a company, except as provided in subsection D of this section, interest shall be added to the assessment for the license year and shall be determined at the rate set forth in § 58.1-15. Interest shall be based on the amount of the underpayment as determined in subsection B for the period of the

underpayment as determined in subsection C.

Drafting Note: The rate of interest will be that established pursuant to § 6621 of the Internal Revenue Code, which is referred to in § 58.1-15.

B. For purposes of subsection A of this section the amount of the underpayment shall be the excess of the amount of the installment which would be required to be paid if the estimated assessment were equal to ninety percent of the assessment for the license year, over any amount of the installment paid on or before the last date prescribed for payment.

Drafting note: The percentage has been changed to 90% (consistent with § 58.1-2527).

C. The period of the underpayment shall run from the date the installment was required to be paid to whichever of the following dates is the earlier:

1. The first day of the third month following the close of the assessable year.

2. For any portion of the underpayment, the date on which the portion is paid. For purposes of this paragraph, a payment of estimated assessment on any installment date shall be considered a payment of any previous underpayment only to the extent the payment exceeds the amount of the installment determined under subsection B for that installment date.

Drafting Note: The change in Paragraph C 1 is for consistency with subsection C of § 58.1-2527. This change was made in the revision to Title 58.

D. Notwithstanding the provisions of subsections A, B and C of this section, the addition to the assessment for any underpayment of an installment shall not be charged if the total amount of all estimated assessment payments made prior to the last date prescribed for the payment meets the following conditions. The total shall equal or exceed the amount which would have been required to be paid on or before the last date prescribed for the payment if the estimated assessment were the lesser of:

1. The assessment for the preceding license year which was computed on the basis of an assessable year of twelve months; or

2. An amount equal to the assessment computed at the rate applicable to the license year based on the facts shown on the company's report, and the applicable law for the preceding license year; or

3. a. An amount equal to ninety percent of the assessment measured by direct gross premium income received or derived in the assessable year computed by placing on an annualized basis the assessable direct gross premium income:

Drafting Note: The percentage has been changed to 90% (consistent with § 58.1-2527).

(1) For the first three months of the assessable year, in the case of the installment required to be paid in the fourth month;

(2) For the first three months or for the first five months of the assessable year, in the case of the installment required to be paid in the sixth month;

(3) For the first six months or for the first eight months of the assessable year, in the case of the installment required to be paid in the ninth month; and

(4) For the first nine months or for the first eleven months of the assessable year, in the case of the installment required to be paid in the twelfth month of the assessable year.

b. For the purposes of this subsection, the assessable direct gross premium income shall be placed on an annualized basis by (i) multiplying by twelve the assessable direct gross premium income referred to in paragraph 3a of this subsection, and (ii) dividing the resulting amount by the number of months in the assessable year referred to in paragraph 3a of this section.

E. The Commission shall determine the application of this section to assessable years of less than twelve months.

§ 38.2-412. Companies going out of business.—If a company goes out of business or ceases to be a company in this Commonwealth in any assessable or license year, the company shall remain liable for the payment of the assessment measured by direct gross premium income for the period in which it operated as a company and received or derived direct gross premium income from business in this Commonwealth.

Drafting Note: Section 38.1-48.8 is being deleted because it is outdated.

§ 38.2-413. Double assessment respecting same direct gross premium income negated.—This chapter shall not be construed to require including any direct gross premium income used previously in calculating the assessment imposed by this chapter for any license year or fraction thereof, and the assessment paid thereon.

Drafting Note: Section 38.1-48.10 is being deleted because it is outdated.

Title 38.2

CHAPTER 5.

Unfair Trade Practices.

The following substantive changes have been proposed:

1. In existing § 38.1-50 (proposed § 38.2-501), amending the definitions of "person" and "insurance policy" to include health, legal, and dental and optometric service plans, health maintenance organizations and their contracts, and further amending "person" to also include premium finance companies.

2. In existing § 38.1-52.1 (proposed § 38.2-502), Misrepresentation and false advertising of insurance policies, the section is amended to place more responsibility on insurers to control material prepared by agents as follows:

   "No person shall make, issue, circulate, or cause or knowingly allow to be made, issued or circulated...".

3. In existing § 38.1-52.2 (proposed § 38.2-503), False information and advertising generally, the section is amended to place more responsibility on insurers to control material prepared by agents as follows:

   "No person shall knowingly make, publish, disseminate, circulate, or place before the public, or cause, or knowingly allow, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public...".

4. In paragraph 3 of existing § 38.1-52.7 (proposed § 38.2-508), Unfair Discrimination, reference to actual or reasonably anticipated experience has been deleted so that refusal, limitation or rate differential for insurance coverage is based only on sound actuarial principles.

5. In paragraph 4 of existing § 38.1-52.7 (proposed § 38.2-508), which prohibits unfair discrimination between individuals or risks of the same class because of the geographical location of the risk, the limitation to property and casualty risks is deleted. The prargraph has been modified to add "solely" because of the geographical location.

6. In subsection B of existing § 38.1-52.8 (proposed § 38.2-509), Rebates:

   A) Item 3 is changed to allow for considering the experience of a group and adjusting the rate for the next year, instead of requiring retroactive rate adjustments; and

   B) Item 4 is changed to allow for employees of insurers to receive premium reductions for insurance on their lives and property and the lives of their spouses and dependent children. (The present law allows life insurance company employees to receive commissions on life insurance they buy on their own lives.)

7. In existing § 38.1-52.9 (proposed § 38.2-510), Unfair claims settlement practices, a new subsection is added to provide that the section does not create a private cause of action.

8. In existing § 38.1-52.12 (proposed § 38.2-513), Favored agent or insurer; coercion of debtors:

   A) The provisions of existing § 38.1-31.3 are incorporated in item 3;

   B) A provision prohibiting unreasonably disapproving a policy provided by a debtor on his own life to protect a loan has been added; and

   C) A provision that a borrower must be told in writing that insurance related to credit extensions may be purchased from an insurer or agent of the borrower's choice has been added.

   D) A new subsection C to ensure that a written commitment to loan money or extend credit is secured prior to the solicitation of insurance has been added.

9. Subsection B of existing § 38.1-53, and §§ 38.1-54 through 38.1-57.1 have been deleted in conformance with the decision to have unified sections dealing with rules and regulations, penalties and appeals.

CHAPTER 5.

UNFAIR TRADE PRACTICES.

§ 38.2-500 Declaration of purpose.—The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the McCarran-Ferguson Act, 15 USC §§ 1011-1015, by defining and prohibiting all practices in this Commonwealth that constitute unfair methods of competition or unfair or deceptive acts or practices.

§ 38.2-501. Definitions.—As used in this chapter:

"Insurance policy" or "insurance contract" shall include annuities and any contract of a health services plan, health maintenance organization, legal organization, legal services plan, or dental or optometric services plan as provided for in Chapters 42, 43, 44 and 45 of this title issued, proposed for issuance, or intended for issuance, by any person.

"Person", in addition to the definition in Chapter 1 of this title, extends to any other legal entity transacting the business of insurance, including agents, brokers and adjusters. "Person" shall also mean health, legal, dental, and optometric service plans and health maintenance organizations, as provided for in Chapters 42, 43, 44 and 45 of this title. For the purposes of this chapter, such service plans shall be deemed to be transacting the business of insurance. "Person" shall also mean premium finance companies.

Drafting Note: The changes in the definitions of "person" and "insurance policy" are designed to update the cross references to prepaid plans and to include health, legal, dental and optometric services plans and health maintenance organizations. The definition of "person" has also been expanded to include premium finance companies.

Drafting Note: Section 38.1-51 has been deleted as being unnecessary. The NAIC Model, upon which this is based, includes the material contained in proposed §§ 38.2-502 through 38.2-514 as part of this section.

§ 38.2-502. Misrepresentations and false advertising of insurance policies.—No person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that:

1. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

2. Misrepresents the dividends or share of the surplus to be received on any insurance policy;

3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

4. Misrepresents or is misleading as to the financial condition of any person or the legal reserve system upon which any life insurer operates;

5. Uses any name or title of any insurance policy or class of insurance policies that misrepresents the true nature of the policy or policies;

6. Misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

7. Misrepresents for the purpose of effecting a pledge, assignment, or loan on any insurance policy; or

8. Misrepresents any insurance policy as being a share of stock.

Drafting Note: "Or knowingly allow" was added to place more responsibility on insurers to control material prepared by agents.

§ 38.2-503. False information and advertising generally.—No person shall knowingly make, publish, disseminate, circulate, or place before the public, or cause or knowingly allow, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement relating to (i) the business of insurance or (ii) any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

Drafting Note: "Or allow" was added to place more responsibility on insurers to control material prepared by agents.

§ 38.2-504. Defamation.—No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature that is false, and maliciously critical of, or derogatory to, any person with respect to the business of insurance or with respect to any person in the conduct of his insurance business and that is calculated to injure that person.

§ 38.2-505. Boycott, coercion and intimidation.—No person shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

§ 38.2-506. False statements and entries.–No person shall:

1. Knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate, or deliver to any person, or place before the public, or knowingly cause, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person; or

2. Knowingly make any false entry of a material fact in any book, report or statement of any person or knowingly fail to make a true entry of any material fact pertaining to the business of any person in any book, report or statement of that person.

§ 38.2-507. Stock operations and advisory board contracts.–No person shall issue or deliver or permit agents, officers, or employees to issue or deliver capital stock, benefit certificates or shares in any corporation, securities, any special or advisory board contracts or any contract promising returns and profits as an inducement to insurance.

§ 38.2-508. Unfair discrimination.–No person shall:

1. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and equal expectation of (i) life in the rates charged for any life insurance or annuity contract, (ii) or in the dividends or other benefits payable on the contract, or (iii) in any other of the terms and conditions of the contract;

2. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner;

3. Refuse to insure, refuse to continue to insure, or limit the amount, extent or kind of insurance coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness, or partial blindness, or mental or physical impairments, unless the refusal, limitation or rate differential is based on sound actuarial principles. This paragraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract;

4. Unfairly discriminate or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage solely because of the geographic location of the individual or risk, unless:

a. The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation or limitation is required by law or regulatory mandate; or

5. Make or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained in a residential property risk, solely because of the age of the residential property, unless:

a. The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation or limitation is required by law or regulatory mandate.

Drafting Notes: In paragraph 4, the reference to property or casualty risk was deleted because some life and health insurers are beginning to limit their underwriting geographically. The word "solely" has been added at the suggestion of industry so that geographic location can be one factor in a company's decision whether to issue, cancel or limit coverage.

§ 38.2-509. Rebates.–A. Except as otherwise expressly provided by law, no person shall:

1. Knowingly permit, offer, or make any insurance or annuity contract or agreement which is not plainly expressed in the contract issued;

2. Pay, allow or give, or offer to pay, allow or give, directly or indirectly, as inducement to any insurance or annuity contract, any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefits on the contract, any valuable consideration or inducement not specified in the contract, except in accordance with an applicable rating plan authorized for use in this Commonwealth;

3. Give, sell, purchase, or offer to give, sell or purchase as inducement to insurance, or annuity contracts, or in connection with such contracts, any stocks, bonds, or other securities of any company, any dividends or profits accrued on any stocks, bonds or other securities of any company, or anything of value not specified in the contract; or

4. Receive or accept as inducement to insurance, or annuity contracts, any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue on the contract,

or any valuable consideration or inducement not specified in the contract.

B. Nothing in § 38.2-508 or in this section shall be construed to include within the definition of discrimination or rebates any of the following practices:

1. In the case of any life insurance or annuity contract, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance if the bonuses or abatement of premiums are fair and equitable to policyholders and in the best interests of the insurer and its policyholders;

2. In the case of life or accident and sickness insurance polices issued on the industrial debit plan, making allowance to policyholders who, for a specified period, have continuously made premium payments directly to an office of the insurer in an amount that fairly represents the savings in collection expense;

3. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience under the policy, at the end of the first or any subsequent policy year of insurance ;

4. In the case of insurers, allowing their bona fide employees to receive a reduction on the premiums paid by them on policies or contracts on their own lives and property, and on the lives and property of their spouses and dependent children;

5. Issuing life or accident and sickness policies or annuity contracts on their own lives and property, and on the lives and property of their spouses and dependent children by way of a salary savings or payroll deduction plan at a reduced rate consistent with the savings made by the use of such plan;

6. Paying commissions or other compensation to duly licensed agents or brokers; or

7. Allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium payments.

Drafting Notes: 1. In subsection B, item 3 was changed to allow for considering the experience of a group and adjusting the rate for the next year, instead of requiring retroactive rate adjustments.

2. Item 4 was changed after discussion with the Life and Health Industry to make a premium reduction available on insurance on property as well as on lives and to extend reductions to a spouse and minor dependent children of an employee. "Commission" was changed to "reduction" because it is more accurate and only agents receive commissions.

§ 38.2-510. Unfair claim settlement practices.—A. No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

1. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

2. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

3. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

4. Refusing arbitrarily and unreasonably to pay claims;

5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

6. Not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

7. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

8. Attempting to settle claims for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

9. Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

10. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

11. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

12. Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, when both contain substantially the same information;

13. Failing to promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

14. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

B. No violation of this section shall of itself be deemed to create any cause of action in favor of any person other than the Commission; but nothing in this subsection shall impair the right of any person to seek redress at law or equity for any conduct for which action may be brought.

Drafting Note: A new subsection B was added to provide that this section does not create a private cause of action.

§ 38.2-511. Failure to maintain record of complaints.—No person other than agents or brokers, shall fail to maintain a complete record of all the complaints that it has received since the date of its last examination under § 38.2-1317 or during the last three years, whichever is the more recent time period. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.

As used in this section, "complaint" shall mean any written communication from a policyholder, subscriber or claimant primarily expressing a grievance.

Drafting Note: At the suggestion of industry, "complaint" has been changed to mean a written communication from a policyholder, subscriber or claimant.

§ 38.2-512. Misrepresentation in insurance applications.—No person shall make false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

§ 38.2-513. Favored agent or insurer; coercion of debtors.—A. No person shall:

1. Require, as a condition precedent to the extension of credit, or any subsequent renewal thereof, that the borrower purchase an insurance policy through a particular insurer, agent or broker.

2. a. Unreasonably disapprove the insurance policy provided by a borrower or debtor for the protection of the property securing the credit or lien or unreasonably disapprove the insurance policy provided by a borrower or debtor on his own life to protect the loan. A disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for disapproval of an insurance policy because the policy contains coverage in addition to those required by the creditor.

b. Every person who lends money or extends credit and who solicits insurance on real or personal property shall explain to the borrower in writing that the insurance related to such credit extensions may be purchased from an insurer or agent of the borrower's choice.

Drafting Note: This section has been changed to prohibit unreasonably disapproving a policy provided by a debtor on his own life to protect a loan.

3. Require directly or indirectly that any debtor, borrower, mortgagor, purchaser, insurer, broker, or agent (i) pay a separate charge or consideration of any kind in connection with the handling of any insurance policy required as security for a loan or real estate, or (ii) pay a separate charge or consideration of any kind for substituting the insurance policy of one insurer for that of another. However, this does not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument.

4. Use or disclose information including, but not limited to, policy information and policy expiration dates on policies insuring any kind of real property being conveyed or used as collateral security to a loan and required by a borrower, mortgagor or purchaser (i) when such information is to the advantage of the mortgagee, vendor, or lender, or any subsidiary of the mortgagee, vendor, or lender, or (ii) when the information is to the detriment of the borrower, mortgagor, purchaser, insurer, agent or broker complying with this requirement, except as required by local, state or federal law or regulation.

B. The Commission may investigate the affairs of any person to whom this section applies to determine whether that person has violated this section. If a violation of this section is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of this chapter.

C. No person who lends money or extends credit shall solicit insurance on real or personal property, after a person indicates interest in securing a first mortgage credit extension, until the person has received a commitment in writing from the lender as to a loan or credit extension.

Drafting Note: In subsection A, item 3 incorporates the provisions of existing § 38.1-31.3.

A new subsection C was added at the request of the AIA to ensure that a written commitment to loan money or extend credit is secured prior to the solicitation of insurance for real or personal property.

The previously existing subsection C was deleted because of the proposed broader definitions of "person" in Chapter 1 and in this chapter (§ 38.2-501).

§ 38.2-514. Failure to make disclosure.--No person shall solicit or effect the sale of an annuity, a life insurance policy or an accident and sickness insurance policy without furnishing the disclosure information required by any rules and regulations of the Commission.

Drafting Note: As a result of the decision to have a unified rules and regulations section, the phrase "is hereby authorized to prescribe by rule or regulation" was deleted and the section now requires furnishing the disclosure information required by the Commission.

§ 38.2-515. Power of Commission.– The Commission shall have power to examine and investigate the affairs of each person subject to this chapter to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by §§ 38.2-502 through 38.2-514.

Drafting Note: Subsection B of existing § 38.1-53 and existing §§ 38.1-54, 38.1-55, 38.1-56, 38.1-56.1, 38.1-57 and 38.1-57.1 were deleted as a result of the decision to have unified sections dealing with rules and regulations, hearings, cease and desist orders, penalties and appeals.

Title 38.2

CHAPTER 6.

Insurance Information and Privacy Protection.

The following changes have been proposed for this article:

1. In subsection A of existing § 38.1-57.4 (proposed § 38.2-601), the reference to January 1, 1982, has been deleted to clarify that the access and correction provisions of proposed §§38.2-608 and 38.2-609, and the disclosure provisions of proposed §38.2-613, apply to information collected before January 1, 1982.

2. In existing § 38.1-57.5 (proposed § 38.2-602), the scope of adverse underwriting decisions is expanded for life and accident and sickness insurance coverages.

3. A new paragraph 18 has been added to existing § 38.1-57.16 (proposed § 38.2-613), to provide disclosure of necessary personal information about an individual collected in connection with an insurance transaction to a lienholder, mortgagee, assignee, lessor or other person having a legal or beneficial interest in the insurance policy.

CHAPTER 6.

INSURANCE INFORMATION AND PRIVACY PROTECTION.

Drafting Notes: Short title sections are being deleted throughout the insurance title.

§ 38.2-600. Purposes.—The purposes of this chapter are to: 1. Establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance-support organizations; 2. Maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; 3. Establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; 4. Limit the disclosure of information collected in connection with insurance transactions; and 5. Enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

§ 38.2-601. Application of chapter.—A. The obligations imposed by this chapter shall apply to those insurance institutions, agents or insurance-support organizations that:

Drafting Note: The reference to January 1, 1982, has been deleted to clarify that the access and correction provisions of §§ 38.2-608 and 38.2-609, and the disclosure provisions of § 38.2-613 apply to information collected before January 1, 1982.

1. In the case of life or accident and sickness insurance:

a. Collect, receive or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this Commonwealth; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this Commonwealth; and

2. In the case of property or casualty insurance:

a. Collect, receive or maintain information in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this Commonwealth; or

b. Engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this Commonwealth.

B. The rights granted by this chapter shall extend to:

1. In the case of life or accident and sickness insurance, the following persons who are residents of this Commonwealth:

a. Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions; and

b. Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions; and

2. In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this Commonwealth; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this Commonwealth.

C. For purposes of this section, a person shall be considered a resident of this Commonwealth if the person's last known mailing address, as shown in the records of the insurance institution, agent or insurance-support organization, is located in this Commonwealth.

D. Notwithstanding subsections A and B of this section, this chapter shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this Commonwealth.

§ 38.2-602. Definitions.—As used in this chapter:

"Adverse underwriting decision" means:

1. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

a. A declination of insurance coverage;

b. A termination of insurance coverage;

c. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

d. In the case of a property or casualty insurance coverage:

(1) placement by an insurance institution or agent of a risk with a residual market mechanism or an unlicensed insurer, or

(2) the charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or

e. In the case of a life or accident and sickness insurance coverage, an offer to insure at higher than standard rates, or with limitations, exceptions or benefits other than those applied for.

Drafting Note: The above change broadens the scope of adverse underwriting decisions for life and accident and sickness insurance coverages.

2. Notwithstanding paragraph 1 of this definition, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall provide the applicant or policyholder with the specific reason or reasons for their occurrence:

a. The termination of an individual policy form on a class or statewide basis;

b. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis;

c. The rescission of a policy.

"Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

"Agent" shall have the meaning as set forth in § 38.2-1800 and shall include surplus lines brokers.

Drafting Note: Proposed § 38.2-1800 now includes definitions for agents of health, dental and optometric service plans, and health maintenance organizations.

"Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

"Consumer report" means any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living that is used or expected to be used in connection with an insurance transaction.

"Consumer reporting agency" means any person who:

1. Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

2. Obtains information primarily from sources other than insurance institutions; and

3. Furnishes consumer reports to other persons.

"Control," including the terms "controlled by" or "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

"Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

"Individual" means any natural person who:

1. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificateholder;

2. In the case of life or accident and sickness insurance, is a past, present, or proposed principal insured or certificate holder;

3. Is a past, present or proposed policyowner;

4. Is a past or present applicant;

5. Is a past or present claimant; or

6. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this chapter.

"Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution or insurance-support organization, other than:

1. An agent;

2. The individual who is the subject of the information; or

3. A natural person acting in a personal capacity rather than in a business or professional capacity.

"Insurance institution" means any corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's type of organization, fraternal benefit society, or other person engaged in the business of insurance, including health maintenance organizations, and health, legal, dental, and optometric service plans. "Insurance institution" shall not include agents or insurance-support organizations.

Drafting Note: Since Chapter 44, § 38.2-4408, states that the Privacy Act is applicable to legal services plans and Chapter 42, § 38.2-4212, states that the Privacy Act is applicable to health services plans, appropriate references have been added to improve clarity.

"Insurance-support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including (i) the furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction or (ii) the collection of personal information from insurance institutions, agents or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity. However, the following persons shall not be considered "insurance-support organizations" for purposes of this chapter: agents, governmental institutions, insurance institutions, medical-care institutions and medical professionals.

"Insurance transaction" means any transaction involving insurance primarily for personal, family, or household needs rather than business or professional needs that entails:

1. The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

2. The servicing of an insurance application, policy, contract, or certificate.

"Investigative consumer report" means a consumer report or a portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information.

"Life insurance" includes annuities.

"Medical-care institution" means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to, hospitals, skilled nursing facilities, home-health agencies, medical clinics, rehabilitation agencies, and public-health agencies or health-maintenance organizations.

"Medical professional" means any person licensed or certified to provide health care services to natural persons, including but not limited to, a physician, dentist, nurse, chiropractor, optometrist, physical or occupational therapist, psychiatric social worker, clinical dietitian, clinical psychologist, pharmacist, or speech therapist.

"Medical-record information" means personal information that:

1. Relates to an individual's physical or mental condition, medical history, or medical treatment; and

2. Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

"Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include privileged information.

"Policyholder" means any person who:

1. In the case of individual property or casualty insurance, is a present named insured;

2. In the case of individual life or accident and sickness insurance, is a present policyowner; or

3. In the case of group insurance that is individually underwritten, is a present group certificateholder.

"Pretext interview" means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

1. Pretends to be someone he or she is not;

2. Pretends to represent a person he or she is not in fact representing;

3. Misrepresents the true purpose of the interview; or

4. Refuses to identify himself or herself upon request.

"Privileged information" means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual. However, information otherwise meeting the requirements of this subsection shall nevertheless be considered personal information under this chapter if it is disclosed in violation of § 38.2-613 of this chapter.

"Residual market mechanism" means an association, organization, or other entity defined, described, or provided for in the Virginia Automobile Insurance Plan as set forth in § 38.2-2015, or in the Virginia Property Insurance Association as set forth in Chapter 27 of this title.

"Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy other than by the policyholder's request, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

Unlicensed insurer" means an insurance institution that has not been granted a license by the Commission to transact the business of insurance in Virginia.

§ 38.2-603. Pretext interviews.—No insurance institution, agent, or insurance-support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction. However, a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily recognized privileged relationship with the person about whom the information relates for the purpose of investigating a claim where, based upon specific information available for review by the Commission, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with the claim.

§ 38.2-604. Notice of insurance information practices.—A. An insurance institution or agent shall provide a notice of insurance information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:

1. In the case of an application for insurance a notice shall be provided no later than:

a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records, or

b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records;

2. In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:

a. Personal information is collected only from the policyholder or from public records, or

b. A notice meeting the requirements of this section has been given within the previous twenty-four months; or

3. In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.

B. The notice required by subsection A of this section shall be in writing and shall state:

1. Whether personal information may be collected from persons other than an individual proposed for coverage;

2. The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;

3. The types of disclosures identified in paragraphs 2, 3, 4, 5, 6, 9, 11, 12, and 14 of § 38.2-613 and the circumstances under which such disclosures may be made without prior authorization. However, only those circumstances need be described that occur with such frequency as to indicate a general business practice;

4. A description of the rights established under §§ 38.2-608 and 38.2-609 and the manner in which those rights may be exercised; and

5. That information obtained from a report prepared by an insurance-support organizaton may be retained by the insurance-support organization and disclosed to other persons.

C. Instead of the notice prescribed in subsection B of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

1. Personal information may be collected from persons other than an individual proposed for coverage;

2. The information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;

3. A right of access and correction exists with respect to all personal information collected; and

4. The notice prescribed in subsection B of this section will be furnished to the applicant or policyholder upon request.

D. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

§ 38.2-605. Marketing and research surveys. --An insurance institution or agent shall clearly specify those questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction.

§ 38.2-606. Content of disclosure authorization forms.--Notwithstanding any other provision of law of this Commonwealth, no insurance institution, agent, or insurance-support organization shall utilize as its disclosure authorization form in connection with insurance transactions involving insurance policies or contracts issued after January 1, 1982, a form or statement that authorizes the disclosure of personal or privileged information about an individual to the insurance institution, agent, or insurance-support organization unless the form or statement:

1. Is written in plain language;

2. Is dated;

3. Specifies the types of persons authorized to disclose information about the individual;

4. Specifies the nature of the information authorized to be disclosed;

5. Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed;

6. Specifies the purposes for which the information is collected;

7. Specifies the length of time such authorization shall remain valid, which shall be no longer than:

a. In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits:

(1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; or

(2) One year from the date the authorization is signed if the application or request involves property or casualty insurance;

b. In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:

(1) The term of coverage of the policy if the claim is for an accident and sickness insurance benefit; or

(2) The duration of the claim if the claim is not for an accident and sickness insurance benefit; and

8. Advises the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

§ 38.2-607. Investigative consumer reports.--A. No insurance institution, agent, or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the insurance institution or agent informs the individual:

1. That he may request to be interviewed in connection with the preparation of the investigative consumer report; and

2. That upon a request pursuant to § 38.2-608, he is entitled to receive a copy of the investigative

consumer report.

B. If an investigative consumer report is to be prepared by an insurance institution or agent, the insurance institution or agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

C. If an investigative consumer report is to be prepared by an insurance-support organization, the insurance institution or agent desiring the report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such interviews, if requested.

§ 38.2-608. Access to recorded personal information.--A. If any individual, after proper identification, submits a written request to an insurance institution, agent, or insurance-support organization for access to recorded personal information about the individual that is reasonably described by the individual and reasonably able to be located and retrieved by the insurance institution, agent, or insurance-support organization, the insurance institution, agent, or insurance-support organization shall within thirty business days from the date the request is received:

1. Inform the individual of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication, whichever the insurance institution, agent, or insurance-support organization prefers;

2. Permit the individual to see and copy, in person, the recorded personal information pertaining to him or to obtain a copy of the recorded personal information by mail, whichever the individual prefers, unless the recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

3. Disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, agent, or insurance-support organization has disclosed the personal information within two years prior to such request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; and

4. Provide the individual with a summary of the procedures by which he may request correction, amendment, or deletion of recorded personal information.

B. Any personal information provided pursuant to subsection A of this section shall identify the source of the information if it is an institutional source.

C. Medical-record information supplied by a medical-care institution or medical professional and requested under subsection A of this section, together with the identity of the medical professional or medical care institution that provided the information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution, agent or insurance-support organization prefers. If it elects to disclose the information to a medical professional designated by the individual, the insurance institution, agent or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

D. Except for personal information provided under § 38.2-610, an insurance institution, agent, or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

E. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection A of this section, an insurance institution, agent, or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

F. The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

G. For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency."

§ 38.2-609. Correction, amendment, or deletion of recorded personal information.--A. Within thirty business days from the date of receipt of a written request from an individual to correct, amend, or delete any recorded personal information about the individual within its possession, an insurance institution, agent, or insurance-support organization shall either:

1. Correct, amend, or delete the portion of the recorded personal information in dispute; or

2. Notify the individual of:

a. Its refusal to make the correction, amendment, or deletion;

b. The reasons for the refusal; and

c. The individual's right to file a statement as provided in subsection C of this section.

B. If the insurance institution, agent, or insurance-support organization corrects, amends, or deletes recorded personal information in accordance with paragraph 1 of subsection A of this section, the insurance institution, agent, or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment, or fact of deletion to:

1. Any person specifically designated by the individual who, within the preceding two years, may have received the recorded personal information;

2. Any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received the recorded personal information from the insurance institution within the preceding seven years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and

3. Any insurance-support organization that furnished the personal information that has been corrected, amended, or deleted.

C. Whenever an individual disagrees with an insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information, the individual shall be permitted to file with the insurance institution, agent, or insurance-support organization:

1. A concise statement setting forth what the individual thinks is the correct, relevant, or fair information; and

2. A concise statement of the reasons why the individual disagrees with the insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information.

D. In the event an individual files either statement as described in subsection C of this section, the insurance institution, agent, or support organization shall:

1. File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it; and

2. In any subsequent disclosure by the insurance institution, agent, or support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the individual's statement along with the recorded personal information being disclosed; and

3. Furnish the statement to the persons and in the manner specified in subsection B of this section.

E. The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

F. For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency."

§ 38.2-610. Notice of adverse underwriting decision; furnishing reasons for decisions and sources of information.–A. In the event of an adverse underwriting decision, including those that involve policies referred to in paragraph 1 of subsection E of § 38.2-2114 and in paragraph 3 of subsection F of § 38.2-2212, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission that:

Drafting Note: For consistency "commissioner of insurance" was changed to "Commission."

1. Either provides the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing; and

2. Provides the applicant, policyholder, or individual proposed for coverage with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609.

B. Upon receipt of a written request within ninety business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within twenty-one business days from the date of receipt of the written request:

1. The specific reason or reasons for the adverse underwriting decision, in writing, if that information was not initially furnished in writing pursuant to paragraph 1 of subsection A of this section;

2. The specific items of personal and privileged information that support those reasons; however:

a. The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the Commission, that the applicant, policyholder, or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure, and

b. Specific items of medical-record information supplied by a medical-care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or agent prefers; and

3. The names and addresses of the institutional sources that supplied the specific items of information given pursuant to paragraph 2 of subsection B of this section. However, the identity of any medical professional or medical-care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or agent prefers.

C. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. However, the insurance institution or agent making an adverse underwriting decision shall remain responsible for compliance with the obligations imposed by this section.

D. When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection A of this section may be given orally.

§ 38.2-611. Information concerning previous adverse underwriting decisions.--No insurance institution, agent, or insurance-support organization may seek information in connection with an insurance transaction concerning: (i) any previous adverse underwriting decision experienced by an individual, or (ii) any previous insurance coverage obtained by an individual through a residual market mechanism, unless the inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

§ 38.2-612. Bases for adverse underwriting decisions.--No insurance institution or agent may base an adverse underwriting decision in whole or in part:

1. On the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism. However, an insurance institution or agent may base an adverse underwriting decision on further information obtained from an insurance institution or agent responsible for a previous adverse underwriting decision;

2. On personal information received from an insurance-support organization whose primary source of information is insurance institutions. However, an insurance institution or agent may base an adverse underwriting decision on further personal information obtained as the result of information received from an insurance-support organization.

§ 38.2-613. Disclosure limitations and conditions.--An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

1. With the written authorization of the individual, provided:

a. If the authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of § 38.2-606; or

b. If the authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

(1) Dated,

(2) Signed by the individual, and

(3) Obtained one year or less prior to the date a disclosure is sought pursuant to this paragraph; or

2. To a person other than an insurance institution, agent, or insurance-support organization, provided the disclosure is reasonably necessary:

a. To enable that person to perform a business, professional or insurance function for the disclosing insurance institution, agent, or insurance-support organization and that person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(1) Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(2) Is reasonably necessary for that person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

b. To enable that person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

(1) Determining an individual's eligibility for an insurance benefit or payment; or

(2) Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or

3. To an insurance institution, agent, insurance-support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

a. To detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or

b. For either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

4. To a medical-care institution or medical professional for the purpose of (i) verifying insurance coverage or benefits, (ii) informing an individual of a medical problem of which the individual may not be aware or (iii) conducting an operations or services audit, provided only that information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

5. To an insurance regulatory authority; or

6. To a law-enforcement or other government authority:

a. To protect the interests of the insurance institution, agent or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

b. If the insurance institution, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

7. Otherwise permitted or required by law; or

8. In response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

9. Made for the purpose of conducting actuarial or research studies, provided:

a. No individual may be identified in any actuarial or research report, and

b. Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed, and

C. The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

10. To a party or a representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurance institution, agent, or insurance-support organization, provided:

a. Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation, and

b. The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization; or

11. To a person whose only use of such information will be in connection with the marketing of a product or service, provided:

a. No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from the information is disclosed,

b. The individual has been given an opportunity to indicate that he does not want personal information disclosed for marketing purposes and has given no indication that he does not want the information disclosed, and

c. The person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

12. To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; or

13. By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent; or

14. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

15. To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

16. To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

17. To a certificateholder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

18. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance, provided that:

a. No medical record information is disclosed unless the disclosure would be permitted by this section; and

b. The information disclosed is limited to that which is reasonably necessary to permit such person to protect his interest in the policy.

Drafting Note: Paragraph 18 was added at the request of the AIA to provide disclosure of necessary personal information about an individual collected in connection with an insurance transaction to the lienholder, mortgagee, assignee, lessor or other person having a legal or beneficial interest in the insurance policy.

§ 38.2-614. Powers of Commission.—A. The Commission shall have the power to examine and investigate the affairs of any insurance institution or agent doing business in this Commonwealth to determine whether the insurance institution or agent has been or is engaged in any conduct in violation of this chapter.

B. The Commission shall have the power to examine and investigate the affairs of any insurance-support organization that acts on behalf of an insurance institution or agent and that either (i) transacts business in this Commonwealth, or (ii) transacts business outside this Commonwealth and has an effect on a person residing in this Commonwealth, in order to determine whether the insurance-support organization has been or is engaged in any conduct in violation of this chapter.

Drafting Note: Subsection C has been deleted because of the decision to have a unified regulations section.

§ 38.2-615. Hearings and procedures.—A. Whenever the Commission has reason to believe that an insurance institution, agent or insurance-support organization has been or is engaged in conduct in this Commonwealth that violates this chapter, or whenever the Commission has reason to believe that an insurance-support organization has been or is engaged in conduct outside this Commonwealth that has an effect on a person residing in this Commonwealth and that violates this chapter, the Commission may issue and serve upon the insurance institution, agent, or insurance-support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be at least ten days after the date of service.

B. At the time and place fixed for the hearing , the insurance institution, agent, or insurance-support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the Commission shall permit any adversely affected person to intervene, appear, and be heard at the hearing by counsel or in person.

C. In all matters in connection with such investigation, charge, or hearing the Commission shall have the jurisdiction, power and authority granted or conferred upon it by Title 12.1.

§ 38.2-616. Service of process on insurance-support organizations.—For the purpose of this chapter, an insurance-support organization transacting business outside this Commonwealth that has an effect on a person residing in this Commonwealth and which is alleged to violate this chapter shall be deemed to have appointed the clerk of the Commission to accept service of process on its behalf. The clerk of the Commission shall cause a copy of the service to be mailed promptly by registered mail to the insurance-support organization at its last known principal place of business. The clerk of the Commission shall file an affidavit of compliance with the requirements of this section with the other papers in the proceeding giving rise to the service.

Drafting Note: This section has been deleted because of the decision to have a unified section on cease and desist orders.

Drafting Note: This section has been deleted because of the decision to have a unified penalties section.

Drafting Note: This section has been deleted because of the decision to have a unified appeals section.

§ 38.2-617. Individual remedies.—A. If any insurance institution, agent, or insurance-support organization fails to comply with §§ 38.2-608, 38.2-609, or 38.2-610, any person whose rights granted under those sections are violated may apply to a court of competent jurisdiction for appropriate equitable relief.

B. An insurance institution, agent, or insurance-support organization that discloses information in violation of § 38.2-613 shall be liable for damages sustained by the individual to whom the information relates. No individual, however, shall be entitled to a monetary award that exceeds the actual damages sustained by the individual as a result of a violation of § 38.2-613.

C. In any action brought pursuant to this section, the court may award the cost of the action and reasonable attorney's fees to the prevailing party.

D. An action under this section must be brought within two years from the date the alleged violation is or should have been discovered.

E. Except as specifically provided in this section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of this chapter.

§ 38.2-618. Immunity of persons disclosing information.—No cause of action in the nature of defamation, invasion of privacy, or negligence shall arise against any person for disclosing personal or privileged information in accordance with this chapter, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent, or insurance-support organization. However, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

§ 38.2-619. Obtaining information under false pretenses.—Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent or insurance-support organization under false pretenses shall be fined not more than $10,000 or punished by confinement in jail for not more than twelve months, or both.

Drafting Note: This section contained a severability clause. There will be a severability clause for the entire title.

§ 38.2-620. Effective date.—

The rights granted under §§ 38.2-608, 38.2-609 and 38.2-613 of this chapter shall take effect on January 1, 1982, regardless of the date of the collection or receipt of the information that is the subject of those sections.

Title 38.2

CHAPTER 7.

Antitrust Provisions.

At the recommendation of the Code Commission, antitrust violations will be subject to the penalty provisions of Virginia Antitrust Act.

CHAPTER 7.

ANTITRUST PROVISIONS.

§ 38.2-700. When domestic insurer may hold stock of another insurer.– Subject to Article 6 (§ 38.2-1335 et seq.) of Chapter 13 and Chapter 14 of this title, any domestic insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer, unless the effect of such action (i) substantially lessens competition generally or (ii) tends to create a monopoly, in the business of insurance.

§ 38.2-701. When director of a domestic insurer may be a director of another insurer.–Any domestic insurer may have a director who is also a director of another domestic, foreign or alien insurer, unless the effect thereof (i) substantially lessens competition generally or (ii) tends to create a monopoly, in the business of insurance.

§ 38.2-702. Violations; procedure; cease and desist orders.–If the Commission has reason to believe that there is a violation of either § 38.2-700 or § 38.2-701, it shall issue and serve upon the insurer or the director concerned a statement of the charges and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than thirty days after notice is served. The notice shall require the insurer or director to show cause why an order should not be issued directing the alleged offender to cease and desist from the violation. At such hearing, the insurer or director shall have an opportunity to be heard and to show cause why an order should not be issued requiring the insurer or director to cease and desist from the violation. In all matters in connection with such charges or hearing, the Commission shall have the jurisdiction, power, and authority granted or conferred upon it by Title 12.1, and, except as otherwise provided in this chapter, the procedure shall conform to and the right of appeal shall be the same as that provided in that title.

§ 38.2-703. Cease and desist orders may be entered.–If, after a hearing, the Commission finds that there has been a violation of § 38.2-700 or § 38.2-701, it may issue an order reciting its findings and directing the insurer or director to cease and desist from the violation.

§ 38.2-704. Penalties.–A. Any person who violates a cease and desist order entered under § 38.2-703 shall be subject to the provisions of § 38.2-218.

B. Any person convicted of violating this chapter may, in addition, be punished under the provisions of Chapter 1.1 (§ 59.1-9.1 et seq.) of Title 59.1.

Drafting Note: At the recommendation of the Code Commission, antitrust violations will be subject to the penalty provisions of the Virginia Antitrust Act.

§ 38.2-705. Antitrust omnibus provision.- A. Nothing in this title is intended to prevent application of federal antitrust laws to any conduct subject to regulation, review or examination by the Commission, unless such conduct constitutes the business of insurance.

B. Notwithstanding the provisions of subsection (b) of § 59.1-9.4 conduct subject to regulation, review or examination pursuant to this title shall, in addition, be subject to the provisions of the Virginia Antitrust Act (§§ 59.1-9.1 et seq.).

Drafting Note: The purpose of this statute is to afford concurrent jurisdiction over competition-related matters to the Commission and to federal and state antitrust law enforcement authorities. It will also insure the existence of private rights of action. The reference to the business of insurance in subsection A is intended to preserve the exemption afforded by the McCarran-Ferguson Act.

Title 38.2

CHAPTER 8.

Service of Process.

The following major changes have been proposed for these articles:

1. In Article 1, a new section, proposed § 38.2-800, Definition, was added so that "insurer" could be defined to include prepaid legal, dental and optometric service plans, health services plans and health maintenance organizations in the event that an unlicensed service plan is operating in Virginia and service of process is required.

2. The minimum attorney fee specified in existing § 38.1-70 (proposed § 38.2-807), has been raised to $100 from $25 to conform with existing practice.

3. In Article 2, a new section, proposed § 38.2-808, Definition, was added so that "agent" could be defined to include agents for prepaid legal, dental and optometric service plans, and health agents.

CHAPTER 8.

SERVICE OF PROCESS.

Article 1.

Unlicensed Insurers Process.

§ 38.2-800. Definition.--For the purposes of this article, "insurer" includes health services plans, health maintenance organizations, legal services plans, and dental or optometric services plans as respectively provided for in Chapters 42, 43, 44 and 45 of this title.

Drafting Note: Service plans have been added in the event an unlicensed plan is operating in Virginia and service of process is required.

§ 38.2-801. What constitutes appointment of agent for service of process.--A. The clerk of the Commission shall be deemed to be appointed by any insurer unlicensed in this Commonwealth as its agent for the service of process in accordance with § 13.1-758 if any of the following acts are effected by mail or otherwise in this Commonwealth:

1. The issuance or delivery of insurance contracts to residents of this Commonwealth or to corporations authorized to do business in this Commonwealth;

2. The solicitation of applications for these insurance contracts;

The collection of premiums, membership fees, assessments or other considerations for these insurance contracts; or

4. The transaction of any other insurance business in connection with these insurance contracts.

§ 38.2-802. How process served.--Service of process or notice upon any unlicensed insurer in any suit, action or proceeding arising out of or in connection with the acts listed in § 38.2-801 in this Commonwealth shall be made in the manner prescribed in § 13.1-758.

Drafting Note: For clarity, "such business" has been changed to a more specific reference, "the acts listed in § 38.2-801."

§ 38.2-803. Alternate method of service.--A. Service of process or notice in any action, suit or proceeding shall be valid if:

1. Served upon any person within this Commonwealth who, in this Commonwealth on behalf of the unlicensed insurer, is (i) soliciting insurance, (ii) making, issuing, or delivering any insurance contract, or (iii) collecting or receiving any premium, membership fee, assessment or other consideration for insurance; and

2. A copy of the process or notice is sent within ten days thereafter by registered mail to the unlicensed insurer at its last known principal place of business.

B. A post office receipt showing the sender's name, and the unlicensed insurer's name and address, and the plaintiff's or plaintiff's attorney's affidavit of compliance with the procedures set out in subsection A of this section shall be filed with the clerk of the court in which the proceeding is pending on or before the date the unlicensed insurer is required to appear, or within such further time as the court allows.

§ 38.2-804. Other legal service not limited.--Nothing in this article shall limit the right to serve any process or notice upon any licensed insurer in any other manner permitted by law.

Drafting Note: "Chapter" has been changed to "article" as service of process for insurers is dealt with exclusively in this article. Article 2 of this chapter deals exclusively with service of process for agents and brokers.

§ 38.2-805. When judgment may be entered. - No judgment based on default of appearance shall be entered against any defendant served pursuant to § 38.2-803 until the expiration of thirty days from the date that the affidavit of compliance is filed.

§ 38.2-806. Defense of action by unlicensed insurer.--A. Before any unlicensed insurer files or causes to be filed any pleading in any action, suit or proceeding instituted against it, that insurer shall either :

1. Deposit cash or securities with the clerk of the court in which the action, suit or proceeding is pending, or file with the clerk a bond in an amount to be fixed by the court which shall be sufficient to secure the payment of any final judgment ; or

2. Procure a certificate of authority and a license to transact the business of insurance in this Commonwealth.

B. The court may order a postponement in any action, suit or proceeding in which service is made in the manner provided in § 38.2-802 or § 38.2-803 to afford the unlicensed insurer reasonable opportunity to

comply with the provisions of subsection A of this section and to defend the action.

C. Nothing in subsection A of this section shall be construed to prevent any unlicensed insurer from appearing specially in the suit or other proceeding in which service was made in the manner provided in this article on the ground either that (i) the insurer has not done any of the acts listed in § 38.2-801, or (ii) the person on whom service was made pursuant to § 38.2-803 was not doing any of the acts listed in § 38.2-803.

§ 38.2-807. Attorney fees.–A. In any action against an unlicensed insurer upon an insurance contract issued or delivered in this Commonwealth to a resident of this Commonwealth or to a corporation authorized to do business in this Commonwealth, the court may allow the plaintiff a reasonable attorney fee if (i) the insurer has failed to make payment in accordance with the terms of the contract for thirty days after demand prior to the commencement of the action and (ii) the court concludes that the refusal was vexatious and without reasonable cause. The fee shall not exceed twelve and one-half percent of the amount that the court or jury finds the plaintiff is entitled to recover against the insurer, but shall be at least $100.

B. Failure of the insurer to defend the action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

Drafting Note: The minimum attorney's fee has been increased from $25 to $100 to conform with existing practice.

Article 2.

Unlicensed Nonresident Brokers and Agents Process.

§ 38.2-808. Definition.–For the purposes of this article, "agent" shall have the meaning as set forth in § 38.2-1800 which shall include a legal services agent, a health agent and a dental or optometric services agent.

Drafting Note: Proposed § 38.2-1800 is existing § 38.1-327.1.

§ 38.2-809. What constitutes appointment of agent for service of process.–The clerk of the Commission shall be deemed to be appointed by any unlicensed nonresident broker or agent as its agent for the service of process pursuant to § 13.1-758 if any of the following acts are effected by mail or otherwise in this Commonwealth by such unlicensed nonresident broker or agent: (i) the issuance or delivery of insurance contracts to residents of this Commonwealth or to corporations authorized to do business in this Commonwealth, (ii) the solicitation of applications for such contracts, (iii) the collection of premiums, membership fees, assessments or other considerations for such contracts, or (iv) the transaction of any other insurance business in connection with such contracts.

§ 38.2-810. How process or notice served. –Service of process or notice upon any unlicensed nonresident broker or agent in any suit, action or proceeding arising out of or in connection with the acts enumerated in § 38.2-809 in this Commonwealth shall be made in the manner prescribed in § 13.1-758.

Drafting Note: For clarity, "such business" has been changed to the more specific reference of "the acts enumerated in § 38.2-809."

§ 38.2-811. Other legal service not limited.–Nothing in this article shall limit the right to serve any process or notice upon any unlicensed nonresident broker or agent in any other manner permitted by law.

Title 38.2

CHAPTER 9.

Transition Provisions.

1. The transition provisions are based on those used in the last Insurance Code revision. The dates have been changed throughout this chapter where appropriate.

2. In existing § 38.1-43.1 (proposed § 38.2-900), "workmen's" has been changed to "workers'" for compliance with Senate Bill 353 enacted by the 1983 General Assembly.

3. In existing § 38.1-43.3 (proposed § 38.2-902), the reference to underwriters' agencies has been deleted because there are no longer any of them. There is no longer a provision for nonresident brokers (only for nonresident agents), so the reference to them has been deleted. Surplus Lines brokers are licensed separately, so a reference to them has been added. No attempt has been made to make this a comprehensive list since the catchall "or other person" is used and person is defined very broadly in § 38.2-100.

4. In existing § 38.1-43.4 (proposed § 38.2-903), insurers will be given twelve months to use up their inventory of old forms before they will be required to begin using new forms that comply with this new title.

5. Existing § 38.1-43.6, Invalidity of title voids repeat of Title 38, was deleted at the recommendationof the Code Commission.

CHAPTER 9.

TRANSITION PROVISIONS.

Drafting Note: The transition provisions are based on those used in the last Insurance Code revision. The Code Commission may want to change these provisions to reflect more recent Code revision approaches. The dates have been changed throughout this chapter where appropriate.

§ 38.2-900. Workers' compensation.—All acts and parts of acts inconsistent with the provisions of this title are hereby repealed to the extent of the inconsistency. However, the provisions of this title shall not amend or repeal any provisions of Title 65.1 relating to workers; compensation.

Drafting Note: The change to workers' compensation is for compliance with Senate Bill 353 enacted by the 1983 General Assembly.

§ 38.2-901. References to former sections of Title 38 or Title 38.1.—Wherever any of the conditions, requirements, provisions or contents of any section of Title 38 as such title existed prior to July 1, 1952, or Title 38.1, as that title existed before July 1, 1986, are transferred to a new or different section, and wherever any such old section is given a new section number in this title, all references to the former section of Title 38 or Title 38.1 appearing elsewhere in this Code than in this title shall be construed to apply to the new or renumbered section containing the conditions, requirements, provisions or contents.

§ 38.2-902. Existing licenses.— Each license of an insurer, agent, surplus lines broker, or other person, issued and in force immediately before July 1, 1986, shall continue in force until its date of expiration or until terminated as provided in this title.

Drafting Note: There are no longer any underwriters' agencies in Virginia, so reference to them has been deleted. There is no longer a provision for nonresident brokers (only for nonresident agents), so that reference to them has been deleted. Surplus lines brokers are licensed separately, so that reference to them has been added. No attempt has been made to make this a comprehensive list since the catchall "or other person" is used and person is defined very broadly in § 38.2-100.

§ 38.2-903. Existing form of policy, contract, certificate, application, rider or endorsement.— If any form does not comply with the provisions of this title but did comply with the provisions of any regulation or statute repealed by chapter [ ] of the Acts of 1986, it may continue to be used for a period of twelve months following July 1, 1986, unless the Commission prescribes otherwise pursuant to authority conferred by law.

Drafting Note: Insurers will be given twelve months to use up their inventory of old forms before they will be required to begin using new forms that comply with this new title.

§ 38.2-904. Existing rates - Every rate filed and presently in effect is continued and made effective until new rates are filed and become effective in accordance with the provisions of this title.

Drafting Note: The specific language dealing with rates subject to Chapter 6.2 was added when that chapter was added and is unnecessary for this transition.

Drafting Note: Existing § 38.1-43.6 was deleted at the recommendation of the Code Commission.

Title 38.2

CHAPTER 10.

Organization, Admission and Licensing of Insurers.

1. The requirement in existing §§38.1-72 and 38.1-74 that the §38.1-108 deposit be made before a charter is granted has been deleted. Section 38.1-108 (proposed § 38.2-1045) itself will still require the deposit before a license is issued.

2. In proposed § 38.2-1002 the requirement that the name of a domestic mutual insurer contain the word "mutual" is being deleted. Also, the requirement that the name not be confusingly similar to the name of any other company doing business in Virginia is being deleted because Title 13.1 contains similar provisions that apply to domestic mutual insurers.

3. A provision has been added to proposed §38.2-1005 allowing a mutual insurer to convert to a stock insurer without having the minimum capital and surplus at conversion time if the Commission finds the insurer will be able to have it within a reasonable time.

4. Existing Article 7 of Chapter 9 providing for conversion of a stock life insurer to a mutual life insurer has been moved to proposed Chapter 10 as Article 2.

5. Existing Chapter 30, redomestication of insurers, has been moved to this Chapter to the new Article 4.

6. Existing §38.1-84 requiring foreign and alien companies to file copies of their charters is being deleted because §§13.1-107 and 13.1-270 already require this. The filing of mutual company bylaws will be required administratively.

7. A new provision allowing an insurer's license to be renewed on a restricted basis is contained in proposed §38.2-1025, a revision of existing §38.1-98. This continues the insurer as a member of the guaranty association.

8. Existing §§38.1-88 through 38.1-95.1 dealing with requirements for licensing of insurers have been reorganized into the following new sections:

   §38.2-1028 - Stock requirements
   §38.2-1029 - Mutual requirements
   §38.2-1030 - Nonassessable mutual requirements
   §38.2-1031 - Alien requirements
   §38.2-1032 - Domestic requirements
   §38.2-1033 - Foreign requirements
   Existing §38.1-90 - Deleted, as provisions moved to §38.2-1035
   Existing §38.1-91 - Deleted, as provisions moved to §38.2-1032
   §38.2-1034 - How domestic mutual insurers may acquire initial surplus
   Existing §38.1-92.1 - Deleted, as provisions moved to §38.2-1034
   §38.2-1035 - Maintain surplus or capital and surplus
   Existing §38.1-94 - Deleted, as provisions moved to §38.2-1029
   Existing §38.1-95 - Deleted, as provisions moved to §38.2-1031
   Existing §38.1-95.1 - Deleted, as provisions moved to §38.2-1030

9. The definition of "trusteed surplus" in existing §38.1-95 (proposed §38.2-1031) has been revised and made more detailed.

10. The surplus lines exception to the prohibition against unlicensed companies in paragraph 1 of subsection D of §38.2-1039 has been revised so that what constitutes acceptable surplus lines insurance is left to the Surplus Lines Law (proposed Chapter 48).

11. The time in proposed §38.2-1043 for publishing a notice of the suspension or revocation of an insurer's license has been shortened from sixty days after final judgment to thirty days (if no appeal is taken) to be consistent with the thirty day period for appealing a decision of the Commission.

12. The standard in proposed §38.2-1045 for when the Commission may require an additional deposit from an insurer has been revised and made more detailed (similar to one of the requirements in proposed §38.2-1024 for obtaining a license).

13. Proposed § 38.2-1047 (How deposits applied to payment of claims; deficit to be made good) has been amended to make it clear that it only applies where no delinquency proceeding has been instituted.

14. The last sentence of existing § 38.1-112 (proposed § 38.2-1048) has been deleted to avoid any possible interpretation that an out-of-state court has jurisdiction over the §38.2-1045 deposit. The deleted sentence has been replaced with a new subsection B that coordinates the release of the deposit with Chapter 3 (Rehabilitation and Liquidation of Companies) when there is a delinquency proceeding.

    The proposed subsection B also replaces the last three sentences of existing § 38.1-110 (proposed § 38.2-1046), which currently provide for a class action to obtain release of the deposit, so there will be one procedure for releasing the deposit when there is a delinquency proceeding. This new procedure will require the appointment of a receiver in Virginia under §38.2-1521 to obtain the release of the deposit where a foreign or alien insurer is the subject of a delinquency proceeding in another state or country. Under this new procedure the priority in proposed §38.2-1046 for distribution of the deposit will be controlling over the priority in proposed Chapter 15, so that wages and certain other liabilities given priority in Chapter 15 will not come ahead of policyholders' claims on the deposit.

15. The alternate insurer deposit provided for in proposed §38.2-1049 has been increased from $200,000 to $500,000 in recognition of inflation and the multi-state purpose of this deposit, and general creditors have been added to policyholders as persons protected by this deposit.

16. The creditors protected by the voluntary deposit in proposed §38.2-1050 have been restricted to general creditors.

CHAPTER 10.

ORGANIZATION, ADMISSION AND LICENSING OF INSURERS.

Article 1.

Organization of Domestic Insurers.

§ 38.2-1000. Incorporation of domestic stock insurers.—Domestic stock insurers shall be incorporated under the provisions of Article 2 (§ 13.1-618 et seq.) of Chapter 9 of Title 13.1. Except as otherwise provided in this title, domestic stock insurers shall be subject to all the general restrictions and shall have all the general powers imposed and conferred by law.

Drafting Note: Existing § 38.1-72 is being deleted since proposed § 38.2-1045 requires a deposit to be made prior to the issuance of a license to transact the business of insurance or suretyship.

Drafting Note: Article 2 is being merged in to Article 1, so that the organization of stock and mutual insurers is treated in the same article.

§ 38.2-1001. Incorporation of domestic mutual insurers.—Domestic mutual insurers shall be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1. Except as otherwise provided in this title, domestic mutual insurers shall be subject to all the general restrictions and shall have all the general powers imposed and conferred by law.

Drafting Note: The last sentence is being deleted since proposed § 38.2-1045 requires a deposit to be made prior to the issuance of a license to transact the business of insurance or suretyship.

§ 38.2-1002. Additional requirements of articles of incorporation; name.—The articles of incorporation for a domestic mutual insurer shall be signed by at least twenty natural persons, a majority of whom are legal residents of this Commonwealth. The articles shall, in addition to complying with the requirements of Article 3 (§ 13.1-818, et seq.) of Chapter 10 of Title 13.1, set forth the classes of insurance the insurer proposes to write.

Drafting Note: The deleted provision at the end of the section is unnecessary because Title 13.1 already has a similar provision. The requirement for "mutual" to be included in the title of a mutual insurer is being deleted.

§ 38.2-1003. When corporate status attained; bylaws filed with Commission.— A domestic mutual insurer shall have legal existence as soon as the charter has been recorded with the Commission, after which the board of directors named in the charter may adopt bylaws and accept applications for insurance. However, no insurance shall be put in force until the insurer has been licensed to transact the business of insurance as provided by this chapter. The bylaws and any amendments shall be filed with the Commission within thirty days after adoption.

§ 38.2-1004. Voting.—Each member of a domestic mutual insurer shall have one vote, or a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as provided in the bylaws of the insurer.

§ 38.2-1005. Certain mutual companies and societies not to become stock companies without approval of State Corporation Commission.—No mutual insurance company, cooperative nonprofit life benefit company, mutual assessment life, accident and sickness company, burial society, or fraternal benefit society shall be converted into a stock corporation unless such conversion and the plan for conversion are approved by the Commission. The insurer shall comply with § 38.2-1028 before approval for conversion is granted by the Commission unless the Commission finds that the insurer will have the required capital and surplus within a reasonable time after conversion.

Drafting Note: The provision added at the end of proposed § 38.2-1005 allows conversion to a stock insurer without the minimum capital and surplus if the Commission finds that the insurer will have the minimum within a reasonable time. The reference to § 38.1-90 in existing § 38.1-79 has been deleted, as that section deals with maintaining the required capital and surplus. That section (now merged into proposed § 38.2-1035) would apply once the insurer became a stock insurer.

Article 2.

Conversion of Domestic Stock Insurer to Mutual Insurer.

Drafting Note: This article, previously Chapter 9, Article 7, has been moved for organization purposes and has been revised to make applicable to all insurers.

§ 38.2-1006. Conversion of a domestic stock insurer to a mutual insurer. - A. Any domestic stock life insurer may become a mutual life insurer, and to that end may carry out a plan for the acquisition of shares of its capital stock by purchase, gift or bequest, if the plan:

1. Has been adopted by a vote of a majority of the directors of the insurer;

2. Has been approved by a vote of the holders of at least two thirds of the stock outstanding at a meeting called for that purpose;

3. Has been submitted to and approved by the Commission; and

4. Has been approved by a majority vote of the policyholders voting at a meeting called for that purpose. Only those policyholders whose insurance is then in force and has been in force for at least one year before the meeting shall be entitled to vote.

B. For the purpose of this article, "policyholder" shall include the employer, or the president, secretary or other executive officer of any corporation or association, to which a master group policy has been issued, but shall exclude the holders of certificates or policies issued under or in connection with a master group policy.

Drafting Note: This section is the former § 38.1-489. The provision of former § 38.1-493 is being moved to the beginning of this section. The definition of policyholder has been shifted to a new subsection B.

§ 38.2-1007. Notice to policyholders of meeting to approve conversion.—At least thirty days before the meeting of policyholders required by § 38.2-1006, the insurer shall mail notice of the meeting to each policyholder at the last known address or shall deliver the notice in person to the policyholder.

§ 38.2-1008. Conduct of and voting at meeting.—The meeting required by § 38.2-1006 shall be conducted in the manner provided in the plan, subject to the following requirements:

1. Policyholders may vote in person, by proxy, or by mail, but all votes shall be cast by ballot; and

2. A representative of the Commission shall supervise the procedure of the meeting and shall appoint an adequate number of inspectors to oversee the voting at the meeting. The inspectors, acting under any rules and regulations prescribed by the Commission, shall have power to determine all questions concerning the verification and validity of the ballots, the qualifications of the voters, and the canvass of the vote. The inspectors shall certify the results of the voting to the representative of the Commission and to the insurer.

All necessary expenses incurred by the Commission or its representative in connection with the meeting shall be paid by the insurer.

§ 38.2-1009. Payment for shares pursuant to conversion plan.—Every payment for the acquisition of any shares of the capital stock of the insurer, the purchase price of which is not fixed by the plan, shall be subject to the approval of the Commission. Neither the plan, nor any payment under the plan, nor any payment not fixed by the plan, shall be approved by the Commission if the making of the payment reduces the surplus to policyholders to an amount less than that required at that time for the licensure of domestic mutual insurers.

Drafting Note: The standard that assets at least equal liabilities (with required surplus counted as a liability) has been reworded to an equivalent one that requires the minimum surplus to policyholders.

Drafting Note: Existing § 38.1-493 is being merged into proposed § 38.2-1006 (existing § 38.1-489).

§ 38.2-1010. How acquired shares held.— Until all shares are acquired, the acquired shares shall be held in trust for the policyholders of the insurer as provided in this article and shall be assigned and transferred on the books of the insurer to not less than three nor more than five trustees and shall be held by them in trust. Shares transferred to the trustees shall be voted by them at all corporate meetings at which stockholders have the right to vote until all of the capital stock of the insurer is acquired. The trustees shall be appointed and vacancies in the office of trustee shall be filled as provided in the plan adopted under § 38.2-1006. The trustees shall file with the insurer and with the Commission a verified acceptance of their appointment and a declaration that they will faithfully discharge their duties as such trustees.

Drafting Note: The provision on retirement of stock and the insurer becoming a mutual insurer is deleted as this is covered by proposed § 38.2-1016 (existing § 38.1-495.5).

§ 38.2-1011. Disposition of dividends after payments provided in conversion plan.—After the payment of stockholder dividends as provided in the plan adopted under § 38.2-1006, and after paying the necessary expenses of executing the trust all dividends and other sums received by the trustees on the shares of acquired stock, shall be immediately repaid to the insurer for the benefit of those who are or may become policyholders of the insurer and entitled to participate in the profits of the insurer. These payments shall be added to and become a part of the earned surplus of the insurer.

§ 38.2-1012. Jurisdiction to compel completion of mutualization.—Whenever (i) a plan of mutualization approved in accordance with the laws of this Commonwealth has been in effect for more than five years, and (ii) the insurer has acquired in the name of its trustees under the plan at least ninety percent of its outstanding stock, and (iii) the plan itself contains no provision for the compulsory completion of mutualization inconsistent with the terms of this article, circuit courts shall have jurisdiction to compel completion of the mutualization of the insurer upon the petition of either the insurer or any stockholder of the insurer.

Drafting Note: Reference to courts of equity has been dropped in favor of circuit courts to parallel Virginia's Court System.

§ 38.2-1013. Venue of proceedings.— The petition may be filed in the circuit court of record with general equity jurisdiction in the county or city in which the principal office of the insurer is located.

§ 38.2-1014. Parties and process.— Necessary parties to the proceeding shall be (i) the insurer, (ii) the registered holders of all its stock still outstanding in the hands of the public, and (iii) its policyholders as a

class. Process may be served on the policyholders as a class by publication but any policyholder may, on motion, be admitted as an individual party. The court shall appoint an attorney to represent all other policyholders.

§ 38.2-1015. Determining value of stock outstanding; dismissal of petition or entry of decree requiring payment for and transfer of stock.--The court shall determine the per share fair cash value as of the date of the filing of the petition of the stock remaining in the hands of the public. If the court finds that on that basis, completion of mutualization may not be effected without jeopardizing the solvency of the insurer or the security of its policyholders, the petition shall be dismissed. Otherwise, the court shall enter an appropriate decree to require (i) the payment into court by the insurer of the aggregate amount due the remaining stockholders, with any interest and costs, which may include attorneys' fees that the court may require, and (ii) the transfer and delivery to the insurer of all stock certificates still outstanding in the hands of the public. Upon payment by the insurer, the trustees under the plan of mutualization shall be considered, for all purposes of the plan of mutualization, to have acquired all of its outstanding stock. The holders of the stock shall possess no further right with respect to the stock, except to receive its fair cash value as determined by the court. The court shall retain jurisdiction over the distribution of the funds.

§ 38.2-1016. Amendment of charter and bylaws; change of name; retirement and cancellation of stock; when mutualization effective; assets and liabilities; officers and directors; general restrictions and powers.--A. Upon acquisition by the trustees of all of the capital stock of the insurer pursuant to the provisions of this article, the charter of the insurer shall be amended to reflect its mutualization. The charter may be amended in any other respect considered necessary by the board of directors and trustees of the insurer in accordance with the provisions of this article and Article 11 (§ 13.1-705 et seq.) of Chapter 9 of Title 13.1. Upon the amendment of the charter of the insurer, the board of directors named in the amendment shall adopt any changes in the bylaws considered necessary, and the bylaws and any amendments to them shall be filed with the Commission within thirty days after adoption.

B. As soon as the charter of the insurer has been amended as provided in this section, the capital stock of the insurer held by the trustees shall be assigned to the insurer and shall be retired and cancelled. Certification of that action by the proper officers of the insurer shall be made to the Commission, and the trustees acting under the plan shall be discharged. The insurer shall then immediately become a mutual insurer owning all the assets of the converted stock insurer and subject to all its liabilities.

C. The officers and directors of the insurer named in the amended charter shall continue as the officers and directors of the mutual insurer until their successors are duly elected in accordance with the provisions of the amended charter and the bylaws adopted under it.

D. The converted mutual insurer, except as otherwise provided in this title, shall be subject to all the general restrictions and have all the general powers imposed and conferred upon nonstock corporations by law.

Article 3.

Mergers.

§ 38.2-1017. Applicability of Title 13.1.-- Except as otherwise provided in this title, Article 12 (§ 13.1-716 et seq.) of Chapter 9 of Title 13.1 shall apply to mergers involving a domestic stock insurer and Article 11 (§ 13.1-894 et seq.) of Chapter 10 of Title 13.1 shall apply to mergers involving a domestic mutual insurer.
Drafting Note: Changes in § 13.1-716 made in 1985 delete reference to consolidation.

§ 38.2-1018. Plan of merger to be approved by Commission.--Before any joint agreement for the merger of domestic insurers is submitted to the stockholders or members, it shall first be submitted to and approved by the Commission. The Commission shall not approve the agreement unless, after a hearing, it finds that the plan of merger is fair, equitable, consistent with law, and that no reasonable objection to the plan exists. If the Commission fails to approve the plan it shall state the reasons in its order.
Drafting Note: Changes in § 13.1-716 made in 1985 delete reference to consolidation.

Article 4.

Redomestication of Insurers.

General Drafting Note: 1. This article was previously Chapter 30.

2. Proposed § 38.2-1021 (existing § 38.1-951) has been modified to provide the Commission the option to refuse to continue the license of a redomesticated company if the nature and operation of the insurer changes or its financial condition deteriorates.

§ 38.2-1019. Change of status from foreign to domestic insurer.--A. Any foreign insurer licensed to transact the business of insurance in this Commonwealth may become a domestic insurer upon (i) complying with the requirements for formation of a domestic insurer under Article 1 (§ 38.2-1000 et seq.) of this chapter at the date of redomestication, and (ii) promptly filing any necessary amendments to its articles of incorporation, charters, bylaws and other corporate documents. When those requirements have been met, the Commission may issue a license dated as of the date of redomestication in accordance with

the provisions of Article 5 (§ 38.2-1024 et seq.) of this chapter to permit the company to transact the business of insurance in the Commonwealth as a domestic insurer. The license shall state the date and domicile of the original incorporation of the insurer, and shall indicate its redomestication into this Commonwealth under the provisions of this chapter.

Drafting Note: The reference in existing subsection A to Article 2 of Chapter 2 (which is now this chapter) has been deleted because that article is being merged into proposed Article 1 of this chapter, which is also referred to in subsection A.

B. An insurer that changes its status from foreign to domestic in accordance with subsection A of this section has all the rights, titles and interests in the assets of the original corporation, as well as all of its liabilities and obligations.

§ 38.2-1020. Transfer of domicile from Virginia to another state.—Any domestic insurer, upon the approval of the Commission, may transfer its domicile from this Commonwealth to any other state in which it is licensed to transact the business of insurance. The Commission may approve the proposed transfer of domicile if it determines that the transfer is in the best interests of the insurer's policyholders and this Commonwealth. If the Commission does not approve the transfer, it shall give the insurer written notice of the refusal and the reasons for it within thirty days after the date the request for transfer was made. If the request for transfer is granted and the insurer is otherwise qualified, it may transact the business of insurance in this Commonwealth as a foreign insurer without interruption in licensing.

§ 38.2-1021. Change of domicile of foreign insurer to another foreign state —Any foreign insurer licensed to transact the business of insurance in this Commonwealth, upon proper notice to the Commission, may change its domicile to another foreign state without interruption in licensing and without reapplying as a foreign insurer if:

1. For a foreign stock insurer, the change in domicile does not result in a reduction in its capital and surplus to policyholders below the capital and surplus requirements for licensure specified in § 38.2-1028;

2. For a foreign mutual insurer, the change in domicile does not result in a reduction in its surplus below the surplus requirements for licensure specified in § 38.2-1029;

3. There is no substantial change in the lines of insurance to be written by the insurer;

4. There is no substantial change in the nature of the insurer or its method of operations and there is no deterioration in its financial condition; and

5. The change in domicile has been approved by the supervising regulatory officials of both the former and new state of domicile.

Drafting Note: 1) The change in domicile resulting from merger, consolidation or otherwise is deleted, as this could result in the unanticipated licensing of a new company.

2) Item 4 is included to give the Commission the opportunity to require a new application for license.

§ 38.2-1022. Commission to be notified of proposed transfer of domicile.—Each insurer licensed to transact the business of insurance in this Commonwealth that transfers its domicile to any other state shall notify the Commission of the proposed transfer and shall file promptly with it any necessary amendments to articles of incorporation, charters, bylaws, and other corporate documents.

§ 38.2-1023. Effect of transfer of domicile on certificate of authority, agents' appointments and licenses, etc.—When any insurer licensed to transact the business of insurance in this Commonwealth transfers its domicile to this or any other state, its certificate of authority, agents' appointments and licenses, policy forms, rates, authorizations, and other filings and approvals that existed at the time of the transfer shall remain in effect after the transfer of domicile occurs.

Drafting Note: Section 38.1-954 is being deleted since a title-wide regulations section is being added in proposed Chapter 2.

Drafting Note: Existing § 38.1-83 has been revised, and moved to Article 5 as proposed § 38.2-1027. With the deletion of existing § 38.1-84, Article 4 has been eliminated.

Drafting Note: This section is being deleted because §§ 13.1-759 and 13.1-921 cover these requirements. The filing of mutual insurer bylaws will be required administratively.

Article 5.

Licensing of Insurers.

§ 38.2-1024. License required to transact the business of insurance; application fee requirements for license.—A. No insurer unless authorized pursuant to Chapter 48 of this title shall transact the business of insurance in this Commonwealth until it has obtained a license from the Commission. For a foreign or alien insurer, this license shall be in addition to the certificate of authority required by § 38.2-1027. Each application for a license to transact the business of insurance in this Commonwealth shall be accompanied by a nonrefundable license application fee of $500. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the Bureau of Insurance's maintenance fund. The license shall be signed by a member or other duly authorized agent of the Commission and shall expire on the next June 30 after the date on which it becomes effective, subject to renewal pursuant to § 38.2-1025.

B. The Commission shall not grant a license to do the business of insurance in this Commonwealth to any insurer until it is satisfied that, from the evidence it requires under uniform procedures suitable to and applied equally to all classes of insurers, the insurer:

1. Has paid all fees, taxes, and charges required by law;

2. Has made any deposit required by this title;

3. Has the minimum capital and surplus if a stock insurer, the minimum surplus if a mutual or a reciprocal insurer, and the minimum trusteed surplus if an alien insurer, prescribed in this title for insurers transacting the same class of insurance;

4. Has filed a financial statement or statements and any reports, certificates or other documents the Commission considers necessary to secure a full and accurate knowledge of its affairs and financial condition;

5. Is solvent and its financial condition, method of operation, and manner of doing business are such as to satisfy the Commission that it can meet its obligations to all policyholders; and

6. Has otherwise complied with all the requirements of law.

Drafting Note: Subsection B above is essentially existing § 38.1-86, which will be deleted.

Drafting Note: § 38.1-85.1 is an outdated grandfather provision that is no longer needed.

Drafting Note: See drafting note for proposed § 38.2-1024.

§ 38.2-1025. Annual renewal of license.—Each insurer licensed to transact the business of insurance in this Commonwealth shall obtain an annual renewal of its license from the Commission. The Commission may refuse to renew the license of any insurer or may renew the license, subject to any restrictions considered appropriate by the Commission, if it finds an impairment of required capital and surplus or if it finds that the insurer has not satisfied all the conditions set forth in subsection B of § 38.2-1024. The Commission shall not fail to renew the license of any insurer to transact the business of insurance without giving the insurer ten days' notice and giving it an opportunity to be heard. The hearing may be informal, and the required notice may be waived by the Commission and the insurer.

Drafting Note: Proposed § 38.2-1025 is a revision of existing § 38.1-98 that adds a provision for renewing a license on a restricted basis. The new provision for a restricted license will allow the Commission to renew the license of an insurer in financial difficulty while restricting it to not writing new business. This continues the insurer as a member of the guaranty association, which refusing to renew the license would not do, and thereby continues the protection of the guaranty association for the insurer's policyholders.

§ 38.2-1026. Retaliatory provisions as to taxes, fees, deposits and other requirements.—

When a domestic insurer or its agents are subject to regulatory costs in another state that are greater than those imposed in this Commonwealth upon insurers domiciled in that state or their agents, then the regulatory costs imposed by this Commonwealth on those foreign insurers or their agents shall be increased to equal the regulatory costs imposed by the other state on the domestic insurer or its agents. For the purpose of this section, regulatory cost includes (i) any deposits of securities, (ii) payment of taxes, fines, penalties or fees exacted for the privilege of doing business or (iii) any restitutions, obligations or conditions necessary for doing business.

For the purposes of this section an alien insurance company shall be considered domiciled in the state wherein it has the largest amount of its assets held in trust and on deposit for the benefit of its policyholders, or of its policyholders and creditors in the United States. An insurance company incorporated in Canada shall be considered domiciled in Canada.

Drafting Note: This section is rewritten to improve readability.

§ 38.2-1027. Admission of foreign and alien insurers.— Before transacting any insurance business in this Commonwealth, each foreign or alien insurer shall obtain a certificate of authority and shall comply with the applicable provisions of Article 17 (§ 13.1-757 et seq.) of Chapter 9 of Title 13.1 in the case of a stock insurer and of Article 14 (§ 13.1-919 et seq.) of Chapter 10 of Title 13.1 in the case of a mutual insurer. The certificate shall be in addition to the license to transact the business of insurance required by § 38.2-1024.

§ 38.2-1028. Additional licensing requirements for stock insurers.—No stock insurer shall be licensed to transact the business of insurance in this Commonwealth unless it has fully paid in capital stock of at least one million dollars and surplus of at least one million dollars.

Drafting Note: The provision deleted at the end of § 38.2-1028 is in proposed §38.2-1032 and now applies to both stock and mutual domestic insurers. Existing §§ 38.1-88 through 38.1-94 have been reorganized into the following new sections:

§ 38.2-1028 has been expanded from applying only to domestic stock companies to applying to all stock companies.

§ 38.2-1029 expands existing § 38.1-94 from applying only to foreign mutual companies to applying to all mutual companies.

§ 38.2-1030 is existing § 38.1-95.1 with editorial changes.

§ 38.2-1031 is existing § 38.1-95 with a more detailed definition of trusteed surplus.

§ 38.2-1032 expands existing § 38.1-91 from applying only to domestic mutual companies to applying to all domestic companies.

§ 38.2-1033 has been expanded from applying only to foreign stock companies to applying to all foreign companies.

§ 38.2-1034 on how domestic mutual insurers may acquire initial surplus, has had existing § 38.1-92.1 (on how they may voluntarily increase their surplus) merged into it.

§ 38.2-1035 has been expanded from applying only to domestic mutual insurers to applying to all domestic insurers.

All portions of former §§ 38.1-90, 38.1-91, 38.1-94, 38.1-95 and 38.1-95.1 have been deleted because of the reorganization. Their provisions are now in §§ 38.2-1035, 38.2-1032, 38.2-1029, 38.2-1031, and 38.2-1030 respectively.

§ 38.2-1029. Additional licensing requirements for mutual insurers.—No mutual insurer shall be licensed to transact the business of insurance in this Commonwealth unless it has a surplus of at least $800,000.

Drafting Note: The provision deleted at the end of § 38.2-1029 has been moved to proposed § 38.2-1033, which applies to both foreign stock and mutual companies.

§ 38.2-1030. Surplus requirements for issuing policies without contingent liability.—No domestic or foreign mutual insurer shall issue policies without contingent liability unless, at the time of issue, the insurer has at least two million dollars of surplus In the case of an alien insurer, policies without contingent liability shall not be issued unless, at the time of issue, the insured has at least two million dollars of trusteed surplus.

However, any mutual insurer that on September 30, 1986 was authorized to issue and was engaged in issuing policies without contingent liability may continue to do so by maintaining at all times the minimum surplus if a domestic or foreign insurer, and the minimum trusteed surplus if an alien insurer, required at the time of authorization.

Drafting Note: In the title of existing § 38.1-95.1 (proposed § 38.2-1030) "nonassessable policies" has been changed to "policies without contingent liability" to agree with the body of the section. All changes to this section are intended to be editorial ones with no change in substance.

§ 38.2-1031. Additional requirements, alien insurers.—A. No alien insurer shall be licensed to transact the business of insurance in this Commonwealth unless it (i) has a "trusteed surplus," as defined in subsection B of this section, of at least two million dollars, and (ii) has filed with the Commission a certificate from the supervising insurance official of the state of entry certifying that it is authorized to write the classes of insurance it proposes to write in this Commonwealth or it has filed with the Commission a certificate of the supervising insurance official of its domiciliary country that it is authorized there to transact the kind of insurance business it proposes to transact in this Commonwealth.

Drafting Note: 1985 Legislation was passed that allows an alien insurer to enter the United States directly through Virginia rather than gaining a license in another state prior to licensing in Virginia.

B. "Trusteed surplus" of an alien insurer means the excess of the aggregate value of the assets set forth in subsection C of this section over the aggregate net amount of all of its liabilities in the United States.

C. 1. General state deposits are all of the alien insurer's assets within the United States on deposit with officers of any state for the benefit and security of all of its policyholders and creditors in the United States.

2. Special state deposits are all of the alien insurer's assets in the United States, other than general state deposits, which are on deposit with officers of any state for the benefit and security of its policyholders and creditors in the state of deposit, or for the benefit and security of certain classes of its policyholders and creditors either in the state of deposit or in the United States. The value of special state deposits shall in no event exceed the value of the liability secured by the special state deposits.

3. Trusteed assets are all of its assets in the United States, other than general state deposits and special state deposits, held by any trustee for the benefit and security of all of its policyholders and creditors in the United States.

4. Interest receivable includes any interest collectable by the state or trustee that is receivable, due and accrued on the general state deposits, the special state deposits, and the trusteed assets of the alien insurer.

D. An alien insurer's liabilities in the United States are all of the reserves and other liabilities incurred by the alien insurer in the United States, from which may be deducted:

1. An amount equal to the reinsurance credits allowed by § 38.2-1316;

2. From the amount of such liabilities for unearned premiums, the unearned portion of premiums receivable by an alien insurer from its agents or policyholders under policies issued by it in the United States and not more than ninety days past due on the date of such statement;

3. Those liabilities in the United States pertaining to any asset in the United States of the alien insurer other than the assets described in subsection C of this section. This deduction shall be allowed only to the extent considered appropriate by the Commission and shall in no case exceed that portion of the value of the asset that is applicable to the liability pertaining to the asset; and

4. The amount of the unpaid principal and interest of any loan made by the alien insurer to the holder of, and solely on the security of, any life insurance policy or annuity contract issued or assumed by

it on the life of or to any person in the United States. This amount shall in no case exceed the amount of the reserve it is required to maintain on the policy or annuity contract.

Drafting Note: The definition of trusteed surplus has been revised and made more detailed.

§ 38.2-1032. Additional licensing requirements for domestic insurers.--No domestic insurer shall be licensed to transact the business of insurance in this Commonwealth until it has furnished the Commission with a statement under the seal of the insurer, verified by the president or treasurer or two of its directors, showing (i) the amount of surplus, (ii) the amount of capital stock fully paid in, (iii) the amount of actual cash in its treasury, (iv) the amount invested with a list of the investments and their cash value, and (v) any other information the Commission requires. In its discretion the Commission may make or direct to be made an examination of the insurer to ascertain if it is entitled to the license.

Drafting Note: The change in the examination language is for consistency with proposed § 38.2-1317.

Drafting Note: The exemption for mutual assessment fire insurance companies is being moved to proposed § 38.2-2506.

§ 38.2-1033. Additional licensing requirements for foreign insurers.--No foreign insurer shall be licensed to transact the business of insurance in this Commonwealth until it has filed with the Commission a certificate from the supervising insurance official of the state in which it is incorporated certifying that it is authorized to write the classes of insurance it proposes to write in this Commonwealth.

Drafting Note: The deleted provision in proposed § 38.2-1033 dealing with capital stock of $1,000,000 is in proposed § 38.2-1028, which will now apply to both foreign and domestic stock insurers.

Drafting Note: Existing § 38.1-90 is being merged into proposed § 38.2-1035.

§ 38.2-1034. How domestic mutual insurers may acquire initial surplus.--Any domestic mutual insurer or mutual assessment property and casualty insurer may, without pledging any of its assets, provide a guaranty fund sufficient to defray the expenses of its organization and its initial minimum surplus required to obtain a license to do the business of insurance. The fund may be increased with the prior approval of the Commission by receiving advances or by borrowing funds upon an agreement that the funds, including interest at a rate not exceeding the one year Treasury bill interest rate plus three percentage points at the time the loan is made or renewed, shall be repaid only if the insurer has sufficient earned surplus. The agreement shall provide that the insurer may repay the advances or loans or any part of them whenever it is able to do so in accordance with the requirements of this article. No commission or brokerage shall be paid in acquiring the funds, and no repayment of the funds, either in whole or in part, shall be made without the approval of the Commission. Any funds advanced or borrowed under this provision shall not form a part of the legal liabilities of the insurer. However, all statements published or filed by the insurer shall show the amount of the funds remaining unpaid.

Drafting Note: The fixed ten percent rate has been changed to a floating rate. This change will allow a mutual company to more easily supplement its surplus capital. County mutuals have been included in this section.

Drafting Note: Existing § 38.1-92.1 has been merged into proposed § 38.2-1034.

§ 38.2-1035. Domestic insurers to maintain minimum capital and surplus; proceedings by Commission if impairment found.--A. Each domestic insurer shall maintain at all times the minimum surplus if a mutual insurer, and the minimum capital and surplus if a stock insurer, required by §§ 38.2-1028, 38.2-1029 or 38.2-1030. If the Commission finds that (i) the minimum capital and surplus of a domestic stock insurer is impaired or (ii) the minimum surplus of a domestic mutual insurer is impaired, the Commission shall issue an order requiring the insurer to eliminate the impairment within a period not exceeding ninety days. The Commission may by order served upon the insurer prohibit the insurer from issuing any new policies while the impairment exists.

B. Any domestic mutual insurer may make an assessment upon its assessable members for an amount that will provide funds to cover all or any part of the impairment. However, no member shall be liable for an assessment exceeding the limit specified in his policy, and no assessment shall be made upon any member under a nonassessable policy. The assessment shall be made upon each assessable member in proportion to the liability as expressed in the policy. With the prior approval of the Commission, the deficiency may be made up from advances or borrowed funds and subject to the restrictions provided in § 38.2-1034 for obtaining guaranty funds.

C. If at the expiration of the designated period the insurer has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the insurer may be entered as provided in Chapter 15 of this title.

§ 38.2-1036. Impairment of capital and surplus of foreign and alien company ground for suspension or revocation of license.--Each foreign and each alien insurer shall maintain at all times the minimum surplus, capital and surplus, or trusteed surplus required by §§ 38.2-1028, 38.2-1029, 38.2-1030 or 38.2-1031. If the Commission finds an impairment of (i) the required minimum capital and surplus of any foreign stock insurer, (ii) the required minimum surplus of any foreign mutual insurer, or (iii) the required minimum trusteed surplus of any alien insurer, the Commission may order the insurer to eliminate the impairment and restore the minimum capital and surplus, minimum surplus or minimum trusteed surplus, to the amount required by law. The Commission may, by order served upon the insurer, prohibit the insurer from issuing any new policies while the impairment exists. If the insurer fails to comply with the Commission's order within a period of not more than ninety days, the Commission may, in the manner set out in Article 6 (§ 38.2-1040 et seq.) of this chapter, suspend or revoke the license of the insurer to transact the business of insurance in this Commonwealth.

Drafting Note: The new first sentence of § 38.2-1036 parallels for foreign and alien insurers the

first sentence of proposed § 38.2-1035 for domestic insurers. An impaired foreign or alien insurer must eliminate a capital impairment within ninety days of being so ordered. This parallels the treatment for a domestic insurer.

§ 38.2-1037. Exceptions for licensed and operating insurers.—A. Notwithstanding the other provisions of this chapter with respect to minimum required capital and surplus, any insurer which, on September 30, 1986,, was licensed to write and was writing any class of insurance in this Commonwealth, may continue to write that class of insurance under the appropriate license from the Commission if it maintains at all times (i) the minimum capital and surplus if a stock insurer, (ii) the minimum surplus if a mutual insurer, and (iii) the minimum trusteed surplus if an alien insurer, required of the insurer as of September 30, 1986.

B. Any insurer not licensed to write a class of insurance in this Commonwealth on September 30, 1986, shall meet all the capital surplus and trusteed surplus requirements of this article before it obtains a license to write that class of insurance.

Drafting Note: This section is no longer needed, since it relates only to the one year period beginning July 1, 1952.

§ 38.2-1038. Authority of Commission to issue orders covering insurers in hazardous financial condition.— If, after examining an insurer's financial condition, method of operation, or manner of doing business, the Commission finds that (i) the insurer cannot meet its obligations to all policyholders, or (ii) the insurer's continued operation in this Commonwealth is hazardous to policyholders, creditors and the public in this Commonwealth the Commission may, order the insurer to take appropriate action to remedy the Commission's concerns. The insurer shall be given ten days notice prior to issuing the order and shall be given the opportunity to be heard and introduce evidence on its behalf. The hearing may be informal, and the required notice may be waived by the Commission and the insurer. If the insurer fails to comply with the Commission's order within the prescribed time, the Commission may suspend or revoke the license of the insurer to transact the business of insurance in this Commonwealth as set forth in Article 6 (§ 38.2-1040 et seq.) of this chapter.

Drafting Note: Existing § 38.1-98 has been merged into proposed § 38.2-1025.

§ 38.2-1039. Enjoining unlicensed foreign or alien insurers from transacting the business of insurance in Commonwealth.—

Drafting Note: The first paragraph of existing § 38.1-98.1 is being deleted because the authority to issue injunctions will be provided for on a title-wide basis in Chapter 2.

A. For the purposes of issuing a temporary or permanent injunction under § 38.2-220 to restrain unlicensed foreign or alien insurers from transacting the business of insurance in this Commonwealth , the following acts, effected by mail or otherwise, shall constitute transacting the business of insurance in this Commonwealth: 1. The issuance or delivery of insurance contracts to residents of this Commonwealth or to corporations authorized to do business in this Commonwealth; 2. The solicitation of applications for such contracts; 3. The collection of premiums, membership fees, assessments or other considerations for such contracts; or 4. The transaction of any other insurance business in connection with such contracts.

B. Process may be served in accordance with § 13.1-758 or in any other manner prescribed by law.

C. This section shall not apply to any nonprofit life insurance or annuity company which is organized and operated for the purpose of issuing insurance and annuity contracts , exclusively to or for the benefit of nonprofit educational or scientific institutions and individuals engaged in the service of those institutions. The clerk of the Commission shall be considered the attorney for service of process in this Commonwealth for all of such insurer's policy and contract holders in this Commonwealth. The appointment shall (i) be irrevocable, (ii) bind the insurer and any successors in interest, and (iii) remain in effect as long as there is in force in this Commonwealth any contract made by the insurer or any obligation arising from the contract.

D. This section shall not apply to the following acts:

1. The procuring of a policy of insurance upon a risk within this Commonwealth in compliance with Chapter 48 of this title;

Drafting Note: Paragraph 1 of subsection D deals with surplus lines insurance. The deletion of the "open market" requirement is being made, so that all aspects of when the surplus lines market can be used will be dealt with in the Surplus Lines Insurance Law proposed Chapter 48, the cross-reference to which has been updated.

2. Issuance of contracts of reinsurance;

3. Acts in this Commonwealth involving a policy lawfully solicited, written and delivered outside this Commonwealth covering only subjects of insurance not resident, located, or to be performed in this Commonwealth at the time of issuance of the policy;

4. Acts in this Commonwealth involving a group or blanket insurance policy or a group annuity lawfully issued and delivered in a state where the insurer was licensed to transact the business of insurance;

5. The procuring of insurance contracts issued to an "industrial insured". For the purposes of this section, an "industrial insured" is an insured (i) who procures the insurance of any risk by use of the services of a full-time employee acting as an insurance manager or buyer, (ii) whose aggregate annual premiums for insurance on all risks total at least $25,000, and (iii) who has at least twenty-five full-time

employees.

F. Nothing in this section shall apply to nonprofit Railroad Brotherhood or other similar fraternal organizations.

Article 6.

Refusal, Suspension or Revocation of Insurer's License.

§ 38.2-1040. Refusal, suspension or revocation of license.--A. The Commission may refuse to issue a license to any domestic, foreign or alien insurer to transact the business of insurance in this Commonwealth, and may suspend or revoke the license of any licensee, whenever it finds that the applicant or licensee:

1. Has refused to submit its books, papers, accounts, or affairs to the reasonable inspection of the Commission or its representative;

2. Has refused, or its officers or agents have refused, to furnish satisfactory evidence of its financial and business standing or solvency;

3. Is insolvent, or is in a condition that any further transaction of business in this Commonwealth is hazardous to its policyholders, creditors and public in this Commonwealth ;

4. Has failed to pay a final judgment against it within sixty days after (i) the judgment became final, (ii) the time for making an appeal has expired, or, (iii) the dismissal of an appeal before final determination, whichever date is the latest;

Drafting Note: The change in paragraph 4 is for clarification. No change in meaning is intended. The new language is similar to language used in proposed § 38.2-1503.

5. Has violated any law of this Commonwealth, or has in this Commonwealth violated its charter or exceeded its corporate powers;

6. Has failed to pay any fees, taxes or charges imposed in this Commonwealth within sixty days after they are due and payable, or within sixty days after final disposition of any legal contest with respect to liability for the fees, taxes or charges;

7. Has had its corporate existence dissolved or its certificate of authority revoked in the state in which it was organized;

8. Has been found insolvent by a court of any other state, or by the Commission or other proper officer or agency of any other state, and has been prohibited from doing business in that state ;

9. Has had all its risks reinsured in their entirety in another insurer; or

10. Has notified the insured in writing or by any other means that any policy of insurance covering the ownership or operation of a motor vehicle issued by the insurer will be cancelled if the insured institutes any legal action against the insurer to pursue any rights of the insured under the policy.

B. The grounds for suspension or revocation of licenses in subsection A of this section are in addition to those provided for elsewhere in this title.

Drafting Note: Subsection B of proposed § 38.2-1040 has been added to clarify that § 38.2-1040 does not replace other grounds for suspension or revocation found elsewhere in the title.

§ 38.2-1041. Notice to company of proposed suspension or revocation.--The Commission shall not revoke or suspend the license of any insurer to do the business of insurance in this Commonwealth upon any of the grounds set out in § 38.2-1040 until it has given the insurer ten days' notice of the reasons for the proposed revocation or suspension and has given the insurer an opportunity to introduce evidence and be heard. However, the Commission may immediately suspend the license on any of the grounds specified in paragraphs 7 and 8 of subsection A of § 38.2-1040 without prior notice to the insurer. The suspension shall remain in force until the hearing is held. Any hearing authorized by this section may be informal, and the required notice may be waived by the Commission and the insurer.

§ 38.2-1042. Agent's authority likewise suspended or revoked.--Upon the suspension or revocation of the license of any insurer, the Commission shall suspend or revoke the authority of the insurer's agents in this Commonwealth to act for the insurer.

§ 38.2-1043. Suspension or revocation published.--Unless an appeal is taken within thirty days, the Commission shall have published in one or more newspapers having general circulation in this Commonwealth a notice of any final order that suspends or revokes the license of an insurer.

Drafting Note: The change from sixty days to thirty days in proposed § 38.2-1043 has been made to conform to the thirty days allowed for appealing a decision of the Commission.

§ 38.2-1044. New business prohibited.--No new business shall be done by any insurer or its agents on behalf of that insurer while its license to do business is suspended or revoked.

Drafting Note: A new penalty section in Chapter 2 will apply to violation of any provision of this title, so the last sentence of proposed § 38.2-1044 is not needed.

Drafting Note: There will be one general section in Chapter 2 providing for appeals, so existing § 38.1-104 is not needed.

Drafting Note: This article has been deleted, as underwriters' agencies are no longer viable organizations.

Article 7.

Deposits.

§ 38.2-1045. Deposits required of insurers generally; surety bonds instead of deposits.—A. Except as otherwise provided in this title, before the Commission issues a license to transact the business of insurance in this Commonwealth to any insurer, that insurer shall deposit with the State Treasurer securities that (i) are legal investments under the laws of this Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, and (iii) have a current market value of not less than $50,000 nor more than $200,000.

B. Instead of the deposit of securities required by subsection A of this section, an insurer may enter into a bond with surety, approved by the Commission, in the penalty of not less than $50,000 nor more than $200,000, with any conditions the Commission requires. The surety shall be licensed in this Commonwealth to transact the business of suretyship and shall not be directly or indirectly under the same ownership or management as the principal on the bond.

C. The Commission may require a reasonable amount of additional deposits in securities that meet the requirements of items (i) and (ii) of subsection A of this section, whenever the Commission determines that the insurer's financial condition, method of operation, or manner of doing business is such that the Commission is not satisfied that it can meet its obligations to all policyholders.

Drafting Note: The rewording of what is being proposed as subsection C provides a more specific standard than the existing language. The new language in subsection C is similar to existing § 38.1-86(5) (proposed § 38.2-1024).

D. Neither the deposit referred to in this section nor the alternate deposit permitted by § 38.2-1049 shall be required of (i) any mutual assessment property and casualty insurance company, (ii) any fraternal benefit society, or (iii) any insurer transacting exclusively an ocean marine business in this Commonwealth.

Drafting Note: The section is no longer needed since former Article 7 of this Chapter which authorizes underwriting agencies has been deleted.

§ 38.2-1046. Purpose of deposits; enforcement of lien.— An insurer's deposits required by § 38.2-1045 shall be held as security for the insurer's liabilities which are incurred or which may be incurred as a result of a loss sustained by (i) this Commonwealth or any of its political subdivisions, (ii) any citizen or inhabitant of this Commonwealth, or (iii) any other person owning property in this Commonwealth, when the insurer fails to meet its obligations incurred in this Commonwealth. Policyholders, without preference, shall have a lien on the deposits for the amounts due or which may become due as a result of any failure of the insurer to meet its obligations. General creditors, without preference, shall be entitled to have a similar lien on the deposits which shall be subordinate to the claims of the policyholders. If the deposits are not sufficient to cover the insurer's liabilities, payment of the available deposits shall be made as prescribed in subsection B of § 38.2-1048.

Drafting Note: The last three sentences of § 38.2-1046 have been deleted and replaced by a new subsection B in proposed § 38.2-1048.

§ 38.2-1047. How deposits applied to payment of claims; deficit to be made good.—A. This section shall apply only where:

1. The insurer has failed to pay any of its liabilities after the liabilities have been ascertained (i) by any agreement of the parties binding the insurer, or (ii) by judgment, order or decree of a court of competent jurisdiction which has not been appealed, superseded or stayed; and

2. No delinquency proceeding has been instituted.

B. Upon application of the person to whom the debt or money is due and after giving notice as provided in subsection C of this section, the State Treasurer shall (i) sell an amount of securities with accrued interest that provides sufficient funds to pay the sums due and the expenses of the sale and (ii) pay the sums due and expenses out of the available funds. This shall be subject to the approval of the Commission.

C. The State Treasurer shall give the insurer or its agent ten days' notice, either by mail or personally, of the time and place of the sale. The sale shall be advertised daily for ten days in a newspaper of general circulation published in the City of Richmond.

D. The insurer shall immediately make good any deficit in its deposit resulting from a sale. The State Treasurer shall report to the Commission in writing (i) the amount and kind of securities sold in accordance with the provisions of this section and (ii) the amount and kind of securities deposited to make good the deficit.

Drafting Note: The first sentence of § 38.2-1047 (now proposed subsection A) has been revised to clarify that this section applies only where no delinquency proceeding has been instituted. A new subsection B in § 38.2-1048 deals with the deposit where a delinquency proceeding has been instituted.

§ 38.2-1048. Return of deposits.—A. The Commission, at its discretion, may direct the State Treasurer to return to any insurer all or a part of the deposit made by it under § 38.2-1045 if the insurer (i) has complied with § 38.2-1049, or (ii) has ceased to transact business in this Commonwealth. In the case of the latter, the fixed or contingent liabilities secured by the deposit shall have been satisfied or terminated or shall have been assumed by another insurer licensed to transact the business of insurance in this Commonwealth. If the Commission finds that any voluntary deposit of any insurer made under § 38.2-1050 no longer is required in whole or in part to comply with the laws of this or any other state, it may to such extent direct the return of that deposit. The Commission, before directing the return of any deposit, may require evidence it considers satisfactory that the insurer is entitled to the return of all or part of the deposit.

B. Whenever a delinquency proceeding has been instituted under §§ 38.2-1503, 38.2-1504, 38,2-1505, or 38.2-1521, the insurer's deposit required by § 38.2-1045 shall be released subject to subsection A of this section and the applicable provisions of Chapter 15 of this title. In the event of any conflict, subsection A of this section shall control.

Drafting Note: The last sentence of § 38.2-1048 has been deleted to avoid any possible interpretation that an out-of-state court has jurisdiction over the § 38.1-108 (proposed § 38.2-1045) deposit. Proposed subsection B of § 38.2-1048 will be the provision in Article 8 dealing with release of the deposit when a delinquency proceeding has been instituted. This provision will require the appointment of a receiver in Virginia, under § 38.2-1521, to obtain the release of the § 38.2-1045 deposit where a foreign or alien insurer is the subject of a delinquency proceeding in another state or country. Also, this provision makes the priority set forth in § 38.2-1046 for distribution of this deposit controlling over the priority in Chapter 15 (see paragraph 1 of subsection B of § 38.2-1505), so wages and certain other liabilities given priority in Chapter 15 do not come ahead of the policyholders' claims on this deposit.

This provision replaces the existing last paragraph of § 38.1-112 and the existing last three sentences of § 38.1-110.

§ 38.2-1049. Alternate deposit requirements.—A. The insurer, at the discretion of the Commission, may be relieved of making the deposit required by § 38.2-1045 if the insurer makes deposits according to the following provisions:

1. Acceptable securities as defined in subsection B of this section are deposited with the State Treasurer or with the insurance commissioner, treasurer or other officer or official body of any other state first for the protection of the insurer's policyholders.

2. The securities are not to be in default as to principal and interest.

3. The securities have a market value of at least $500,000.

4. A certificate is furnished to the Commission and authenticated by the appropriate state official holding the deposit that the requirements of this subsection have been met.

Drafting Note: The alternate deposit has been increased from $200,000 to $500,000 to recognize inflation and in recognition of its multistate purpose, and general creditors have been added as persons protected by this deposit.

B. For the purpose of this section, acceptable securities are defined as bonds of the United States, or of any state, or of any city, county or town of any state, or bonds or notes secured by mortgages or deeds of trust on otherwise unencumbered real estate of a market value in each case of not less than double the amount loaned, or other securities approved by the Commission.

§ 38.2-1050. Voluntary deposit in excess of amount required.—Any domestic insurer, in order to comply with the laws of any other state or of the United States, may make a voluntary deposit with the State Treasurer in excess of the amount required by § 38.2-1045. This excess deposit shall be subject to all other applicable provisions of the laws of this Commonwealth relating to the deposits of insurers. However, this excess deposit shall be for the protection of all the insurer's policyholders and general creditors, notwithstanding the provisions of § 38.2-1046.

Drafting Note: The definition of "state" in Chapter 1 makes the deleted language "or territory" unnecessary. The term "creditors" has been changed to "general creditors" because § 38.2-1050 should agree with § 38.2-1046 on this point.

§ 38.2-1051. Authority to transfer to accompany certain deposits.—If any of the securities deposited under this title are registered bonds, the insurer shall at the same time deliver to the State Treasurer a power of attorney and a resolution of its board of directors authorizing him to transfer such bonds, or any part of them, for the purpose of paying any of the liabilities provided for in this title.

§ 38.2-1052. Exchange of securities.—A depositing insurer may from time to time exchange for any of the deposited securities other securities eligible for deposit under this article if in the opinion of the Commission the aggregate value of the deposit will not be reduced below the amount required by law.

§38.2-1053. Interest on deposits; to whom paid.—The State Treasurer, at the time of receiving any securities deposited under this title, shall give the insurer authority to collect the interest for its own use as

the interest is paid. This authority shall continue in force until the insurer fails to pay any of its liabilities for which the deposit is security. In that case, the party paying interest shall be notified of the failure, and thereafter the interest shall be payable to the State Treasurer, and shall be applied, if necessary, to the payment of the liabilities.

§ 38.2-1054. Duty of State Treasurer when securities deposited are paid.—When the principal of any securities deposited under this title is paid to the State Treasurer, the money received shall be paid to the insurer. However, if the securities were required to be deposited under § 38.2-1045, the payment shall not be made until the insurer deposits an equal amount of other securities of the character required for similar deposits. If the insurer fails to deliver to the State Treasurer, within thirty days after receiving notice of this requirement, the securities necessary to maintain its required deposit, the State Treasurer with the approval in writing of the Commission, may use the money to purchase and hold other securities of the required character.

§ 38.2-1055. Annual report of State Treasurer to Commission.—Each January the State Treasurer shall certify to the Commission the kind and face value of all securities, bonds, notes, mortgages or deeds of trust deposited under this title and held at the end of the preceding calendar year.

§ 38.2-1056. Treasurer to receipt for deposits; responsibility of Commonwealth; taxation of deposited bonds.—The State Treasurer shall provide receipts to the insurer for all securities deposited with him under the provisions of this title. The Commonwealth shall be responsible for the safekeeping of the securities. If some or all of the securities are lost, destroyed or misappropriated, the Commonwealth shall pay or satisfy the loss to the insurer making the deposit. Securities deposited with the State Treasurer shall not be subject to taxation.

38.2-1057. Assessment for expense of holding deposits.—For the purpose of defraying the expense of the State Treasurer's office in the safekeeping and handling of the securities or surety bonds deposited under the provisions of this title, the State Treasurer shall levy annually against each insurer an assessment of not more than one tenth of one percent of the par or face value of the securities or surety bonds deposited to its account. The assessment shall be collected every January. No part of the amount collected shall be used to increase the compensation of any person connected with the office of the State Treasurer. Whatever remains of the assessment after the payment of the expense described above shall be paid into the general fund of the state treasury.

§ 38.2-1058. Felony for State Treasurer to dispose of securities illegally.—If the State Treasurer disposes of any securities deposited with him under this title, other than as provided in this title, he shall be guilty of a Class 3 felony, and, upon conviction, shall be punished by a fine double the amount of the disposed securities.

CHAPTER 11.

Captive ~~Insurance Companies~~ Insurers.

1. The definitions of "association captive insurer" and "pure captive insurer" in proposed § 38.2-1101 have limited them to only insuring the risks of the members, or risks of the parent and related companies, respectively, so that members of the general public are not being insured by an insurer exempt from the guaranty association.

2. The mandatory examination of a captive insurer in paragraph 2 of subsection C of proposed § 38.2-1104 before a license is issued has been made discretionary.

3. Existing §§ 38.1-923 (Examination and investigations), 38.1-924 (Legal Investments), and 38.1-925 (Reinsurance) are being deleted because captive insurers are already subject to other parts of proposed Title 38.2 dealing with these matters.

4. Existing §§ 38.1-927 (Exemption from compulsory associations) and 38.1-929 (Rules and regulations of the Commission) are being deleted because proposed new sections or provisions elsewhere in proposed Title 38.2 will deal with these matters.

5. Proposed § 38.2-1108 has been rewritten to delete those provisions already in Title 58.1.

CHAPTER 11.

CAPTIVE INSURERS.

Drafting Note: Short titles are being deleted throughout the title.

§ 38.2-1100. Scope of chapter.– The provisions of this chapter shall apply solely to captive insurers or association captive insurers domiciled in this Commonwealth.

§ 38.2-1101. Definitions.–As used in this chapter:

Drafting Note: Unnecessary definitions have been deleted and other definitions made more concise.

"Affiliated company" means (i) any company that directly or indirectly owns, controls, or holds, with power to vote, ten percent or more of the outstanding voting securities of a pure captive insurer, or (ii) any company of which ten percent or more of the voting securities are directly or indirectly owned, controlled, or held, with power to vote, by a parent, subsidiary, or associated company.

"Associated company" means any company in the same corporate system with a pure captive insurer.

"Association captive insurer" means any domestic insurer transacting the business of insurance and reinsurance only on risks, hazards, and liabilities of the members of an insurance association.

"Captive insurer " means any pure captive insurer or any association captive insurer.

Drafting Note: The definitions of "association captive insurer" and "pure captive insurer" in proposed § 38.2-1101 have limited them to only insuring the risks of the members, or risks of the parent and related companies, respectively, so that members of the general public are not being insured by an insurer exempt from the guaranty association.

"Insurance association" means any group of individuals, corporations, partnerships, associations, or governmental units or agencies whose members collectively own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurer.

Drafting Note: The one-year requirement above has been moved to paragraph 2 of subsection B of proposed § 38.2-1102.

"Parent" means a corporation, partnership, governmental unit or agency, or individual who directly or indirectly owns, controls or holds, with power to vote, more than fifty percent of the outstanding voting securities of a pure captive insurer.

"Pure captive insurer " means any domestic insurer transacting the business of insurance and reinsurance only on risks, hazards, and liabilities of its parent, subsidiary companies of its parent, and associated and affiliated companies.

"Subsidiary company" means any corporation of which fifty percent or more of the outstanding voting securities are directly or indirectly owned, controlled, or held, with power to vote, by a parent or by a company that is a subsidiary of the parent.

§ 38.2-1102. Application for license; limitations on authority.–

Drafting Note: Existing subsection A is being merged into existing subsection C to form a new subsection A. The procedure for procuring and renewing the license has been made exactly the same as for any other insurer by appropriate cross references.

A. No captive insurer shall transact any insurance business in this Commonwealth unless (i) it is permitted to do so by its articles of incorporation or charter and (ii) it procures a license to transact the business of insurance from the Commission in accordance with Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title. The license shall be renewed in accordance with § 38.2-1025. A captive insurer may only be licensed to write the classes of insurance described in §§ 38.2-110 through 38.2-120, 38.2-124, 38.2-126 and reinsure in accordance with § 38.2-136.

B. 1. The Commission shall not issue a license to transact the business of insurance in this Commonwealth to any pure captive insurer until it is satisfied that the total insurance coverage necessary to insure all risks, hazards, and liabilities would develop, in the aggregate, gross annual premiums of at least $500,000.

2. The Commission shall not issue a license to transact the business of insurance in this Commonwealth to any association captive insurer until it is satisfied (i) that the total insurance coverage necessary to insure all risks, hazards, and liabilities would develop, in the aggregate, gross annual premiums of at least one million dollars and (ii) that its insurance association has been in existence for at least one year. The Commission may waive the requirement that the insurance association be in existence for at least one year if the association captive insurer satisfies the Commission that each member of the insurance association would have a gross annual premium in excess of $100,000.

Drafting Note: The one-year provision added to paragraph B.2 above came from the definition of "association" in existing § 38.1-917 (proposed § 38.2-1101).

Drafting Note: Existing subsection C has been moved to subsection A.

C. No captive insurer may write classes of personal insurance coverage for individuals unless the individual is a parent.

Drafting Note: The revision of proposed subsection C (existing subsection D) is editorial only, and no change in meaning is intended.

D. No captive insurer may write insurance or reinsurance on personally owned motor vehicles or homeowners' insurance or any component of them.

§ 38.2-1103. Name.—A captive insurer shall not adopt the name of any existing company transacting a similar business or any name so familiar that it may mislead the public.

§ 38.2-1104. Formation; licensure after examination; amendment of articles; principal and home office.—A. Captive insurers with shares of capital stock shall be incorporated under Article 2 (§ 13.1-618 et seq.) of Chapter 9 of Title 13.1 as modified by this title and, except as provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred upon such corporations by law.

B. Captive insurers without shares of capital stock shall be incorporated under Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, as modified by this title and, except as provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred upon such corporations by law.

C. 1. No charter shall be granted to any captive insurer until the Commission receives a certificate from the State Treasurer showing that (i) cash, bonds or other securities in the amount required by § 38.2-1105 have been deposited or (ii) an irrevocable letter of credit in that amount has been deposited and is to be held under the provisions, terms and conditions set forth in § 38.2-1105.

2. When the certificate has been presented to the Commission, the Commission may make or direct to be made an examination of the captive insurer.

Drafting Note: Paragraph C 2 above is being revised for consistency of language with proposed § 38.2-1317 and to make the examination discretionary on the part of the Commission.

3. The Commission shall issue a license if the captive insurer complies with this chapter.

D. Any amendment of the articles of incorporation of a captive insurer shall be pursuant to Article 11 (§ 13.1-705 et seq.) of Chapter 9 or of Article 10 (§ 13.1-884 et seq.) of Chapter 10 of Title 13.1.

E. The principal and home office of every captive insurer shall be in this Commonwealth.

Drafting Note: The phrase "incorporated under this Chapter" is unnecesary in light of the definitions in this chapter.

§ 38.2-1105. Deposit of minimum capital; letter of credit instead of deposit.—A. No captive insurer shall be issued a license to transact the business of insurance in this Commonwealth until it has met the requirements of Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title.

B. The captive insurer shall deposit with the State Treasurer cash, bonds, or securities equal to the minimum capital or, if a mutual insurer, fifty percent of the minimum surplus, as required by Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title. The State Treasurer shall accept an irrevocable letter of credit, in a form acceptable to the Commission, on behalf of a captive insurer instead of requiring the above-mentioned deposit. The letter of credit shall be issued by a national or state bank and approved by the Commission.

C. The deposit or letter of credit shall be held by the State Treasurer for the benefit of all policyholders and creditors wherever located and shall be administered as provided in Article 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

D. The State Treasurer shall furnish to the captive insurer a certificate certifying that the State Treasurer holds the securities or letters of credit in trust for the benefit of the policyholders and creditors of the captive insurer.

§ 38.2-1106. Minimum surplus in form of letter of credit.—A. Any licensed captive insurer may, subject to the approval of the Commission, hold all or a portion of (i) the minimum surplus as set forth in Article 5 (§ 38.2-1024 et seq.) of Chapter 10 in the form of an irrevocable letter of credit, if a stock insurer, or (ii) fifty percent of minimum surplus not subject to subsection B of § 38.2-1105, if a mutual insurer. The letter of credit shall be issued by a national or state bank and approved by the Commission.

B. Any letter of credit permitted pursuant to this section shall be held by the State Treasurer for the benefit of all policyholders and creditors and shall be administered as provided in Article 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

Drafting Note: There appears to be no need for examination authority beyond that contained in Article 3 of Chapter 4. so existing § 38.1-923 is being deleted.

Drafting Note: Captives are subject to the investment chapter of the Code and consequently this section is not needed. The exception in existing § 38.1-924 was needed when the investment of minimum capital and surplus was severely restricted. Under the change in investment laws effective July 1, 1983, the exception was no longer needed.

Drafting Note: Proposed § 38.2-1316 provides sufficient regulation of reinsurance by captive insurers, so existing § 38.1-925 is being deleted.

§ 38.2-1107. Membership in rating organizations.—No captive insurer shall be required to join a rating organization.

Drafting Note: The exemption from joining the property and casualty insurance guaranty association will be placed in proposed Chapter 16. The life, accident and sickness insurance guaranty association is not involved, as captives cannot write life or accident and sickness insurance.

§ 38.2-1108. Tax on premiums collected.—All captive insurers transacting business in this Commonwealth shall pay taxes as provided for in Chapter 25 (§ 58.1-2500 et seq.) of Title 58.1, except that taxes shall be paid on risks and property situated in any state in which the captive insurer is not licensed and upon which no premium tax is otherwise paid or payable.

Drafting Note: Proposed § 38.2-1108 has been rewritten to delete those provisions already in Title 58.1.

Drafting Note: Existing § 38.1-929 is being deleted in favor of a single regulation section at the beginning of the title.

§ 38.2-1109. Applicability of other provisions of title.—Except as otherwise provided, all laws of this title that apply to insurers writing the same classes of insurance that captive insurers are permitted to write, shall apply in every respect to captive insurers.

Drafting Note: The deleted phrase from the end of existing § 38.1-930 is unnecessary in light of the definitions in this chapter.

Title 38.2

CHAPTER 12.

Reciprocal Insurance.

Substantive changes made to Chapter 12 include the following:

1. In proposed § 38.2-1208, an alien reciprocal will be allowed to apply for a license in this Commonwealth directly from its domiciliary country rather than having to go through another state. This parallels a 1985 legislative change for regular alien insurance companies.

2. In proposed § 38.2-1212, the requirement that each assessable policy contain a statement of the contingent liability has been expanded to require that this statement be on the front of the policy in large type capital letters.

3. In proposed § 38.2-1216, the agent for service of process for reciprocals has been changed from the Secretary of the Commonwealth to the Clerk of the Commission.

4. In proposed § 38.2-1220, the bond of $25,000 required of the attorney-in-fact of a reciprocal has been changed to a bond in an amount set at the discretion of the Commission but not less than $50,000.

The following organizational changes have been made in Chapter 12:

1. Existing §§ 38.1-692 and 38.1-693 both deal with the power of persons, including corporations, to enter into reciprocal insurance contracts and so have been combined into proposed § 38.2-1204.

2. Proposed §§ 38.2-1223 and 38.2-1224 as currently worded only apply to domestic reciprocals and so have been moved to Article 2 (Domestic Reciprocals).

3. Existing §§ 38.1-702 and 38.1-716, dealing with assessments, both apparently apply to foreign and alien reciprocals as well as to domestic reciprocals, even though existing § 38.1-716 is in Article 2 (Domestic Reciprocals). These two sections overlap and appear to be partly contradictory. By merging these two sections into one and keeping existing § 38.1-702 (proposed § 38.2-1212) as the surviving section in Article 1 (General Provisions), any contradictions have been eliminated, and it will be clear that the proposed § 38.2-1212 does apply to foreign and alien reciprocals as well as to domestic reciprocals. Proposed § 38.2-1226 (existing § 38.1-714), also dealing with assessments, will remain in Article 2 and its text will be modified to make it clear that it applies only to domestic reciprocals. The additional requirements of proposed § 38.2-1226 for assessments do not appear contradictory to those of the proposed § 38.2-1212.

CHAPTER 12.

RECIPROCAL INSURANCE.

Article 1.

General Provisions.

§ 38.2-1200. Scope of chapter.– This chapter applies to all reciprocals and reciprocal insurance as defined in § 38.2-1201.

Drafting Note: The current Code uses both "reciprocal" and "reciprocal insurer." Only one term, "reciprocal," is being used throughout the chapter.

§ 38.2-1201. Definitions.–A. As used in this title :

Drafting Note: The existing sets of definitions are overlapping. The new proposed set of definitions is based on "reciprocal insurance" as the key term. "Subscriber" is defined using "reciprocal insurance"; "reciprocal" is defined using "subscriber"; and "attorney" is defined using "reciprocal insurance" and "subscriber." "Attorney" and "subscriber" are general terms given special meaning for this chapter, so their definitions are limited to this chapter. The reference in the existing definition of "subscriber" to being obligated "separately and severally" is covered by proposed § 38.2-1212.

"Reciprocal" means the aggregation of subscribers under a common name.

"Reciprocal insurance" means insurance resulting from the mutual exchange of insurance contracts among persons in an unincorporated association under a common name through an attorney-in-fact having authority to obligate each person both as insured and insurer.

B. As used in this chapter:

"Attorney" means the person designated and authorized by subscribers as the attorney-in-fact having authority to obligate them on reciprocal insurance contracts.

"Subscriber" means a person obligated under a reciprocal insurance agreement.

§ 38.2-1202. Insuring power of reciprocals.– A reciprocal licensed to transact the business of insurance in this Commonwealth may write the classes of insurance enumerated in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title, except life insurance, annuities, and title insurance.

Drafting Note: Proposed § 38.2-1203 makes the deleted introductory language unnecessary.

§ 38.2-1203. What laws applicable to reciprocals; compliance with § 38.2-208.–A. Except as otherwise provided, all the provisions of this title relating to insurers generally, and those relating to insurers writing the same classes of insurance that reciprocals are permitted to write, are applicable to reciprocals.

B. A reciprocal shall be deemed to have complied with § 38.2-208 if:

1. It issues policies containing a contingent assessment liability as provided for in § 38.2-1212 and;

2. It has and maintains reinsurance in an amount that the Commission considers adequate to reasonably limit the reciprocal's aggregate losses to the lesser of:

a. Ten percent of the surplus to policyholders of the reciprocal multiplied by the number of subscribers ;

b. The surplus to policyholders of the reciprocal multiplied by three; or

c. Five million dollars.

Drafting Note: Surplus has been clarified as surplus to policyholders, a term defined in Chapter 1.

§ 38.2-1204. Power to enter into reciprocal insurance contracts.–A. Persons of this Commonwealth may enter into reciprocal insurance contracts with each other and with persons of other states and countries.

B. For any corporation now existing or hereafter organized under the laws of this Commonwealth, the power and authority to enter into reciprocal insurance contracts shall be in addition to the powers conferred upon it in its certificate of incorporation, and shall be incidental to the purposes for which the corporation is organized.

Drafting Note: The definition of "person" in Chapter 1 is broad enough to cover the deleted language from the beginning of existing § 38.1-692.

Existing §§ 38.1-692 and 38.1-693 deal with the same subject and therefore are being combined.

Drafting Note: Relevant portions of existing § 38.1-693 have been moved to paragraph B of proposed § 38.2-1204.

§ 38.2-1205. Name.–Every reciprocal shall have and use a business name that includes the word "reciprocal," "interinsurer," "interinsurance," "exchange," "underwriters," or "underwriting."

§ 38.2-1206. License required of reciprocals; surplus.—A. No reciprocal shall engage in any insurance transaction in this Commonwealth until it has obtained a license to do so in accordance with the applicable provisions of Articles 5 (§ 38.2-1024 et seq.) and 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

B. No domestic or foreign reciprocal shall be licensed to transact the business of insurance in this Commonwealth unless it has a surplus to policyholders of at least $800,000, and no alien reciprocal shall be so licensed unless it has a trusteed surplus, as defined in § 38.2-1031, of at least $800,000.

Drafting Note: Surplus over and above all liabilities has been clarified as surplus to policyholders, a term defined in Chapter 1. Trusteed surplus has been cross-referenced to proposed § 38.2-1031 (existing § 38.1-95).

§ 38.2-1207. Exceptions as to reciprocals licensed and operating.—A. Notwithstanding other provisions of this chapter regarding minimum required surplus, any reciprocal that was licensed to write and was writing any class of insurance in this Commonwealth on June 30, 1977, may continue to write that class of insurance under the appropriate license from the Commission. The reciprocal shall maintain at all times the minimum surplus, and the minimum trusteed surplus if an alien reciprocal, required on June 30, 1977.

B. Before any reciprocal obtains a license to write in this Commonwealth any class of insurance that it was not writing and licensed to write in this Commonwealth on June 30, 1977, it shall comply with all the requirements of this article regarding surplus.

§ 38.2-1208. Additional requirements, foreign and alien reciprocals.—No foreign reciprocal shall be licensed to transact the business of insurance in this Commonwealth unless it has filed with the Commission a certificate of the supervising insurance official of the state in which it is organized. The certificate shall show that the foreign reciprocal is licensed to write and is writing actively in that state the class of insurance it proposes to write in this Commonwealth. No alien reciprocal shall be licensed to transact the business of insurance until it has filed with the Commission a certificate of the supervising insurance official of (i) the state through which it entered the United States or (ii) the alien reciprocal's domiciliary country. The certificate shall show that the alien reciprocal is licensed to write and is writing actively in that state or country the class of insurance it proposes to write in this Commonwealth.

Drafting Note: To parallel 1985 legislative changes, an alien reciprocal will be allowed to apply for a license in this Commonwealth directly from its domiciliary country rather than having to go through another state.

§ 38.2-1209. Residence and office of attorney of foreign and alien reciprocals.—Nothing in this title regarding the admission and licensing of foreign and alien insurers requires that the attorney of a foreign or alien reciprocal be resident or domiciled in this Commonwealth, or that the principal office of the attorney be maintained in this Commonwealth. The office or offices of the attorney shall be determined by the subscribers through the power of attorney.

§ 38.2-1210. Contracts executed by attorney.—Reciprocal insurance contracts shall be executed by the attorney of the reciprocal.

Drafting Note: The deleted language is contained in the definition of "attorney" in existing § 38.1-689 (proposed § 38.2-1201).

Drafting Note: Existing § 38.1-700 applies only to domestic reciprocals and so is being deleted here and moved to Article 2 (Domestic Reciprocals) as proposed in § 38.2-1223.

§ 38.2-1211. License required of agent.—No person shall act in this Commonwealth as an agent of a reciprocal in the solicitation or procurement of applications for insurance, subscriber's agreements and powers of attorney, or in the collection of premiums in connection with the reciprocal insurer, without first procuring a license from the Commission pursuant to the requirements in Chapter 18 of this title. An agent shall be appointed by each reciprocal the agent represents.

Drafting Note: 1. The change to "subscriber's" here and throughout the chapter when used with "agreement" or "agreements" is for consistency with existing § 38.1-700.

2. To conform with 1985 legislative changes, agents will be appointed rather than licensed with each reciprocal represented.

Drafting Note: Subsection B of existing § 38.1-700.1 is an outdated grandfather provision and is being deleted.

Drafting Note: Existing § 38.1-701 applies only to domestic reciprocals and so is being deleted here and moved to Article 2 (Domestic Reciprocals) as proposed in § 38.2-1224.

§ 38.2-1212. Subscribers' liability.—A. Each subscriber insured under an assessable policy shall have a contingent assessment liability for payment of actual losses and expenses incurred while his policy was in force. This shall be in the amount provided for in the power of attorney or subscriber's agreement.

Drafting Note: The individual and several liability provision deleted above has been moved to a new subsection C of this section.

B. The contingent assessment liability on any one policy in any one calendar year shall equal the premiums earned, as defined in § 38.2-1226, on the policy for that year multiplied by not less than one nor more than ten.

Drafting Note: In subsections B and D of proposed § 38.2-1212 and throughout the chapter, "contingent liability" is being changed to "contingent assessment liability" for consistency with subsection A of proposed § 38.2-1212.

C. The contingent assessment liability shall not be joint, but shall be individual and several.

D. Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent assessment liability on the front of the policy in capital letters in no less than ten point type.

Drafting Note: Existing § 38.1-716 has been merged into this section. The statement of contingent assessment liability currently required in the policy will now have to be on the front of the policy in large-type capital letters.

§ 38.2-1213. Nonassessable policies.—A. The Commission may issue a certificate authorizing the reciprocal to reduce or extinguish the contingent assessment liability of subscribers under its policies then in force in this Commonwealth, and to omit provisions imposing contingent assessment liability in all policies delivered or issued for delivery in this Commonwealth for as long as all such surplus to policyholders remains unimpaired. The certificate may be issued if (i) a reciprocal has surplus to policyholders of at least two million dollars, and (ii) an application of the attorney has been approved by the subscribers' advisory committee.

Drafting Note: "Surplus of assets over all liabilities" has been changed to "surplus to policyholders," a term defined in Chapter 1.

B. The Commission shall issue this certificate if it determines that the reciprocal's surplus to policyholders is reasonable in relation to the reciprocal's outstanding liabilities and adequate to meet its financial needs. In making that determination the following factors, among others, shall be considered:

1. The size of the reciprocal as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

2. The extent to which the reciprocal's business is diversified among different classes of insurance;

3. The number and size of risks insured in each class of insurance;

4. The extent of the geographical dispersion of the reciprocal's insured risks;

5. The nature and extent of the reciprocal's reinsurance program;

6. The quality, diversification, and liquidity of the reciprocal's investment portfolio;

7. The recent past and trend in the size of the reciprocal's surplus to policyholders;

8. The surplus to policyholders maintained by other comparable insurers; and

9. The adequacy of the reciprocal's reserves.

C. Upon impairment of the surplus to policyholders, the Commission shall revoke the certificate. After revocation, the reciprocal shall not issue or renew any policy without providing for the contingent assessment liability of subscribers.

D. The Commission shall not authorize a domestic reciprocal to extinguish the contingent assessment liability of any of its subscribers or in any of its policies to be issued, unless it has the required surplus to policyholders and extinguishes the contingent assessment liability of all of its subscribers and in all policies to be issued for all classes of insurance written by it. However, if required by the laws of another state in which the domestic reciprocal is transacting the business of insurance as a licensed insurer, it may issue policies providing for the contingent assessment liability of its subscribers acquiring policies in that state and need not extinguish the contingent assessment liability applicable to policies already in force in that state.

§ 38.2-1214. Savings returned to subscribers.—A reciprocal may return to its subscribers any savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks or policies, or between subscribers. However, the distribution may vary for classes of subscribers based upon the experience of those classes.

§ 38.2-1215. Reserves.—Each reciprocal shall maintain the same unearned premium and loss or claim reserves required for stock and mutual companies writing the same classes of insurance.

§ 38.2-1216. Clerk of Commission to be appointed agent for service of process; procedure thereafter.—A. Each attorney of a domestic reciprocal who files the declaration required by § 38.2-1219, and each attorney of a foreign or alien reciprocal who applies for a license to transact the business of insurance in this Commonwealth shall file with the Commission a written power of attorney executed in duplicate by the attorney appointing the clerk of the Commission as agent of the reciprocal. Upon the appointment, the clerk of the Commission (i) may be served all lawful process against or notice to such reciprocal, and (ii) shall be authorized to enter an appearance in behalf of the reciprocal. A copy of the power of attorney, duly certified by the Commission, shall be received in evidence in all courts of this Commonwealth. Any domestic, foreign or alien reciprocal that, on the effective date of this section, has appointed the Secretary of the Commonwealth as its agent for service of process shall comply with the requirements of this section within six months of the effective date of this section.

B. Whenever any such process or notice is served upon the clerk of the Commission, a copy of the process or notice shall be mailed to the attorney at the address shown on the power of attorney. Nothing in this section shall limit the right to serve any process or notice upon any reciprocal in any other manner permitted by law.

Drafting Note: The change of the agent for service of process from the Secretary of the Commonwealth to the clerk of the Commission is for consistency with proposed §§ 38.2-801 and 38.2-809 and existing §§ 13.1-758 and 13.1-766.

§ 38.2-1217. Reciprocal may be sued as such; where action or suit may be brought; upon whom service of process had.—A. Any reciprocal doing business in this Commonwealth may sue or be sued in the name or designation under which its insurance contracts are effected.

B. Any action or suit against a reciprocal may be brought in any county or city (i) where its principal office is located, or (ii) where the cause of action or any part of the cause of action arose. If the action or suit is to recover a loss under a policy of insurance, it may also be brought in the county or city where the property insured was situated at the date of the policy. Any action or suit against a foreign or alien reciprocal may also be brought in any county or city of this Commonwealth in which it has any debts owed to it.

C. In an action or suit against a reciprocal, process against or notice to the reciprocal may be served upon the clerk of the Commission. If the defendant in the action or suit is a domestic reciprocal, process against or notice to that domestic reciprocal shall be served upon the attorney for that domestic reciprocal unless service upon that attorney is not feasible.

Drafting Note: See drafting note for proposed § 38.2-1216.

§ 38.2-1218. Effect of judgment against reciprocal.—Any judgment against a reciprocal based upon legal process duly served as provided in this chapter shall be binding upon the reciprocal and upon each of the reciprocal's subscribers as their respective interests may appear, in an amount not exceeding their respective contingent assessment liabilities.

Article 2.

Domestic Reciprocals.

§ 38.2-1219. Organization of reciprocals; what declaration to contain.—A. Twenty-five or more persons domiciled in this Commonwealth and designated as subscribers may organize a domestic reciprocal and apply to the Commission for a license to transact the business of insurance. The original subscribers and the proposed attorney shall execute and file with the Commission a declaration setting forth:

1. The name of the attorney, and the name of the reciprocal;

2. The location of the reciprocal's principal office, which shall be the same as that of the attorney, and shall be in this Commonwealth;

3. The classes of insurance proposed to be written;

4. The names and addresses of the original subscribers;

5. The designation and appointment of the attorney, and a copy of the power of attorney and subscriber's agreement;

6. The names and addresses of the officers and directors of the attorney if a corporation, or of its members if not a corporation;

7. The powers of the subscribers' advisory committee, and the names and terms of office of its members;

8. A statement that each of the original subscribers has in good faith applied for insurance of the class proposed to be written and that the reciprocal has received from each original subscriber the anticipated premium or premium deposit for a term of not less than six months for the policy for which application is made;

Drafting Note: The change to "anticipated" premiums eliminates the problem of how to recognize and approve a filing of an entity not yet licensed.

9. A statement of the financial condition of the reciprocal including a schedule of its assets ;

10. A statement that the reciprocal has the surplus to policyholders required by § 38.2-1206; and

11. A copy of each policy, endorsement and application form it proposes to issue or use.

B. The declaration shall be acknowledged by each original subscriber and by the attorney in the manner required for the acknowledgment of deeds in § 55-113.

Drafting Note: The Code section for the acknowledgment of deeds has been added to the declaration acknowledgment provision.

§ 38.2-1220. Attorney to file bond.—A. Concurrent with the filing of the declaration provided for in § 38.2-1219, the attorney of a domestic reciprocal shall file with the Commission a bond payable to this Commonwealth. The bond shall be executed by the attorney and by a fidelity insurer licensed in this

Commonwealth and shall be subject to the approval of the Commission.

B. The bond shall be in an amount established at the discretion of the Commission, which shall be at least $50,000. The bond shall be on the condition that the attorney will faithfully account for all moneys and other property of the reciprocal coming into the attorney's control and that the attorney will not withdraw or appropriate for his own use from the funds of the reciprocal any moneys or property to which he is not entitled under the power of attorney.

Drafting Note: The change to subsection B of proposed § 38.2-1220 gives the Commission discretion in setting the amount of the bond on the attorney of a reciprocal. The minimum of $50,000 recognizes inflation since the existing, fixed amount of $25,000 was set.

C. The bond shall provide that it is not subject to cancellation unless thirty days' written notice of intent to cancel is given to both the attorney and the Commission.

§ 38.2-1221. Deposit instead of bond.—Instead of filing the bond required by § 38.2-1220, the attorney may maintain on deposit with the State Treasurer an equal amount in cash or in value of securities of the kind specified in § 38.2-1045, subject to the same conditions as the bond.

§ 38.2-1222. Subscribers' advisory committee.—The advisory committee exercising the subscribers' rights in a domestic reciprocal shall be selected under rules adopted by the subscribers. At least three-fourths of the committee shall be composed of subscribers other than the attorney or any person employed by, representing, or having a financial interest in the attorney. The committee shall supervise the finances of the reciprocal and the reciprocal's operations to the extent required to assure their conformity with the subscriber's agreement and power of attorney and shall exercise any other powers conferred on it by the subscriber's agreement.

§ 38.2-1223. Subscriber's agreement and power of attorney.—A. Every subscriber of a domestic reciprocal shall execute a subscriber's agreement and power of attorney setting forth the rights, privileges and obligations of the subscriber as an underwriter and as a policyholder, and the powers and duties of the attorney. The subscriber's agreement and power of attorney shall contain in substance the following provisions:

1. A designation and appointment of the attorney to act for and bind the subscriber in all transactions relating to or arising out of the operations of the reciprocal;

2. A provision empowering the attorney (i) to accept service of process on behalf of the reciprocal and (ii) to appoint the clerk of the Commission agent of the reciprocal upon whom may be served all lawful process against or notice to the reciprocal;

Drafting Note: See drafting note for proposed § 38.2-1216.

3. Except for nonassessable policies, a provision for a contingent assessment liability of each subscriber in a specified amount in accordance with § 38.2-1212; and

4. The maximum amount to be deducted from advance premiums or deposits to be paid the attorney, and the items of expense, in addition to losses, to be paid by the reciprocal.

B. The subscriber's agreement may:

1. Provide for the right of substitution of the attorney and revocation of the power of attorney ;

2. Impose any restrictions upon the exercise of the power agreed upon by the subscribers;

3. Provide for the exercise of any right reserved to the subscribers directly or through an advisory committee; or

4. Contain other lawful provisions considered advisable.

Drafting Note: Proposed § 38.2-1223 above is existing § 38.1-700, and proposed § 38.2-1224 below is existing § 38.1-701. These two sections are being renumbered to place them in Article 2 (Domestic Reciprocals) because they apply only to domestic reciprocals.

§ 38.2-1224. Modification of power of attorney and subscriber's agreement.—Modification of the terms of the power of attorney and subscriber's agreement of a domestic reciprocal shall be made jointly by the attorney and the subscribers' advisory committee. No modification shall be effective retroactively, nor shall it affect any insurance contract issued prior to the modification.

§ 38.2-1225. Contributions.—The attorney or other interested persons may advance to a domestic reciprocal any funds required in its operations. The funds advanced shall not be treated as a liability of the reciprocal and shall not be withdrawn or repaid except out of the reciprocal's earned surplus in excess of its minimum required surplus.

Drafting Note: The term "realized earned surplus" is being changed to "earned surplus" for consistency with other provisions.

§ 38.2-1226. Assessments.—A. Assessments may be levied upon the subscribers of a domestic reciprocal by the attorney in accordance with § 38.2-1212. The assessments shall be approved in advance by the subscribers' advisory committee and the Commission.

Drafting Note: The authority of a receiver in liquidation is contained in Chapter 15, so there is no

need to grant the receiver any authority in proposed § 38.2-1226.

B. Each domestic reciprocal subscriber's share of a deficiency for which an assessment is made shall be computed by multiplying the premiums earned on the subscriber's policies during the period to be covered by the assessment by the ratio of the total deficiency to the total premiums earned during the period upon all policies subject to the assessment. However, no assessment shall exceed the aggregate contingent assessment liability computed in accordance with § 38.2-1212. For the purposes of this section, the premiums earned on the subscriber's policies are the gross premiums charged by the reciprocal for the policies minus any charges not recurring upon the renewal or extension of the policies. No subscriber shall have an offset against any assessment for which he is liable on account of any claim for unearned premium or losses payable.

§ 38.2-1227. Time limit for assessment.--Every subscriber of a domestic reciprocal having contingent assessment liability shall be liable for and shall pay his share of any assessment computed in accordance with this article if, while the policy is in force or within one year after its termination, the subscriber is notified (i) by the attorney of his intention to levy the assessment or (ii) that delinquency proceedings have been commenced against the reciprocal under the provisions of Chapter 15 of this title, and the Commission or receiver intends to levy an assessment.

Drafting Note: Existing § 38.1-716 has been merged into proposed § 38.2-1212.

§ 38.2-1228. Subscribers' share in assets.--Upon the liquidation of a domestic reciprocal, the assets remaining after discharge of its (i) indebtedness and policy obligations, (ii) the return of any contributions of the attorney or other person made as provided in § 38.2-1225, and (iii) the return of any unused deposits, savings or credits, shall be distributed. The distribution shall be according to a formula approved by the Commission or the court to the persons who were its subscribers within the twelve months prior to the final termination of its license.

Title 38.2

CHAPTER 13.

Reports, Reserves and Examinations; Insurance Holding Companies.

1. Proposed § 38.2-1304 is being amended so that filing false or fraudulent statements, reports or other instruments shall be a Class Five felony rather than such actions being deemed perjury.

2. Subsection C of proposed § 38.2-1308 has been added to set forth three valuation options that can be used for estimating the value of certain assets. These methods are book value, market value and acquisition cost. Additionally, the Commission is given the authority to specify the manner of valuing a subsidiary if a situation warrants such intervention.

3. Proposed § 38.2-1312 has been changed to require mortgage guaranty insurance unearned premium reserves to be calculated in a manner similar to other property and casualty unearned premium reserves.

4. Subsection C of proposed § 38.2-1315 has been changed to conform with the NAIC standard. Previously, mortgage guaranty insurers could utilize contingency reserves when the loss ratio exceeded 20%. This loss ratio has been increased to 35%.

5. Subsection C of proposed § 38.2-1319 has been added to allow the Commission to employ experts, at the expense of the person examined, to perform accounting services when the Commission deems that the person's accounting is unacceptable.

6. In proposed § 38.2-1322 the definition of an "insurance holding company system" has been broadened to be similar to the NAIC model.

7. Subsection E of proposed § 38.2-1329 has been amended to parallel more closely the NAIC model.

8. In proposed § 38.2-1331 prior approval will be required for investments resulting in holdings of assets in affiliated holding companies in excess of fifty percent of surplus. This requirement is from the NAIC model.

CHAPTER 13.

REPORTS, RESERVES AND EXAMINATIONS,

INSURANCE HOLDING COMPANIES.

Article 1.

Annual Statements and Other Reports.

§ 38.2-1300 Annual statements.—A. Each insurer licensed to transact the business of insurance in this Commonwealth shall file with the Commission annually, on or before March 1, an annual statement showing its financial condition on December 31 of the previous year. The annual statement shall be considered filed on the date the statement was sent by mail as shown by the postmark. The annual statement shall contain a detailed report of the insurer's assets and liabilities, the investment of its assets, its income and disbursements during the previous year, and all other information which the Commission considers necessary to secure a full and accurate knowledge of the affairs and condition of the insurer. The annual statement of every domestic or foreign insurer shall be verified by at least two of its principal officers. No publication of the annual statement shall be required.

B. The annual statement of an alien insurer shall relate only to its transactions and affairs in the United States unless the Commission requires otherwise. The annual statement shall be verified by the alien insurer's United States manager, assistant manager or by any of its duly authorized officers.

C. The Commission may prescribe the form of the annual statement and supplemental schedules and exhibits, and may vary the form for different types of insurers. However, as far as practicable, the form for annual statements, supplementary schedules, and exhibits shall be the same as other such forms in general use in the United States.

§ 38.2-1301. Additional reports.—In addition to the annual statement, the Commission may require a licensed insurer to file additional reports, exhibits or statements considered necessary to secure complete information concerning the condition, solvency, experience, transactions or affairs of the insurer. The Commission shall establish deadlines for filing these additional reports, exhibits or statements and may require verification by any officers of the insurer designated by the Commission.

§ 38.2-1302. Extension of filing time .—The Commission may extend an insurer's deadline for filing annual statements, other reports or exhibits provided the deadline for annual statements is not extended beyond April 30.

Drafting Note: The penalty provision has been deleted in accordance with the approach of having one general penalty section in Chapter 2. The requirement of a newspaper publication has been deleted as unnecessary.

§ 38.2-1303. Printed forms to be furnished insurers; certificates to domestic insurers.—A. The Commission shall be responsible for preparing and distributing printed forms or blanks to each licensed insurer for all statements, reports, schedules or exhibits required by law or order.

B. The Commission shall furnish without charge to domestic insurers any certificates required to entitle them to do business in other states or countries.

§ 38.2-1304. False statements, reports, etc., deemed a Class 5 felony.—Any officer, manager, attorney, agent or employee of any insurer or surplus lines broker who is responsible for making or filing any annual or other statement, report, exhibit or other instrument required by this title and who knowingly or willfully makes or files any false or fraudulent statement, report or other instrument shall be charged with a Class 5 felony. If convicted, such person shall be guilty of a Class 5 felony.

Drafting Note: In the event of conviction, punishment will be that designated for a Class 5 felony.

§ 38.2-1305. Voluntary reports .—Any insurer may elect to file with the Commission, in addition to the annual statement required by § 38.2-1300, a statement in condensed form of its financial condition as of the end of any calendar year or as of any other date. Any statement shall be verified by at least two of the principal officers of the insurer. No insurer nor anyone on its behalf shall publish in any manner in this Commonwealth a statement purporting to show its financial condition if that statement does not correspond in substance with the verified statement last filed with the Commission by the insurer pursuant to §§ 38.2-1300, 38.2-1301, or this section.

Drafting Note: The penalty provision has been deleted in accordance with the approach of having one general penalty section in Chapter 2.

§ 38.2-1306. Reports to be open to public inspection.—The Commission shall keep on file for at least three years all reports required by law and all special reports required by it to be filed by insurers. The Commission shall keep the reports available for inspection by interested persons at any reasonable time.

Drafting Note: The three year standard has been added to make it clear that reports do not have to be kept in the Commission's office indefinitely. It is anticipated that the domestic companies' reports would not be destroyed after three years, but would be shipped to storage.

Drafting Note: Section 38.1-165.1 has been moved to § 38.2-1810 (Insurance Agents Chapter).

Article 2.

Valuation of Securities.

Drafting Note: Existing article 2 has been divided into two new articles, one on valuation and one on reserves.

§ 38.2-1307. Valuation of bonds.—All bonds or other evidences of indebtedness having a fixed term and rate of interest and held by any insurer licensed to transact business in this Commonwealth, if amply secured and not in default as to principal or interest, may be valued as follows:

1. If purchased at par, at the par value; or

2. If purchased above or below par, (i) on the basis of the purchase price adjusted so as to bring the value to par at the maturity date or the first callable date at par, whichever is earlier, in order to annually yield the effective rate of interest at which the purchase was made or, (ii) at the discretion of the Commission, on the basis of the method commonly known as the pro rata or straight line method.

In applying this rule, the purchase price shall not be taken at a higher amount than the actual market value at the time of acquisition.

All bonds or other evidences of indebtedness that in the judgment of the Commission are not amply secured or that are in default as to principal or interest shall be valued as provided in § 38.2-1308.

§ 38.2-1308. Valuation of stocks and other securities.—A. All stocks, except as otherwise provided in this section, and all bonds or other evidences of indebtedness, except as provided in § 38.2-1307, owned by an insurer licensed to transact business in this Commonwealth, shall be valued at an amount not to exceed their market value as determined by current sales or stock market quotations, or at an amount not to exceed prices determined by the Commission as representing their fair market value.

B. If paying full dividends and at the discretion of the Commission, preferred or guaranteed stocks may be carried at a fixed value instead of market value or in accordance with any method of valuation the Commission approves.

Drafting Note: The shifting of the "full dividend" language to the beginning of the sentence is to make it clear that this language applies to both preferred and guaranteed stocks.

C. The stock of a subsidiary of an insurer shall be valued, at the discretion of the insurer, at not more than book value, market value, or acquisition cost. Market value may be used only if the stock of the subsidiary company is listed on a national securities exchange or entered in the NASDAQ system. For other than market valuation the value of the stock shall include only the assets that would constitute admitted assets of the insurer if held directly by the insurer. The Commission, upon notice and informal hearing, can specify the manner in which the stock of a subsidiary will be valued.

Drafting Note: The last paragraph (proposed subsection C) is a revision of the deleted paragraph immediately preceding it. This revision provides for three methods of valuing a subsidiary, with the insurer having the discretion to decide which one to use. Additionally, the Commission is given the flexibility to specify the manner of valuation of a subsidiary after notice and informal hearing if the situation warrants intervention.

§ 38.2-1309 Valuation of real estate, leaseholds, and purchase money mortgages.—A. In the absence of a recent appraisal which the Commission considers reliable, real estate acquired by foreclosure or by deed instead of foreclosure by any insurer licensed to transact business in this Commonwealth shall be valued at an amount not to exceed the acquisition cost. This amount shall not be greater than the sum of (i) the unpaid principal of the defaulted loan at the date of the foreclosure or deed, (ii) any taxes and expenses paid or incurred at the time of and in connection with the acquisition, excluding any unpaid interest on the defaulted loan, (iii) the cost of additions or improvements made after acquisition, and (iv) any amounts paid after acquistion on any assessments levied for improvements in connection with the property.

B. Any real estate referred to in subsection A of this section that is subject to a contract of sale shall be valued in an amount not exceeding the lesser of the acquisition cost or the contract sale price decreased in either case by any amounts paid under the contract.

C. The value of the real estate or any interest in the real estate acquired or held as an investment for the production of income or acquired to be improved and developed for investment purposes according to a development plan shall be adjusted by an amount that includes a write-down of that part of the insurer's cost of its interest in the property which is allocable to any improvements. The write-down will be at a rate that will average not less than two percent annually of the cost for each year or fraction of that year that the property has been held.

D. Any leasehold shall be valued at not more than the cost of its acquisition and its improvement and shall be amortized within a period not exceeding the lesser of (i) eight-tenths of the unexpired term of the leasehold following the acquisition or improvement, or (ii) within a period of forty years thereafter.

E. Real estate held by an insurer for which no method of valuation has been provided in this section

shall not be valued in excess of the fair market value determined by appraisals the Commission considers reliable.

F. Purchase money mortgages shall be valued at an amount not exceeding the lesser of (i) the acquisition cost of the real estate encumbered by the mortgage or (ii) ninety percent of the fair market value of the real estate.

Drafting Note: Proposed subsection D is being changed to make it clear that it is a valuation provision.

§ 38.2-1310. Valuation of other investments.—All investments of insurers licensed to transact business in this Commonwealth, for which no method of valuation has been provided in this article shall be valued at the discretion of the Commission (i) at their market value, (ii) at their appraised value, or (iii) at amounts determined by the Commission as representing their fair market value.

Article 3.

Reserves.

§ 38.2-1311. Valuation reserves.—A. Every insurer licensed to transact the kinds of insurance specified in §§ 38.2-102, 38.2-106 and 38.2-109 and subject to the applicable provisions of this title, shall maintain:

1. Reserves on all of its life insurance policies or certificates and annuity contracts in force, computed according to the applicable tables of mortality and interest rates prescribed in this title ;

2. Reserves for both reported and unreported (i) disability benefits, including reserves for disabled lives, and (ii) accidental death benefits; and

3. Any additional reserves prescribed by the Commission as necessary on account of the insurer's policies, certificates and contracts.

B. For all accident and sickness insurance policies the insurer shall maintain an active life reserve that shall (i) place a reasonable value on its liabilities under the policies, (ii) be not less than the reserve according to appropriate standards set forth in any regulations issued by the Commission and, (iii) be not less in the aggregate than the pro rata gross unearned premiums for those policies.

§ 38.2-1312. Unearned premium reserves.—A. Except for risks or policies for which reserves are required under §§ 38.2-1311 and 38.2-4610 through 38.2-4612, each insurer licensed to transact business in this Commonwealth, subject to the applicable provisions of this title, shall maintain reserves equal to the unearned portions of the gross premiums charged on unexpired or unterminated risks and policies.

B. Premiums charged for bulk assumption reinsurance assumed from other insurers shall be included in gross premiums charged on the basis of the original premiums and the original terms of the policies of the ceding insurer.

C. No deduction shall be made from the gross unearned premiums except for premiums paid or credited for risks reinsured as provided in § 38.2-1316.

D. The reserve for unearned premiums shall be computed, at the insurer's option, on the annual, monthly or daily pro rata fraction basis. However, the Commission, at its discretion, may (i) prescribe the basis to be used, (ii) require that the reserve be computed on each respective risk from the date of issuance of the policy, or (iii) prescribe special rules for computing the reserve for premiums covering indefinite terms. For marine insurance, premiums on unterminated trip risks shall be considered unearned, and the reserve to be carried on unterminated risks at the end of any month shall equal 100 percent of the premiums on trip risks written during the month unless the Commission prescribes otherwise. The reserve for premium deposits on perpetual fire insurance risks shall equal not less than ninety percent of the gross amount of those deposits.

Drafting Note: In D (ii), "if necessary" has been deleted because it conflicted with "at its discretion" in the same sentence. The exception for mortgage guaranty insurance (§ 38.2-1315(a)) has been deleted, resulting in mortgage guaranty insurance unearned premium reserves being calculated like other unearned premium reserves under § 38.2-1312. The difference between the calculation of unearned premium reserve for mortgage guaranty insurance companies in existing § 38.2-1315(a), and the general property and casualty unearned premium reserve calculation in § 38.2-1312 is that the general property and casualty provision allows pro rata calculations based on daily, monthly or annual intervals while § 38.2-1315 sets forth mortgage guaranty insurance pro rata calculations only on a monthly basis.

Drafting Note: Existing § 38.1-171.1 is being renumbered as proposed § 38.2-1316, which will move it to the end of the article. It is more appropriate to deal with reinsurance credit for reserves after the various kinds of reserves have been specified.

§ 38.2-1313. Loss records.— Each insurer licensed to transact business in this Commonwealth shall, except for accident and sickness insurance as defined in § 38.2-109, maintain a complete and itemized record showing all losses and claims for which notice has been given. When necessary, the insurers shall maintain a record of all notices received of the occurrence of any event that may result in a loss.

Drafting Note: The exception for life and annuities has been deleted but the exception for accident and sickness remains.

§ 38.2-1314. Loss or claim reserves.– Except as provided in §§ 38.2-1311 and 38.2-4609, each insurer licensed to transact the business of insurance in this Commonwealth shall maintain reserves:

1. In an amount estimated in the aggregate as being sufficient to provide for reported and unreported unpaid losses or claims arising on or prior to the date of any annual or other statement for which the insurer may be liable;

2. In an amount estimated to provide for loss adjustment expenses ; and

3. For those classes of insurance specified by the Commission, any additional reserves for unpaid losses as required by the Commission. Each insurer authorized to write these classes of insurance shall file with its annual statement, schedules of its experience for such insurance in the form the Commission requires and shall calculate the reserves required by this paragraph in the manner prescribed by the Commission.

Drafting Note: This paragraph has been revised to state more clearly the requirement for a special additional reserve (shown in Schedule P of the annual statement) required for certain classes of insurance. The designation of the classes of insurance subject to this requirement has been left to the Commission as they may change from time to time. See the drafting note for paragraph 1 a of subsection B of § 38.2-1316 in regard to deletion of the paragraph below.

Drafting Note: See drafting note for § 38.2-1315.

§ 38.2-1315. Mortgage guaranty insurance contingency reserve.–A. To protect against the effect of adverse economic cycles, each insurer transacting the business of mortgage guaranty insurance in this Commonwealth shall establish and maintain a contingency reserve equal to fifty percent of its earned premium.

B. Allocations to the contingency reserve shall be maintained for 120 months. That portion of the contingency reserve that has been maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve and shall be allocated to surplus to policyholders.

C. Subject to the approval of the Commission, the contingency reserve shall be available for loss payments only when the incurred losses in any one year exceed thirty-five percent of the corresponding earned premium.

D. In the event of release of the contingency reserve for payment of losses, the contributions required by subsection A of this section shall be treated on a first-in-first-out basis.

E. Whenever the laws of any other state require a greater unearned premium reserve than that set forth in § 38.2-1312, the mortgage guaranty insurance contingency reserve of mortgage guaranty insurers organized under the laws of that state may be an amount that, when added to such unearned premium reserve, will result in a reserve equal to the sum of the unearned premium reserve required by § 38.2-1312 and the contingency reserve required by this section.

F. The authority of the Commission under § 38.2-223 to issue rules and regulations includes the authority to require that a greater reserve be established for mortgage guaranty insurance on liens other than first liens.

Drafting Note: Existing §§ 38.1-173.1 and 38.1-173.2, which address three types of reserves, have been combined into a new expanded § 38.2-1315.

Existing § 38.1-173.1(b), which sets forth the basic requirement of contingency reserves, has been combined with the relevant provisions of proposed § 38.2-1315, which deals with the disposition of such reserves. Existing § 38.1-173.1(c), the calculation of loss reserves by the case method for mortgage guaranty insurance companies, has been deleted as it is not significantly different from proposed § 38.2-1314, which requires for reserves to be developed by rules prescribed by the Commission.

The NAIC standard of releasing contingency reserves when losses exceed 35% of premiums (instead of 20%) has been adopted.

Subsection E of § 38.2-1315 (existing subsection (d)) has been reworded, including deleting the language at the end implying that only "insurers organized under the laws of Virginia" are subject to the Virginia contingency reserve requirement.

Proposed subsection F of § 38.1-1315 is taken from the latter part of existing § 38.1-173.1(b). This provision is being retained in addition to the general rules and regulations section because the authority to require more than a statutory standard is a special regulation authority.

§ 38.2-1316. When credit allowed for reinsurance; what reinsurance agreement may provide; effect on reserves.–A.1. In computing valuation reserves required by § 38.2-1311, unearned premium reserves required by §§ 38.2-1312 or 38.2-4610 through 38.2-4612, or loss or claim reserves required by §§ 38.2-1314 or 38.2-4609, credit shall be allowed as an admitted asset or as a deduction from liability to any ceding insurer for reinsurance made, ceded, renewed, or otherwise becoming effective if the reinsurance:

a. Is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer;

b. Is payable directly to the ceding insurer or to its domiciliary liquidator or receiver except (i) where the contract specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer and (ii) where the assuming insurer with the consent of the direct insured has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the obligations of the ceding insurer to the payees; and

c. Is effected by the ceding insurer with assuming insurers licensed in this Commonwealth or any other state and meeting standards of solvency at least equal to those required in this Commonwealth.

Drafting Note: The first part of the language being deleted in the introductory part of subsection B below is being placed in the new paragraph 1 c of subsection A. above as a more appropriate place. The language "of the United States or the District of Columbia" in subsection B below has not been used in new paragraph 1 c of subsection A. above because "state" is defined in Chapter 1 to include "any state, territory, district or insular possession of the United States".

2. The reinsurance agreement for which credit is allowed under paragraph 1 of this subsection shall provide that the receiver, liquidator or statutory successor of an insolvent ceding insurer shall give written notice to the assuming insurer of any impending claim on the policy or bond reinsured. This notice shall be given within a reasonable time after the claim is filed in the insolvency proceeding. While waiting for the settlement of the claim, any assuming insurer at its own expense may investigate the claim and interpose in the proceeding in which the claim is to be adjudicated, any defense it considers available to the ceding insurer or its receiver, liquidator or statutory successor. The expense incurred by the assuming insurer shall be chargeable, subject to the approval of the court, against the insolvent ceding insurer as part of the expense of liquidation. The expense shall be chargeable to the extent of the proportionate share of any benefit that accrues to the ceding insurer solely as a result of the defense undertaken by the assuming insurer.

3. Where two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to the claim, the expense shall be apportioned according to the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer.

B. For the purpose of determining the financial condition of a ceding insurer, the ceding insurer shall receive credit for any reinsurance for which credit is allowed under subsection A of this section, calculated as follows:

Drafting Note: 1. No reserve is subject to more than one of the sections referred to in paragraph 1 of subsection A above, so they should be connected by "or", not "and".

2. The reference to existing § 38.1-173 has been deleted because new paragraph 1. b. of subsection B below covers the provision in the last paragraph of § 38.1-173 being referred to. That paragraph in § 38.1-173 has been deleted.

1. For reinsurance of the whole or any part of any risk other than those risks specified in paragraph 2 of this subsection, the ceding insurer shall receive credit for the reinsurance by way of deduction from its:

a. Unearned premium liability specified in §§ 38.2-1312, 38.2-1315 or 38.2-4610 through 38.2-4612, as the case may be, and

Drafting Note: In paragraph 1.a. of subsection B the reference to paragraph (a) of existing § 38.1-173.1 has been deleted to be consistent with the deletion of the same paragraph in § 38.2-1312.

b. Loss and expense reserve liability specified in §§ 38.2-1314 or 38.2-1629, as the case may be, except in the case of reinsurance covering a loss paid by the ceding insurer for which payment is owed but has not been made by the assuming insurer, the ceding insurer shall receive credit as an admitted asset for the amount owed by the assuming insurer until the payment is made.

Drafting Note: Paragraph 1.b. of subsection B has been added to make explicit in the law how insurers are currently receiving credit for reinsurance as an admitted asset.

Reinsurance ceded to an assuming insurer may be deducted on the basis of original premiums and original terms except that excess loss or catastrophe reinsurance may be deducted only on the basis of actual reinsurance premiums and actual reinsurance terms.

2. For reinsurance of the whole or any part of any life insurance, annuity or accident and sickness insurance risk, the ceding insurer shall receive credit by way of deduction from its reserve liability, specified in § 38.2-1311. The credit shall not exceed the amount which the ceding insurer would have reserved on the reinsured portion of the risk if there had been no reinsurance.

Drafting Note: Paragraph 2 of subsection B has been changed by adding the reference to § 38.2-1311 to be consistent with referring to the appropriate reserve sections in paragraph 1 of subsection B.

C. The Commission may prescribe the conditions under which a ceding insurer may be allowed credit for reinsurance recoverable from an insurer not licensed in this Commonwealth. Such credit may be allowed as an asset or as a deduction from valuation reserves, loss reserves, loss expense reserves and unearned premium reserves.

D. For the purpose of determining the financial condition of any reinsurer, the reinsurer shall establish a reserve liability at least equal to the amount that it would be required to maintain in accordance with this title if it were the direct insurer of the assumed risks as specified in the reinsurance agreement. The reinsurer shall establish unearned premium liability equal to the amount of the deduction specified in paragraph 1 of subsection B of this section.

Article 4.

Examinations.

§ 38.2-1317. Examinations; when authorized or required.—A. Whenever the Commission considers it expedient for the protection of the interests of the people of this Commonwealth, it may make or direct to be made an examination into the affairs of any person licensed to transact any insurance business in this Commonwealth or any other person licensed under this title. The Commission may also make or direct to be made, whenever necessary or advisable an examination into the affairs of (i) any person having a contract under which he has the exclusive or dominant right to manage or control any licensed insurer, (ii) any person holding the shares of capital stock or policyholder proxies of any domestic insurer amounting to control as defined in § 38.2-1322 either as voting trustee or otherwise or (iii) any person engaged or assisting in, or proposing or claiming to engage or assist in the promotion or formation of a domestic insurer.

Drafting Note: The authority of the Commission to examine non-insurers has been clarified.

B. The Commission shall examine or cause to be examined every domestic insurer at least once in every five years.

C. The examination of any foreign or alien insurer or any other foreign or alien organization subject to examination shall be made to the extent practicable in cooperation with the insurance departments of other states. The examination of any alien insurer shall be limited to its insurance transactions in the United States unless the Commission considers a complete examination of the insurer to be necessary.

D. Instead of making its own examination, the Commission may accept a full report of the examination of a foreign or alien person, duly authenticated by the insurance supervisory official of the state of domicile or of entry.

§ 38.2-1318. Examinations; how conducted.—A. Whenever the Commission examines the affairs of any person, as set forth in § 38.2-1317, it may appoint as examiners one or more competent persons not connected with any insurer or other person examined in any manner other than as policyholders. To the extent practicable, the examiners shall be regular employees of the Commission.

B. The person examined shall provide the examiners convenient access at all reasonable hours to its books, records, files, securities and other documents or those of any person, including any affiliates or subsidiaries of the person examined, that are relevant to the examination. The examiners shall have the power to administer oaths and to examine under oath any director, officer, employee or agent of the persons regarding any matter relevant to the examination.

C. In connection with any examination, the Commission may appoint one or more competent persons as appraisers with authority to appraise the real property of the person examined, or any real property on which it holds security.

Drafting Note: The broad definition of "person" in Chapter 1 means it is sufficient to use it in this section and in §§ 38.2-1319, 38.2-1320, and 38.2-1321 to include corporations, partnerships, etc.

§ 38.2-1319. Expense of examination.—

A. Any person domiciled or having its home office in this Commonwealth shall pay the necessary traveling and other actual expenses of the examiners for its examination under this article. The Commission may, at its discretion and for good cause, waive payment of the expenses.

B. Any person having its domicile and home office outside this Commonwealth shall be liable for and shall pay to the Commission's examiners, upon presentation of an itemized statement, the examiners' actual travel expenses, their reasonable living expense allowance, and their per diem compensation at a reasonable rate approved by the Commission, incurred on account of its examination.

C. If the Commission finds the accounts to be inadequate, or inadequately kept or posted, it may employ experts to rewrite, post or balance them at the expense of the person examined if that person has failed to complete or correct the accounts after notice and reasonable opportunity has been given by the Commission.

Drafting Note: The authority granted by new subsection C is similar to that found in other states.

§ 38.2-1320. Examination reports.—A. The Commission's examiners shall make a true report of every examination. The report shall include only facts appearing upon the books, records or other documents of the person examined or as ascertained from the sworn testimony of its directors, officers, employees, agents or other persons examined concerning its affairs and any conclusions and recommendations reasonably warranted from such facts.

B. Upon the completion of any examination, the Commission shall furnish two copies of the report to the person examined and shall notify the person that it may, within thirty days, request a hearing on the report with reference to its facts, conclusions or recommendations. Any hearing shall be informal and private.

C. Pending, during, and after an examination of any person, neither the Commission nor any of its representatives or examiners shall make public or allow to be made public the financial statement, findings or report of examination, or any report affecting the status or standing of the person examined, until that person has either accepted the final report or has been given a reasonable opportunity to be heard. If the person examined has neither notified the Commission of its acceptance of the report nor requested a hearing within thirty days after receiving the final report, the report shall then be filed in the office of the Commission as a public document.

D. Notwithstanding the other provisions of this section, the Commission, with full discretion, may take any action provided for or exercise any power conferred by any other statute to suspend or revoke the license of any person.

§ 38.2-1321. Records of examination preserved.—The Commission shall keep and preserve in permanent form the reports of all official examinations of domestic insurers or other persons, including all records, exhibits or schedules filed in connection with these reports.

Article 5.

Insurance Holding Companies.

§ 38.2-1322. Definitions.—As used in this article :

"Acquiring person" means any person by whom or on whose behalf acquisiton of control of any domestic insurer is to be effected.
Drafting Note: The definition of "acquiring person" has been moved from existing § 38.1-178.1:2(1) (proposed § 38.2-1324).

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

"Control," including the terms "controlling," "controlled by" and "under common control with," means direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, through (i) the ownership of voting securities, (ii) by contract other than a commercial contract for goods or nonmanagement services, or (iii) otherwise unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing collectively ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection I of § 38.2-1329 that control does not exist. After giving all interested persons notice and opportunity to be heard and making specific findings to support its determination, the Commission may determine that control exists, notwithstanding the absence of a presumption to that effect.

"Insurance holding company system" means two or more affiliated persons, one or more of which is a person licensed pursuant to this title.
Drafting Note: The definition of "insurance holding company system" has been broadened to be similar to the NAIC model.

"Material transaction" means (i) any sale, purchase, exchange, loan or extension of credit, or investment, involving at least the lesser of either one-half of one percent of the insurer's admitted assets or five percent of the insurer's surplus to policyholders as of the immediately preceding December 31; (ii) any dividend or distribution: (iii) any reinsurance treaty or agreement; (iv) any management or service contract; or (v) any other transaction or agreement that the Commission by order, rule or regulation determines to be material. Any series of transactions occurring within a twelve-month period that are sufficiently similar in nature as to be reasonably construed as a single transaction and that in the aggregate exceed any minimum limits shall be deemed a material transaction.
Drafting Note: Here and throughout the article, "surplus" has been clarified as "surplus to policyholders", a term defined in Chapter 1.

"Subsidiary" of a specified person means an affiliate directly or indirectly controlled by that person through one or more intermediaries.

"Voting security" means any security that enables the owner to vote for the election of directors. Voting security includes any security convertible into or evidencing a right to acquire a voting security.
Drafting Note: The definition of "voting security" has been made to parallel the SEC definition. No change in meaning is intended.

§ 38.2-1323. Acquisition of control of domestic insurer.—No person shall acquire or attempt to acquire control of any domestic insurer unless the person has previously filed with the Commission and has sent to the insurer an application for approval of acquisition of control of the insurer, and the Commission has issued an order approving the application.
Drafting Note: Reference to control acquired through the acquisition of stock or otherwise is deleted as these methods are included in the definition of control.

§ 38.2-1324. Contents of application.—A. The application filed with the Commission under § 38.2-1323 shall be made under oath or affirmation and shall contain the following information:

1. The name and address of each acquiring person including:
Drafting Note: The definition of "acquiring person" has been moved to § 38.2-1322.

a. If the acquiring person is a natural person, his principal occupation, all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past

ten years, and

b. If the acquiring person is not a natural person, (i) a report of the nature of its business operations during the existence of the acquiring person and any of its predecessors, not to exceed five years; (ii) an informative description of the business intended to be done by the person and the person's subsidiaries; and (iii) a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to those positions. The report shall include the information required by paragraph 1 a of this subsection.

2. The source, nature, and amount of the consideration used or to be used in effecting the acquisition of control, a description of any transaction in which funds were or are to be obtained for that purpose, and the identity of persons furnishing the consideration. However, where a source of the consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if requested by the person filing the application;

3. Fully audited financial information regarding the earnings and financial condition of each acquiring person during the existence of the acquiring person or the predecessors, not to exceed five years, and similar unaudited information as of a date not earlier than ninety days prior to the filing of the application;

4. Any plans or proposals that each acquiring person may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

5. The number of shares of any security of the insurer that each acquiring person proposes to acquire and the terms of the acquisition;
Drafting Note: The Commission's concern relates to the safety of the policyholder. The fairness of the transaction to a stockholder is not of primary regulatory concern.

6. The amount of each class of any such security that each acquiring person beneficially owns or has a right to acquire beneficial ownership of;

7. A full description of any contracts, arrangements or understandings with respect to any security in which an acquiring person is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been made;

8. A description of any acquiring person's purchase of any such security during the twelve calendar months preceding the filing of the application, including the dates of purchases, names of the purchasers, and consideration paid or agreed to be paid for the security;

9. A description of any recommendations to purchase any such security made by any acquiring person or by any person based upon interviews or at the suggestion of any acquiring person during the twelve calendar months preceding the filing of the application;

10. Copies of all tender offers, requests or invitations for tenders of exchange offers and agreements to acquire or exchange any such security and of additional related soliciting material which has been distributed;

11. The terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of these securities for tender and the amount of any associated fees, commissions or other compensation to be paid to broker-dealers; and

12. Any additional information the Commission may prescribe as necessary or appropriate for the protection of the policyholders or the public.
Drafting Note: Shareholders are deleted, as primary regulatory concern is directed to the policyholder.

B. If the person required to file the application referred to in § 38.2-1323 is a partnership, limited partnership, syndicate or other group, the Commission may require that the information called for by subsection A of this section be given with respect to (i) each partner of the partnership or limited partnership, (ii) each member of the syndicate or group, and (iii) each person who controls any partner or member. If any partner, member or person is a corporation, or if the person required to file the application referred to in § 38.2-1323 is a corporation, the Commission may require that information be given for the corporation, each officer, and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation as required by subsection A of this section.

C. If any material change occurs in the facts set forth in the application filed with the Commission and sent to an insurer pursuant to § 38.2-1323, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the Commission and sent to the insurer within two business days after the person filing the application learns of the change.

§ 38.2-1325. Alternate filing materials.—If any acquisition referred to in § 38.2-1323 is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under the

Take-Over-Bid Disclosure Act (§ 13.1-528 et seq.), the person required by § 38.2-1323 to file an application may use these documents in furnishing the required information.

Drafting Note: The deletion of "offer, request, invitation, agreement or" makes this section consistent with proposed § 38.2-1323. (See also proposed § 38.2-1326(2),(4), and (6) and proposed § 38.2-1328.) The deletion of "pursuant to the section" and the insertion of "by § 38.2-1323" have been made for clarity.

§ 38.2-1326. Approval by Commission.—The Commission shall approve the application required by § 38.2-1323 unless, after giving notice and opportunity to be heard, it determines that:

1. After the change of control, the insurer would not be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed;

2. The acquisition of control would lessen competition substantially or tend to create a monopoly in insurance in this Commonwealth;

Drafting Note: The deletion of the words before the word "acquisition" in subsection 2 above and subsections 4 and 6 below make these subsections consistent with proposed § 38.2-1323.

3. The financial condition of any acquiring person might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders ;

4. Any plans or proposals of the acquiring party to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

5. The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the acquisition of control; or

6. After the change of control, the insurer's surplus to policyholders would not be reasonable in relation to its outstanding liabilities or adequate to its financial needs.

Drafting Note: Provisions relating to the protection of shareholders are deleted. Regulatory concern is for the policyholder and not the shareholder.

Drafting Note: This section is being deleted because it is self-evident that failure to comply with a law is a violation of that law.

§ 38.2-1327. Time for hearing; order of Commission.—Any hearing held pursuant to § 38.2-1326 shall begin within forty days of the date the application is filed with the Commission. In approving any application filed pursuant to § 38.2-1323, the Commission may include in its order any conditions, stipulations, or provisions which the Commission determines to be necessary to protect the interests of the policyholders of the insurer and the public.

Drafting Note: The cross-references were changed because the only section mentioning a hearing is proposed § 38.2-1326 and only proposed § 38.2-1323 is needed to identify the application referred to.

§ 38.2-1328. Exemption.—The provisions of §§ 38.2-1323 through 38.2-1327 shall not apply to any acquisition that the Commission, by order, exempts from those sections. Acquisitions granted exemption shall include those which (i) have not been made or entered into for the purpose of and do not have the effect of changing or influencing the control of a domestic insurer, or (ii) otherwise are not comprehended within these sections.

Drafting Note: It is illogical to apply the exemption to itself, so existing § 38.1.178.1:7 has been changed to § 38.1-178.1:6 (proposed § 38.2-1327). The deletion of the words before the word "acquisiton" makes this section consistent with proposed § 38.2-1323.

§ 38.2-1329. Registration of insurers that are members of holding company system.—A. Each insurer licensed to do business in this Commonwealth that is a member of an insurance holding company system shall register with the Commission. Any insurer subject to registration under this section shall register within fifteen days after it becomes subject to registration, unless the Commission extends the time for registration for good cause shown.

Drafting Note: Subsection (h) of this section has been combined with part of the first sentence and the last sentence of subsection (a) of this section and made into a proposed subsection B.

B. 1. This section shall not apply to:

a. Any foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section; or

b. Any insurer, information, or transaction if and to the extent that the Commission exempts the same from this section.

Drafting Note: Subsection B is a combination of portions of the previous subsections (a) and (h) of this section. The change is only for organizational purposes.

2. Any licensed insurer that is a member of a holding company system but not subject to registration under this section may be required by the Commission to furnish a copy of the registration statement, or other information filed by the insurer, with the insurance regulatory authority of its domiciliary jurisdiction.

C. Each insurer subject to registration under this section shall file a registration statement on a form provided by the Commission. Such statement shall contain current information on:

1. The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

2. The identity of every member of the insurance holding company system;

3. The following agreements in force, continuing relationships and transactions currently outstanding between the insurer and its affiliates:

a. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

b. Purchases, sales, or exchanges of assets;

c. Transactions not in the ordinary course of business;

d. Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

e. All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles; and

f. Reinsurance agreements covering all or substantially all of one or more classes of insurance of the ceding insurer; and

4. Other matters relating to transactions between registered insurers and any affiliates which may be included from time to time in any registration forms adopted or approved by the Commission.

D. If information is not material for the purposes of this section, it need not be disclosed on the registration statement filed pursuant to subsection B of this section. Unless the Commission prescribes otherwise, information about transactions that are not material transactions shall not be deemed material for purposes of this section.

Drafting Note: The term "material transaction," which is defined in proposed § 38.2-1322, is used instead of essentially repeating that definition as done in the existing subsection (c).

E. Each registered insurer shall report all additional material transactions with affiliates and any material changes in previously reported material transactions with affiliates on amendment forms provided by the Commission. Each insurer shall make its report within fifteen days after the end of the month in which it learns of each additional material transaction or material change in material transaction. Each insurer shall report to the Commission all dividends and other distributions to shareholders within two business days following their declaration. Each registered insurer shall also keep current the information required by subsection C of § 38.2-1329 by filing an amendment to its registration statement within 120 days after the end of each fiscal year of the ultimate controlling person of the insurance holding company system.

F. The Commission shall terminate the registration of any insurer that demonstrates it no longer is a member of an insurance holding company system.

G. The Commission may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

H. The Commission may allow an insurer which is authorized to do business in this Commonwealth and which is part of an insurance holding company system, to register on behalf of any affiliated insurer required to register under subsection A of this section and to file all information and material required to be filed under this section.

Drafting Note: Provisions of this subsection have been moved to subsection B of this section.

I. Any person may file with the Commission a disclaimer of affiliation with any authorized insurer. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. After a disclaimer has been filed, the insurer shall be relieved of any registering or reporting requirements under this section that may arise out of the insurer's relationship with the person unless and until the Commission disallows the disclaimer. The Commission shall disallow the disclaimer only after giving all interested parties notice and opportunity to be heard. Any disallowance shall be supported by specific findings of fact.

Drafting Note: Subsection (j) is deleted since it is self-evident that failure to comply with a section is a violation of the section.

§ 38.2-1330. Standards for transactions with affiliates; adequacy of surplus; dividends and other distributions.—A. Material transactions by registered insurers with their affiliates shall be subject to the following standards:

1. The terms shall be fair and reasonable;

2. The books, accounts, and records of each party shall disclose clearly and accurately the precise nature and details of the transactions; and

3. The insurer's surplus to policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

B. For purposes of this article, in determining whether an insurer's surplus to policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

1. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

2. The extent to which the insurer's business is diversified among different classes of insurance;

3. The number and size of risks insured in each class of business;

4. The extent of the geographical dispersion of the insurer's insured risks;

5. The nature and extent of the insurer's reinsurance program;

6. The quality, diversification, and liquidity of the insurer's investment portfolio;

7. The recent past and projected future trend in the size of the insurer's surplus to policyholders;

8. The surplus to policyholders maintained by other comparable insurers;

9. The adequacy of the insurer's reserves; and

10. The quality and liquidity of investments in subsidiaries. The Commission in its judgment may classify any investment as a nonadmitted asset for the purpose of determining the adequacy of surplus to policyholders.

C. No insurer subject to registration under § 38.2-1329 shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders or confer any rights on its shareholders regarding the dividend or distribution until approved by the Commission. The Commission must approve or disapprove the distribution within thirty days after receiving notice of the declaration of distribution. If the Commission does not disapprove the distribution within the thirty day period, the distribution shall be considered approved.

D. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds either (i) ten percent of the insurer's surplus to policyholders as of the immediately preceding December 31, or (ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, for the twelve-month period ending the immediately preceding December 31, but shall not include pro rata distributions of any class of the insurer's own securities.

Drafting Note: The last paragraph of existing subsection (c) has been merged into the first paragraph of that subsection (proposed subsection C). The last paragraph has been interpreted as only applying to insurers subject to registration under this article, so no change in meaning is intended by this change. Net investment income has been changed to net income to conform with the NAIC model.

§ 38.2-1331. Commission approval required for certain transactions.—A. Prior written approval of the Commission shall be required for (i) any material transaction between a domestic insurer and any of its affiliates involving more than either five percent of the insurer's admitted assets or twenty-five percent of the insurer's surplus, whichever is less, as of the immediately preceding December 31, and (ii) any investment in affiliated companies being in excess of fifty percent of the lesser of surplus to policyholders reported on the immediately preceeding December 31, or the surplus to policyholders at the time application is made to the Commission for approval of the transaction. For the purpose of this section, an insurer's investment in affiliated companies is the sum of (i) the assets held by the insurer that represent securities issued by companies of the affiliate system, and (ii) the assets of the insurer that are pledged on behalf of companies in the affiliate system. Failure of the Commission to act within thirty days after notification by the insurer shall constitute approval of the transaction.

Drafting Note: In addition to the requirement for prior approval of the affiliated transaction to be based on a transaction amounting to the lesser of 5% of admitted assets or 25% of surplus, prior approval must be granted for investments resulting in holdings of assets in affiliated holding companies being in excess of 50% of surplus. The 50% of surplus requirement is NAIC model language.

B. Nothing contained in this section shall authorize or permit any transaction that would be otherwise contrary to law.

C. The Commission, in reviewing any material transaction under this section, shall consider whether the material transaction complies with the standards set forth in § 38.2-1330 and whether it may adversely affect the interest of policyholders. The Commission shall set forth the specific reasons for the disapproval of any material transactions.

D. The approval of any material transaction under this section shall be deemed an amendment under subsection E of § 38.2-1329 to an insurer's registration statement without further filing.

E. This section shall not apply to a material transaction that is a dividend or distribution.

§ 38.2-1332. Examinations.—A. In addition to the powers the Commission has under § 38.2-1317, the Commission shall also have the power to order any insurer registered under § 38.2-1329 to produce any records, books, or other information papers in the possession of the insurer or its affiliates necessary to determine the financial condition or legality of conduct of the insurer. If the insurer fails to comply with the order, the Commission shall have the power to examine its affiliates to obtain the information.

B. The Commission shall exercise its power under subsection A of this section only if the examination of the insurer under § 38.2-1317 is inadequate or the interests of the policyholders of the insurer may be adversely affected.

C. The Commission may retain at the registered insurer's expense any attorneys, actuaries, accountants and other experts reasonably necessary to assist in the conduct of the examination under subsection A of this section. Any persons so retained shall be under the direction and control of the Commission and shall act in a purely advisory capacity.

D. Each insurer producing books and papers for examination records pursuant to subsection A of this section shall be liable for and shall pay the expense of the examination in accordance with the provisions of § 38.2-1319.

Drafting Note: The word "registered" has been deleted in the above sentences as the "pursuant to" phrase sufficiently identifies what kind of insurer is being referred to.

§ 38.2-1333. Confidential treatment of information and documents.—All information, documents, and copies obtained by or disclosed to the Commission or any other person in the course of an examination or investigation made pursuant to § 38.2-1332, and all information reported pursuant to § 38.2-1329, shall be confidential and shall not be made public by the Commission or any other person without the prior written consent of the insurer to which they pertain. However, this provision shall not apply to information given to insurance departments in other states. After an insurer and its affiliates have been given notice and opportunity to be heard, the Commission may publish all or any part of the information and materials referred to in this section in any manner it considers appropriate, if it determines that the interests of policyholders or the public will be served by the publication.

Drafting Note: In light of the unified regulation section in Chapter 2, existing § 38.1-178.6 is being deleted.

Drafting Note: In light of the unified cease and desist section in Chapter 2, existing § 38.1-178.7 is being deleted. (See also existing § 38.1-178.17.)

Drafting Note: In light of the unified penalty section in Chapter 2, existing § 38.1-178.8 is being deleted. (See also existing § 38.1-178.18.)

§ 38.2-1334. Revocation, suspension, or nonrenewal of insurer's license.—Whenever it appears to the Commission that any person has committed a violation of this article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commission after giving notice and an opportunity to be heard, may suspend, revoke or refuse to renew the insurer's license to transact business in this Commonwealth for whatever period it finds is required for the protection of policyholders or the public. Any such action shall be supported by specific findings of fact and conclusions of law.

Drafting Note: This section goes beyond proposed § 38.2-1040 in that it applies to violations by persons other than insurers as well as to insurers, so it is being retained.

Article 6.

Subsidiaries of Insurance Companies.

§ 38.2-1335. Definitions.—The terms defined in § 38.2-1322 shall have the same meaning in this article.

§ 38.2-1336. Subsidiaries of insurers.—Notwithstanding the provisions of any other law, a domestic insurer shall not organize, acquire, or obtain control of any subsidiary, either by itself or in cooperation with one or more persons, unless the subsidiary is engaged in the following kinds of business:

1. Transacting any kind of insurance business authorized by the jurisdiction in which the subsidiary is incorporated;

2. Acting as an insurance broker or as an insurance agent for its parent or for any of its parent's insurer subsidiaries;

3. Investing, reinvesting or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

4. Managing any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

5. Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

6. Rendering investment advice to governments, governmental agencies, corporations or other

organizations or groups;

7. Rendering other services related to the operations of an insurance business including, but not limited to, actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;

8. Owning and managing assets that the domestic insurer could itself own or manage;

9. Acting as administrative agent for a governmental instrumentality that is performing an insurance function;

10. Financing of insurance premiums or agents;

11. Engaging in any other business activity the Commission determines to be reasonably ancillary to an insurance business; or

12. Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

§ 38.2-1337. Disclaimer of control.—1. A domestic insurer may acquire voting securities of any company in an amount sufficient to presume control without the company's being considered a subsidiary if the domestic insurer files a disclaimer of affiliation with the Commission. The disclaimer shall disclose fully (i) the nature and purpose of the investment, (ii) all material transactions and relationships between the domestic insurer and the company, and (iii) the basis for the disclaimer. The Commission may disallow the disclaimer only after giving the domestic insurer and the company notice and an opportunity to be heard. Any disallowance shall be supported by specific findings of fact.

2. If the Commission disallows the disclaimer, the domestic insurer shall immediately take action sufficient to satisfy the Commission that the domestic insurer does not control the company.

§ 38.2-1338. Applicability.—This article shall not apply to any investment or subsidiary relationship that was in effect prior to June 1, 1977 between a domestic insurer and another company. However, no domestic insurer may increase its investment or ownership of voting securities or otherwise materially increase its control over the affairs of the company without prior approval of the Commission.

§ 38.2-1339. Exemptions.—Nothing in this article shall exempt any domestic insurer from the provisions of Article 5 (§ 38.2-1322 et seq.) of this chapter.

Drafting Note: In light of the unified rules and regulations section in Chapter 2, existing § 38.1-178.16 is being deleted.

Drafting Note: In light of the unified cease and desist section in Chapter 2, existing § 38.1-178.17 is being deleted.

Drafting Note: In light of the unified penalty section, existing § 38.1-178.18 is being deleted.

§ 38.2-1340. Revocation, suspension, or nonrenewal of insurer's license.— Whenever it appears to the Commission that any person has committed a violation of this article that makes the continued operation of a domestic insurer contrary to the interests of policyholders or the public, the Commission may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer's license to do business in this Commonwealth for whatever period it finds is required for the protection of policyholders or the public. Any such action shall be supported by specific findings of fact and conclusions of law.

Drafting Note: This section goes beyond proposed § 38.2-1040 in that it applies to violations by persons other than insurers as well as to insurers, so it is being retained.

Title 38.2

CHAPTER 14.

Investments.

Among the changes proposed for Chapter 14 are:

1. Subsection B of § 38.2-1402 has been added to give the Commission the authority to classify investments not considered by the chapter.

2. A provision has been added to § 38.2-1423 for a pro forma dividend standard for preferred stocks issued less than three years before the date of investment.

3. In § 38.2-1429, the collateral requirement has been reduced to 102 percent.

4. In proposed § 38.2-1432, United States government bond mutual funds have been added as a Category 1 investment.

5. Subsection A of § 38.2-1437 has been rewritten to allow the loan-to-value ratios for leasehold mortgages and mortgages to employees of insurers to be exceeded if the excess is covered either by FHA, VA, etc. or by private mortgage guaranty insurance. The existing options for other mortgages to be exceeded under these conditions will be continued.

6. Subsection A of § 38.2-1441 has been changed to clarify that "real estate" includes a leasehold of real estate of twenty years or more.

7. Section 38.2-1442 has been added specifying that obligations of the two Virginia guaranty associations qualify as Category 1 investments.

CHAPTER 14.

INVESTMENTS.

Article 1.

General Provisions.

§ 38.2-1400. Scope and purpose of chapter.—This chapter applies to and regulates the investments of all domestic insurers. A foreign or alien insurer may invest its funds and assets in investments permitted by the laws of its state or country of domicile.

§ 38.2-1401. Definitions.—As used in this chapter:

"Category 1 investment" means any investment complying with Article 1 (§ 38.2-1400 et seq.) and either Article 2 (§ 38.2-1412 et seq.) or 3 (§ 38.2-1443 et seq.), or both Articles 2 and 3, of this chapter.

"Category 2 investment" means any investment complying with Article 1, but with neither Article 2 nor Article 3, of this chapter.

"Date of investment" means the date on which funds are disbursed for an investment.

"Domestic governmental entity" means the United States, any state, or any municipality or district in any such state, or any political subdivision, civil division, agency or instrumentality of one or more of the foregoing.

"Excess capital and surplus" means the capital or surplus, or both the capital and surplus, that a particular insurer has in excess of its minimum capital and surplus. "Excess capital and surplus" includes any security valuation reserves for Category 2 investments in common stock, either required by law or prescribed by the Commission.

"Fair market value" means the price that property will bring when (i) offered for sale by one who desires, but who is not obligated, to sell it; (ii) bought by one who is under no necessity of having it; and (iii) sufficient time has elapsed to allow interested buyers the opportunity to become informed of the offer for sale.

"Fixed charges" means actual interest incurred in each year on funded and unfunded debt, excluding interest on bank deposit accounts, and annual apportionment of debt discount or premium. Where interest is partially or entirely contingent upon earnings, "fixed charges" includes contingent interest payments.

"Institution" means a corporation, church or religious body.

"Minimum capital and surplus" means the capital or surplus, or both the capital and surplus, a particular insurer must have to obtain its license to transact insurance in this Commonwealth.

"Net earnings available for fixed charges" means income minus operating expenses, maintenance expenses, taxes other than income taxes, depreciation, and depletion. Extraordinary nonrecurring income and expense items are excluded from the calculation of "net earnings available for fixed charges."

"Obligation" means a bond, debenture, note or other evidence of indebtedness.

"Prohibited investment" means any investment prohibited by § 38.2-1407.

"Wrap-around mortgage" means a loan made by an insurer to a borrower, secured by a mortgage or deed of trust on real property encumbered by a first mortgage or first deed of trust, where the total amount of the obligation of the borrower to the insurer under the loan is not less than the sum of (i) the principal amount initially disbursed by the insurer on account of the loan and (ii) the unpaid principal balance of the obligation secured by the preexisting mortgage or deed of trust.

§ 38.2-1402. Authority to invest; classification of investments by category.—A. A domestic insurer may invest its funds and assets in accordance with this chapter. All investments of a domestic insurer shall be classified as (i) Category 1 investments, (ii) Category 2 investments, or (iii) prohibited investments.

B. The Commission, upon application by an insurer, may classify any investments made or proposed to be made and not otherwise specifically classified in Articles 1 and 2 of this chapter as a Category 1 investment.

Drafting Note: The additional language will give the Commission the right to classify new investments, not covered by this chapter, as Category 1. If the Commission does not approve the application and investment is not prohibited by § 38.2-1407, the default classification is Category 2.

§ 38.2-1403. Category 2 investments exceeding excess capital and surplus.—The value of Category 2 investments in excess of the value of excess capital and surplus shall be excluded from the value of admitted assets.

§ 38.2-1404. Classification of existing investments.–Any investment held on July 1, 1983, that was permitted at the time it was made under former § 38.1-181 or former §§ 38.1-183 through 38.1-217, shall be classified as a Category 1 investment.

§ 38.2-1405. Dates of determination.–The classification by investment category of each investment shall be determined as of the date of investment.

Any limitations based on the amount of the insurer's total admitted assets shall relate to those assets as shown by its most recent annual statement.

§ 38.2-1406. Investment conversions.–Investments converted to a new form and resulting in a different investment classification under § 38.2-1402, at the election of the insurer, shall retain their previous investment classification for a period not exceeding three years unless the Commission prescribes in writing that a longer period is reasonable. Any prohibited investments shall be divested within that period. The investment conversions shall include those resulting (i) from investments acquired in satisfaction of or on account of loans, mortgages, liens, judgments, or other debts previously owing to the insurer in the course of its business, or (ii) from investments acquired through lawful distributions of assets, lawful plans of reorganization, or lawful and bona fide agreements of bulk reinsurance or of consolidation.

§ 38.2-1407. Prohibited investments.– No domestic insurer shall invest in or loan funds secured by:

1. Issued shares of its own capital stock without the Commission's approval. This approval shall be based on an evaluation that indicates the investment does not adversely affect the insurer or its policyholders. The insurer shall not invest in or own more than twenty percent of its outstanding issued stock, except for the purpose of mutualization;

2. Securities of an insolvent institution;

3. Securities that, by their terms, will subject the insurer to any assessment other than for taxes or for wages; or

4. Investments that, as determined by the Commission, are designed to evade any prohibition of this title.

§ 38.2-1408. Authorization of investments.–No domestic insurer shall make any loan, investment, or any sale or exchange of a loan or investment, except policy loans of an insurer issuing life insurance policies or annuities, unless authorized or approved. Authorization or approval shall be made by (i) its board of directors, or other governing body, or (ii) a committee authorized by the governing body or bylaws, to make investments, loans, sales or exchanges. The minutes of the committee shall be recorded, and reports of the investments, loans, sales or exchanges authorized or approved shall be submitted to the board or other governing body at its next meeting.

§ 38.2-1409. Powers with respect to property.–Subject to any applicable limitations and restrictions in this chapter, a domestic insurer may own, hold, maintain, manage, operate, lease, sell, convey, and collect and receive income from any property acquired as permitted in this chapter.

§ 38.2-1410. Items not deemed to be prior liens or encumbrances.–In construing and applying this title, the following shall not be deemed prior liens or encumbrances: easements; rights-of-way; joint driveways; party wall agreements; current taxes and assessments not delinquent; restrictions as to building, use and occupancy unless there is a right of reentry or forfeiture for violation; instruments reserving mineral, oil, or timber rights; title matters for which the insurer is insured against loss by a title insurer; and leases under which rents are reserved to the owner of the real estate.

§ 38.2-1411. Powers with respect to partnership agreements, joint ventures or other associations.– Notwithstanding the provisions of §§ 13.1-627 and 13.1-826, a domestic insurer may enter into partnership agreements, joint ventures or other associations, whether or not in corporate form, with other companies for the purpose of making or participating in investments otherwise permissible for domestic insurers under the provisions of this chapter.

Drafting Note: Section 38.1-217.13 is being deleted in light of the proposed general regulation section.

Drafting Note: The severability section is being deleted here in favor of a title-wide severability section.

Article 2.

Category 1 Investments.

§ 38.2-1412. Scope of article.–This article sets forth requirements for qualifying as a Category 1 investment. If an investment or portion thereof does not comply either with this article or Article 3 (§ 38.2-1443 et seq.) of this chapter, then that investment or portion of it shall be classified as a Category 2 investment or a prohibited investment, as provided in this chapter.

§ 38.2-1413. Investment limits for one obligor, one issue or one loan.–A. No domestic insurer shall have at any one time any combination of investments in or loans upon the security of the property and securities of any one obligor or issuer aggregating an amount exceeding five percent of the insurer's total admitted assets. The limitation prescribed by this section shall not apply (i) to investments in or loans upon

the security of general obligations of the United States or any state or (ii) to investments in foreign securities made eligible by § 38.2-1433.

B. No domestic insurer shall invest in excess of one percent of its total admitted assets in any one issue of any obligations made eligible for investment under §§ 38.2-1422, 38.2-1423, or § 38.2-1424.

C. No domestic insurer shall invest in excess of one-half of one percent of its total admitted assets in any one loan made eligible by paragraph 3 of § 38.2-1434.

D. The principal loan amount disbursed, excluding advances made to enforce or protect the security for the loan, by a domestic insurer under any single wrap-around mortgage made pursuant to § 38.2-1435 shall not exceed one percent of it's total admitted assets.

E. The amount loaned under § 38.2-1430 shall be subject to the limitations of this section applicable to the kinds of securities or obligations pledged in connection with the loan.

F. The limitations of this section apply to the insurer's ownership interests in investments authorized by § 38.2-1411.

§ 38.2-1414. Limits by type of investment.—A. The portion of a domestic insurer's total admitted assets in the following types of investments shall not exceed:

1. Ten percent for the investments made eligible by § 38.2-1416;

2. Ten percent for the investments made eligible by § 38.2-1417;

3. Five percent for the investments in each agency made eligible by § 38.2-1418;

4. Ten percent for the investments made eligible by § 38.2-1420;

5. Ten percent for the investments made eligible by § 38.2-1423;

6. Five percent for the investments made eligible by § 38.2-1424;

7. Five percent for the investments made eligible by § 38.2-1425;

8. Five percent for the investments made eligible by § 38.2-1427;

9. An amount equal to its deposit and reserve obligations incurred in a foreign country for the investments made eligible by § 38.2-1433;

10. Two percent for the investments made eligible (including those that the insurer is obligated to make as well as those made) by paragraph 3 of § 38.2-1434;

11. Two percent for the investments made eligible by § 38.2-1435;

12. Ten percent for the investments made eligible by § 38.2-1436;

13. Two percent for the investments made eligible by § 38.2-1440; and

14. Twenty-five percent for the total of investments made eligible by § 38.2-1441, of which no more than five percent of the total admitted assets shall be in investments in real property to be used primarily for hotel purposes.

B. The amount loaned under § 38.2-1430 shall be subject to the limitations of this section applicable to the kinds of securities or obligations pledged in connection with the loan.

C. The limitations of this section apply to the insurer's ownership interest in investments authorized by § 38.2-1411.

§ 38.2-1415. . Obligations of domestic governmental entities.—A. A domestic insurer may invest in:

1. Direct obligations of the United States, any agency or instrumentality of the United States or any state, or obligations for which the full faith and credit of any of the foregoing is pledged for the payment of principal and interest; or

2. Valid and legally authorized obligations issued, assumed or guaranteed by any domestic governmental entity if, by statutory or other legal requirements applicable to those obligations, they are payable as to both principal and interest, (i) from taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of the domestic governmental entity, or (ii) from adequate special revenues pledged or otherwise appropriated or required by law to be provided for the purpose of the payment, excluding any obligation payable solely out of special assessments on properties benefited by local improvements.

B. The obligations of any domestic governmental entity that has defaulted in the payment of principal or interest of any of its obligations within the five years immediately preceding the date of investment

shall not be eligible for investment under this section.

§ 38.2-1416. Canadian governmental obligations.—A domestic insurer may invest in obligations that:

1. a. Are obligations of Canada, any province of Canada, or of any municipality in Canada having a population of at least 100,000, if the foregoing types of obligations meet the standards required for obligations of domestic governmental entities in paragraph 2 of subsection A of § 38.2-1415; or

b. Are direct obligations of Canada or any province of Canada, or are obligations for which the full faith and credit of either is pledged for payments of both principal and interest;

2. Are payable both as to principal and interest in lawful money of the United States or of Canada; and

3. Meet the standard required for obligations of domestic governmental entities in subsection B of § 38.2-1415.

§ 38.2-1417. Canadian corporate obligations.—A domestic insurer may invest in obligations issued, assumed or guaranteed by any solvent institution created or existing under the laws of Canada, or any province of Canada. However, those obligations shall meet the standards specified in § 38.2-1421 for obligations of institutions created or existing under the laws of the United States or any state .

§ 38.2-1418. Obligations of certain international agencies.—A domestic insurer may invest in valid and legally authorized obligations issued, assumed or guaranteed by an international development bank of which the United States is a member and whose obligations are included in the three highest grades or their equivalent by a national rating agency recognized by the Commission.

§ 38.2-1419. Railroad terminal and other securities.—A domestic insurer may invest in obligations secured by first mortgages, first deeds of trust or other similar liens upon terminal, depot or tunnel property, including lands, buildings and appurtenances, used in the service of transportation by one or more railroad corporations whose obligations are eligible as investments under § 38.2-1421. However, these obligations shall be (i) the direct obligation of the corporation or corporations, or (ii) guaranteed by endorsement by, or guaranteed by endorsement assumed by the corporation for the payment of principal and interest of those obligations. If the guarantee or assumption of guarantee is by two or more of the corporations, it shall be joint and several as to each. No such investment shall be made if there has been any default in the payment of principal or interest since the issuance of the obligations but not to exceed five years from the date of investment.

§ 38.2-1420. Transportation equipment trust certificates.—A domestic insurer may invest in adequately secured equipment trust certificates or other adequately secured instruments evidencing (i) an interest in transportation equipment wholly or partly within the United States and (ii) a right to receive determined portions of rental, purchase or other fixed obligatory payments for the use or purchase of the transportation equipment.

§ 38.2-1421. Corporation obligations.—A domestic insurer may invest in obligations issued, assumed or guaranteed by any solvent institution that is not in default as to principal or interest on the date of investment and which is created or existing under the laws of the United States or any state if:

1. a. For a period of five fiscal years immediately preceding the date of investment, except in the case of finance companies, the net earnings available for fixed charges of the institution have averaged per year not less than one and one-half times, and in the case of finance companies, not less than one and one-quarter times, its fixed charges for that year, or

b. During either of the last two fiscal years immediately preceding the date of investment, except in the case of finance companies, the net earnings available for fixed charges of the institution have been not less than one and one-half times, and in the case of finance companies, not less than one and one-quarter times, its fixed charges for that year; or

2. The obligations at the time of investment are included in the four highest grades or their equivalent by a national rating agency recognized by the Commission.

§ 38.2-1422. Obligations secured by certain leases.—A domestic insurer may invest in obligations of any solvent company other than companies referred to in § 38.2-1419, incorporated under the laws of the United States or of any state if:

1. The obligations are secured by an assignment to the insurer of a lease, and the rents payable under the lease, of real or personal property or both to (i) a domestic governmental entity; (ii) Canada, or any province of Canada; or (iii) one or more companies incorporated under the laws of the United States, any state, Canada or any province of Canada;

2. The rentals assigned are sufficient to repay the indebtedness within the unexpired term of the lease, excluding any term that may be provided by an enforceable option of renewal;

3. The lessee on any lease securing an obligation under this section, or the guarantor of the lease, is an entity whose obligations would be eligible for investment by an insurer in accordance with §§ 38.2-1415, 38.2-1421 or 38.2-1425;

4. The lessee or guarantor has not defaulted in payment of interest or principal on any of its obligations during the five fiscal years immediately preceding the date of investment; and

5. A first lien on the interest of the lessor in the unencumbered leased property is obtained as additional security for any obligation acquired pursuant to this section.

§ 38.2-1423 Preferred stocks.– A domestic insurer may invest in preferred stocks of any company incorporated under the laws of the United States or any state if:

1. a. The preferred stock under consideration is not in arrears as to dividends if cumulative, or

b. Full dividends on the preferred stock under consideration have been paid in the last three years, or since issue if issued less than three years before the date of investment, if noncumulative;

2. Required sinking fund payments are on a current basis; and

3. For each of the most recently completed three years, net earnings available for fixed charges of the issuer are at least equal one and one-quarter times the sum of (i) the issuer's fixed charges and (ii) dividend requirements both of the preferred stock under consideration and of all preferred stock on a parity with it or having a greater priority. To the extent the preferred stock under consideration was issued less than three years before the date of investment, its pro forma dividend requirements shall be included in item (ii) in the preceding sentence.

Drafting Note: A pro forma dividend standard for preferred stocks issued less than three years before the date of investment has been added to § 38.2-1423.

§ 38.2-1424. Guaranteed stocks.– A domestic insurer may invest in stocks guaranteed by a solvent company incorporated under the laws of the United States or of any state if for the past three years the guarantor's net earnings available for meeting fixed charges is at least one and one-quarter times the sum of (i) the fixed charges of the guarantor and (ii) the dividends on the guaranteed stock.

§ 38.2-1425. Stock or obligations of banks or trust companies.–A. A domestic insurer may invest in the capital stock, notes or debentures of any bank or trust company that is a member of the Federal Deposit Insurance Corporation and that has earned a rate of return on its net worth of at least five percent for each of the preceding three years.

B. No domestic insurer shall invest in more than ten percent of the actually issued and outstanding common capital stock of any one such bank or trust company.

C. For the purpose of this section, the term "bank" includes a registered bank holding company as defined by the Federal Bank Holding Act of 1956, as amended, and a registered bank holding company shall be considered a member of the Federal Deposit Insurance Corporation if all its subsidiary banks are members of the Federal Deposit Insurance Corporation.

§ 38.2-1426. Application of earnings tests.–If the issuing, assuming or guaranteeing institution has not been in operation for the entire period for which earnings tests are being applied pursuant to §§ 38.2-1421 through 38.2-1425, the earnings tests shall be based upon pro forma statements incorporating statements of any predecessor or constituent institutions for that portion of the earnings tests period that the current institution was not in operation, if:

1. The current institution was formed as a consolidation or a merger of two or more institutions, at least one of which was in operation at the beginning of the test period; or

2. The current institution has acquired all of the assets of an institution or any division or other unit of an institution that was in operation at the beginning of the test period.

§ 38.2-1427. Common stock; covered call options.–A. A domestic insurer may invest in the common capital stock of any company incorporated under the laws of the United States or any state, if the common capital stock of the corporation (i) is traded on a securities exchange or on an over-the-counter market regulated under the Securities Exchange Act of 1934, as amended, or (ii) is that of an issuer registered and operated as an open-end investment company in accordance with the Investment Company Act of 1940, as amended.

B. A domestic insurer also may write exchange-traded, covered call options on shares of common capital stock it owns.

C. No domestic insurer shall invest in more than ten percent of the issued and outstanding common capital stock of any one corporation or issuer.

§ 38.2-1428. Hedging transactions.– A domestic insurer may effect or maintain bona fide hedging transactions pertaining to securities otherwise eligible for investment under §§ 38.2-1415 through 38.2-1427 including, but not limited to: (i) financial futures contracts, warrants, options, calls and other rights to purchase, and (ii) puts and other rights to require another person to purchase such securities. The contracts, options, calls, puts, and rights shall be traded on a commodity exchange regulated under the Commodity Exchange Act, as amended, or on a securities exchange or on an over-the-counter market regulated under the Securities Exchange Act of 1934, as amended. For purposes of this section, a "bona fide hedging transaction" means a purchase or sale of a contract, warrant, option, call, put or right entered

into for the purpose of (a) minimizing interest rate risks in respect of interest obligations on insurance policies or contracts supported by securities held by the insurer or (b) offsetting changes in the market values or yield rates of securities held by the insurer.

§ 38.2-1429. Lending of securities.—A. A domestic insurer may lend securities held by it pursuant to §§ 38.2-1415 through 38.2-1427 if:

1. Simultaneously with the delivery of the securities, the insurer receives collateral from the borrower consisting of cash or consisting of securities issued, assumed or guaranteed by the United States, an agency of the United States or any state. The securities shall have a present market value of at least 102% of the market value of the securities loaned;

Drafting Note: The collateral requirement has been reduced to 102% from 103% to conform with industry practice.

2. The securities are loaned only for the purpose of making delivery of securities in the case of short sales, in the case of failure to receive securities requested for delivery or in other similar cases;

3. Prior to the loan, the borrower furnishes the insurer with the most recent statement of the borrower's financial condition and a representation by the borrower that there has been no material adverse change in its financial condition since the date of that statement;

4. The insurer receives a reasonable fee related to the value of the borrowed securities and to the duration of the loan;

5. The loan is made pursuant to a written loan agreement; and

6. The borrower is required to furnish by the close of each business day during the term of the loan a report of the market value of all collateral and the market value of all borrowed securities as of the close of trading on the previous business day. If at the close of any business day the market value of the collateral is less than 102% of the market value of the securities loaned, then the borrower shall deliver by the close of the next business day an additional amount of cash or securities. The market value of these additional securities, together with the market value of all previously delivered collateral, shall equal at least 102% of the market value of the securities loaned.

B. For the purposes of this section, "market value" includes accrued interest.

§ 38.2-1430. Collateral loans.— A domestic insurer may make loans secured by securities eligible for investment under this article. At the date of investment, the loan shall not exceed eighty percent of the market value of the collateral pledged. However, if the collateral consists of obligations issued, assumed or guaranteed by the United States, the loan may equal the market value of the collateral pledged.

§ 38.2-1431. Policy loans.—A domestic insurer issuing life insurance policies or annuities may loan any sum not exceeding the cash surrender value specified in the policy to its policyholder upon the pledge of the policy as collateral.

§ 38.2-1432. Savings, certificates, etc.—A domestic insurer may invest in any of the following:

1. Interest-bearing checking or savings accounts, certificates of deposit, or other short-term investments made available or issued by any solvent bank or trust company that is a member of the Federal Deposit Insurance Corporation;

2. Interest-bearing savings or share accounts, certificates of deposit or any other short-term investments made available or issued by any solvent building and loan or savings and loan association that is a member of the Federal Savings and Loan Insurance Corporation;

3. Bankers acceptances of the kinds and maturities made eligible by law for rediscount with Federal Reserve Banks, provided that these securities are accepted by a bank or trust company that is a member of the Federal Reserve System;

4. Money market mutual funds; or

5. United States government bond mutual funds.

Drafting Note: United States government mutual funds have been added as they represent a viable investment alternative.

§ 38.2-1433. Foreign securities.—A. A domestic insurer transacting the business of insurance in a foreign country may invest in securities of or issued in that country of substantially the same kinds, classes, and investment grades as the insurer may acquire in the United States.

B. These investments shall be payable in lawful currency of the United States, except where payment in other lawful currencies is required to match obligations denominated in such other lawful currencies.

§ 38.2-1434. Mortgage loans.— Subject to the provisions of § 38.2-1437, a domestic insurer may invest in:

1. Obligations secured by first mortgages or first deeds of trust on improved unencumbered real property located in the United States;

2. Obligations secured by first mortgages or first deeds of trust upon leasehold estates on improved and otherwise unencumbered real property where:

a. The leasehold interest lasts for a term of not less than ten years beyond the maturity of the loan as made or as extended, and

b. The mortgagee is subrogated to all the rights of the lessee on foreclosure or on taking a deed in lieu of foreclosure; or

3. Obligations secured by first mortgages or first deeds of trust on unimproved and unencumbered real property in the United States for the purpose of financing the construction of a building or other improvements on the real property subject to the mortgage or deed of trust, if:

a. These obligations mature not more than sixty months from the effective date of the mortgage or deed of trust and are the unlimited and unconditional liability of the obligor,

b. The obligor provides the insurer with a completion bond for the building or improvements at the time of making the loan, and

c. The insurer at or prior to the making of the loan (i) enters into an agreement with another party to provide permanent financing or (ii) agrees to provide permanent financing upon completion of the building or other improvement.

§ 38.2-1435. Second mortgages; wrap-around mortgages.—A domestic insurer may invest in obligations secured by second mortgages or second deeds of trust on real property encumbered only by a first mortgage or first deed of trust complying with §§ 38.2-1434 and 38.2-1437, subject to either of the following conditions:

1. The insurer also owns the obligation secured by the first mortgage or first deed of trust, and the aggregate value of both loans does not exceed the applicable loan-to-value ratio specified in § 38.2-1437, or

2. The obligation is secured by a wrap-around mortgage where:

a. Only one preexisting mortgage or deed of trust encumbers the real property,

b. The mortgage or deed of trust securing the loan is (i) recorded and (ii) insured for at least the total amount of the obligation of the borrower to the insurer by title insurance, and

c. The insurer agrees to make the payments due under the first mortgage or first deed of trust upon receipt of payments due from the borrower under the wrap-around mortgage.

§ 38.2-1436. Mortgage participations.—Notwithstanding the provisions of §§ 13.1-627 and 13.1-826, a domestic insurer may acquire or sell participation interests in any loans secured by a mortgage or deed of trust qualifying under § 38.2-1434 if the insurer has all or substantially all the rights of a first mortgagee.

§ 38.2-1437. Limitations on mortgages.—A. The amount of any loan secured by a mortgage or deed of trust referred to in §§ 38.2-1434 through § 38.2-1436 shall not exceed the following percentages of the fair market value of the real estate:

1. Seventy-five percent for a leasehold loan made pursuant to paragraph 2 of § 38.2-1434;

2. Ninety percent for a loan made to an employee of the insurer, other than a director or trustee thereof, whether such loan be made in connection with the initial employment of the employee or in connection with the transfer of the place of employment of the employee; or

3. Eighty percent for all other loans.

However, the percentage limits specified in this subsection may be exceeded if the excess is (i) insured or guaranteed or is to be insured or guaranteed by the United States, any state or any agency of either or (ii) insured by an insurer licensed to insure mortgage guaranty risks in this Commonwealth.

Drafting Note: The change to subsection A of § 38.1-217.40 allows the leasehold mortgage loan limit of 75% and the mortgage loan to employees limit of 90% to be exceeded if there is FHA, VA, etc. coverage or private mortgage guaranty insurance by an insurer licensed in Virginia. A legislative typographical error has been corrected by changing the reference to § 38.1-217.52 to a reference to § 38.1-217.37 (proposed § 38.2-1434).

B. Any loan made pursuant to §§ 38.2-1434 through 38.2-1436 not in compliance with the requirements of subsection A of this section shall be classified as a Category 2 investment in its entirety.

C. The fair market value of the real estate interest mortgaged shall be determined by written appraisals of at least two competent real estate appraisers as of the date of the initial loan commitment. If the loan commitment is revised to reflect a change in the value of the real estate, the fair market value shall be determined as of the date of that revision.

D. Buildings and other improvements on the mortgaged premises shall be insured against fire loss for the benefit of the mortgagee in an amount not less than the lesser of their insurable value or the unpaid

principal balance of the obligation.

E. The maximum term of any mortgage or deed of trust referred to in §§ 38.2-1434 through 38.2-1436 secured by real property primarily improved by a single-family residence shall not exceed thirty years.

§ 38.2-1438. Renewals and extensions when value of property decreases.—Nothing in this chapter shall prohibit a domestic insurer from renewing or extending, or consenting to the renewal or extension of, evidences of indebtedness secured by real property or leasehold estates for the original or a lesser amount when a decrease in value of the property or estate causes the indebtedness to exceed the applicable loan-to-value ratio specified by § 38.2-1437. Nothing in this chapter shall prohibit a domestic insurer from accepting as part payment for any real property or leasehold estate sold by it, a mortgage or other lien on the real property or leasehold estate securing a loan that exceeds the applicable loan-to-value ratio specified in § 38.2-1437.

§ 38.2-1439 Chattel mortgages.—A. In connection with a mortgage loan on the security of real property designed and used primarily for residential purposes and acquired pursuant to § 38.2-1434, a domestic insurer may make a loan on the security of a chattel mortgage, deed of trust or other appropriate lien. The chattel mortgage or other lien may be created separately or in combination with the mortgage loan on the real estate. It shall not exceed five years and shall constitute a first and prior lien, except for taxes not then delinquent, on personal property comprised of durable equipment owned by the mortgagor and kept and used on the mortgaged premises.

B. The term "durable equipment" includes only mechanical refrigerators, mechanical laundering machines, heating and cooking stoves and ranges, mechanical kitchen aids, vacuum cleaners, and fire extinguishing devices; and, for apartment houses and hotels, may also include room furniture and furnishings.

C. Before any loan or investment is made under this section, the items of property included in the security shall be separately appraised by a competent appraiser and the fair market value of the items determined. No loan made under this section shall exceed the lesser of (i) an amount obtained by multiplying the loan to the value ratio applicable to the companion loan on the real property by the fair market value of the personal property or (ii) an amount equal to twenty percent of the amount secured by the lien on the real property.

§ 38.2-1440. Investment in personal property.—A. A domestic insurer may invest in interests in tangible personal property for the production of income, evidenced by trust certificates or other instruments.

B. The investments shall be accompanied by (i) a right to receive rental, charter hire, purchase or other payments for the use or purchase of the personal property, (ii) a valid, binding and enforceable contract or lease for the purchase or use of the tangible personal property, and (iii) a provision for contractual payments to be made that will return the cost of the property and provide earnings on the investments within the anticipated useful life of the property which shall be at least three years.

C. The payments must be made payable or guaranteed by one or more domestic governmental entities or institutions whose obligations would qualify for investment under § 38.2-1421.

D. The unit cost of of such property shall not be less than $25,000, and the cost of all property covered by any single contract or lease shall not be less than $100,000.

E. The tangible personal property shall not include furniture or fixtures.

§ 38.2-1441. Real estate.—A. Except as prohibited by other provisions of this title, a domestic insurer may invest in real estate unless the property is to be used primarily for agricultural, horticultural, ranch, recreational, amusement or club purposes. The term "real estate" as used in this subsection shall include a leasehold of real estate having an unexpired term of not less than twenty years.

Drafting Note: The change to subsection A of § 38.2-1441 based on the last sentence of the first paragraph of former § 38.1-216 (repealed July 1, 1983), clarifies that leaseholds of real estate qualify as Category 1 investments.

B. Real property serving as the residence of an employee of any domestic insurer, other than a director or trustee of the insurer, may be acquired only in connection with the (i) relocation by the insurer of the place of employment of the employee, or (ii) any relocation in connection with the initial employment of the employee. The purchase price shall not exceed the fair market value of the property as determined by written appraisals of at least two competent independent real estate appraisers for the purpose of the acquisition. The employee shall have made reasonable efforts otherwise to dispose of the property for a period of not less than one month immediately prior to the acquisition.

§ 38.2-1442. Guaranty association obligations.— A domestic insurer may invest in any obligation not in default of the Virginia Life, Accident and Sickness Insurance Guaranty Association issued pursuant to paragraph 3 of subsection J of § 38.2-1704 or the Virginia Property and Casualty Insurance Guaranty Association issued pursuant to paragraph 2 of subsection B of § 38.2-1606.

Drafting Note: New § 38.2-1442 replaces a provision in paragraph 3 of subsection J of § 38.2-1704 allowing obligations of the Virginia Life, Accident and Sickness Guaranty Association as "legal investments" and "admitted assets". It also specifies for the first time the investment status of obligations of the Virginia Insurance Guaranty Association.

Article 3.

Separate Accounts.

§ 38.2-1443. Investment of amounts allocated to separate accounts for variable life insurance and variable annuities.—A. The amounts allocated to separate accounts for variable life insurance and variable annuities, pursuant to the provisions of § 38.2-3113, and accumulations on them, may be invested and reinvested by a domestic insurer in any type of Category 1 investment.

B. The limitations of §§ 38.2-1413 and 38.2-1414 shall not apply to investments made pursuant to this section. A domestic insurer may invest the amounts allocated to the accounts in the shares of any open-end investment company registered under the Investment Company Act of 1940, as amended, without regard to the limitations of § 38.2-1427.

§ 38.2-1444. . Establishment of separate accounts for pension, retirement or profit-sharing plans; investment of funds in such accounts.—A. A domestic insurer, after adoption of a resolution by its board of directors and certification of that adoption to the Commission, may allocate to one or more separate accounts, in accordance with the terms of a written agreement, any amounts paid to or held by the insurer in connection with a pension, retirement or profit-sharing plan. The plan may provide (i) retirement benefits pursuant to the terms of the agreement or under the insurer's policies or contracts and (ii) other benefits incidental to the agreement or policies. The retirement benefits may vary according to the terms of the agreement, policies or contracts and any standards incorporated in them. Any income and any realized or unrealized gain or loss on each account shall be credited to or charged against that account in accordance with the agreement, without regard to the other income, gains or losses of the insurer.

B. Notwithstanding any other provision in this title, the amounts allocated to the accounts and accumulations on them may be invested and reinvested in any kinds of investment specified in the agreement other than those prohibited by § 38.2-1407. The investments shall not be taken into account in applying the investment limitations of this chapter to investments made by the insurer.

C. Amounts allocated by an insurer to separate accounts pursuant to this section shall be owned by the insurer, and the insurer shall not be, nor hold itself out to be, a trustee for the amounts. The insurer's liability under the accounts shall be limited to the amount of funds in the account.

§ 38.2-1445. Separate accounts deemed Category 1 investments.—All investments made in compliance with this article shall be deemed Category 1 investments.

CHAPTER 15.

Rehabilitation and Liquidation of ~~Companies~~ Insurers.

1. The definition of Association has been expanded to include the Life, Accident and Sickness Guaranty Association.

2. In § 38.2-1514, the amount that employees of an insolvent insurer can collect for unpaid wages has been raised from $300 to $1,000.

CHAPTER 15.

REHABILITATION AND LIQUIDATION OF INSURERS.

§ 38.2-1500. Scope of chapter.–This chapter shall, except as otherwise stated, apply to every insurer transacting, attempting to transact, or representing itself as transacting an insurance business in this Commonwealth, or which is in the process of organization as an insurer.

§38.2-1501.–Definitions. As used in this chapter:

"Association" means the Virginia Property and Casualty Insurance Guaranty Association created by Chapter 16 of this title or the Virginia Life, Accident and Sickness Insurance Guaranty Association created by Chapter 17 of this title or any person performing a similar function in another state.

Drafting Note: "Association" was defined in existing §§ 38.1-131.1 and 38.1-133.1. The definition has been moved to this section and has been expanded to include the Virginia Life, Accident and Sickness Insurance Guaranty Association.

"Delinquency proceeding" means any proceeding commenced against an insurance company for the purpose of liquidating, rehabilitating, reorganizing or conserving an insurer.

"Insolvent" means (i) the condition of an insurer that has liabilities in excess of assets or (ii) the inability of an insurer to pay its obligations as they become due in the usual course of business.

Drafting Note: The definition includes language originally incorporated in § 13.1-2(K) as well as language that parallels the Commission's practice. The recodified version of Title 13.1 deletes this definition.

"Receiver" means the Commission or any person appointed to manage delinquency proceedings.

Drafting Note: Language in the definition of "receiver" is deleted as it is included in the definition of "delinquency proceedings."

§ 38.2-1502. Jurisdiction and procedure.–The jurisdiction of delinquency proceedings shall be determined by general law, except that if the Commission files a delinquency proceeding application, it shall be filed with the Circuit Court of the City of Richmond. Unless otherwise provided, all delinquency proceedings shall be conducted as a suit in equity.

§ 38.2-1503. Grounds for delinquency proceedings commenced by Commission against domestic insurer.– Delinquency proceedings may be commenced by the Commission against any domestic insurer whenever the insurer:

1. Has been determined to be insolvent by the Commission;

Drafting Note: "Insolvent" has been defined in § 38.2-1501.

2. Has refused to submit its books, papers, accounts, records, or affairs to the reasonable inspection of the Commission or its representative;

3. Has refused or failed to comply with any order of the Commission to make good within the time prescribed by law (i) any impairment of its minimum capital and surplus if the insurer is a stock insurer, (ii) any impairment of its minimum surplus if the insurer is other than a stock insurer, or (iii) membership requirements as set forth in § 38.2-2515 if the insurer is a mutual assessment property and casualty insurer and has had its license revoked;

Drafting Note: § 38.2-2515 refers to delinquency proceedings in the event membership requirements are not met. This section has been moved from the mutual assessment property and casualty insurers chapter.

4. Has transferred or attempted to transfer substantially its entire property, or has entered into any transaction which merges substantially its entire property or business, into the property or business of any other company without prior written approval of the Commission;

5. Has removed, attempted to remove, or is about to remove from this Commonwealth any material part of its property or business necessary for the continued conduct of its business if it endangers the interests of its policyholders, stockholders or members;

6. Has reinsured all or substantially all of its risks without prior written approval of the Commission;

7. Is found, after an examination, to be in a condition where any further transaction of business will be hazardous to its policyholders, creditors, members, subscribers, stockholders, or to the public;

8. Has willfully violated its charter or any law of this Commonwealth;

9. Has an officer, director or manager who has refused to be examined under oath concerning its affairs;

10. Has had any material part of its entire property sequestered in any other state or country;

11. Has not organized or completed its organization and obtained a license to transact the business of

insurance in this Commonwealth within the period of time set by law ; or

12. Has failed to pay a final judgment rendered against it in any state upon any insurance contract issued or assumed by it (i) within sixty days after the judgment has become final, (ii) within sixty days after time for taking an appeal has expired, or (iii) within sixty days after dismissal of an appeal before final determination, whichever date is the latest.

§ 38.2-1504. Requirements when proceedings instituted by any person other than Commission.—A. No circuit court in this Commonwealth shall appoint a receiver for any domestic insurer on application of any person other than the Commission until:

1. The applicant has presented to the Commission a copy of a bill in equity for receivership and has given reasonable notice to the affected insurer that a copy of the bill has been presented to the Commission.

2. The affected insurer has been given ten days after the service of this notice to present to the Commission a copy of the answer that it proposes to file.

3. The Commission has investigated the merits of the application for receivership and has held a hearing on the results of the investigation. The Commission shall act within a reasonable period of time.

4. Within a reasonable time after completing its investigation the Commission shall make a recommendation to the proper court regarding the appointment of the proposed receiver.

B. The court shall appoint or refuse to appoint the proposed receiver after considering the merits of the application for a receiver.

§ 38.2-1505. Commission may apply for receiver and for other relief; what orders court may enter.—A. Whenever the Commission finds that any of the grounds for rehabilitation or liquidation of a domestic insurer set out in § 38.2-1503 exist, it may apply to the Circuit Court of the City of Richmond for an order directing the insurer to show cause on or before a designated date (i) why a receiver other than the Commission should not be appointed for the insurer, (ii) why an order should not be entered authorizing the Commission, as a receiver, to proceed with the rehabilitation or liquidation of the insurer or (iii) why other appropriate steps authorized by this chapter should not be taken. The application and order may include any other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members of the insurer and of the public may require. A copy of the application and the order to show cause shall be served upon the insurer and shall constitute legal process. The State Treasurer shall be made a party to the proceeding.

B. On or after the return of the order to show cause, and after a full hearing, the court shall either deny the application, appoint a receiver for the insurer, authorize the Commission to proceed with the rehabilitation or liquidation of the insurer or to take any other appropriate proceedings as the Commission considers advisable.

§ 38.2-1506. Requirements when receiver appointed; disbursement of available assets to association, etc. —A. Whenever a receiver, other than the Commission, is appointed pursuant to § 38.2-1504 for any domestic insurer other than an insurer writing exclusively title, fidelity and surety, credit or ocean marine insurance, the receiver shall petition the court for approval of a plan to disburse the assets. This shall be completed within 120 days of a final determination by the Commission that the insurer is insolvent. After the application of an association for an insolvent insurer's available assets has been granted, the insolvent insurer's assets will be disbursed to any association entitled to them as they become available.

Drafting Note: This section has been expanded to cover all associations and types of insurers covered by the association.

B. The plan shall include provisions for the receiver to take all the actions required by subsections B and C of § 38.2-1509.

Drafting Note: The old B and C are replaced with the new versions of B and C. There is no change in meaning.

C. Notice of the petition by the receiver to the court for approval of a plan to disburse an insurer's assets shall be given to the associations and the commissioners of insurance of the other states. This notice shall be deemed given when sent by certified mail at least thirty days before submission of the petition to the court. Action on the petition may be taken by the court or a judge of the court if the required notice has been given and the plan of the receiver contains the provisions set forth in this section.

§ 38.2-1507. Further procedure; injunction may be issued.— The court may issue an injunction restraining the insurer and its officers, directors, stockholders, members, trustees, agents, employees and all other persons from transacting any business of the insurer, and from transferring, removing or disposing of its property or business until a further order of the court. The injunction may be issued on or after the institution of any delinquency proceeding, except where the rehabilitation or liquidation of the insurer has been referred to the Commission. If the Commission is authorized to proceed with the rehabilitation or liquidation, it may issue injunctions or enter any other appropriate order for the protection of the insurer's policyholders and creditors and the preservation of its property.

§ 38.2-1508. Powers of Commission when authorized to rehabilitate or liquidate companies.—Whenever the Commission is authorized to act as a receiver to rehabilitate or liquidate an insurer or to take any

other authorized steps that it considers advisable in connection with the affairs of the insurer, it shall have all the power and authority of a court of record as provided in Article IX, § 3, of the Constitution. All further proceedings in connection with the rehabilitation or liquidation shall be conducted by the Commission without any control or supervision by the court to which the application was made. For the violation of any injunction or order issued under this chapter, the Commission shall have the same power to punish for contempt as a court and shall follow the procedure set forth in § 12.1-34. The Commission may deal with the property and affairs of the insurer in its own name or in the name of the insurer. The Commission shall be vested by law with the title to all of the property, contracts and rights of action of the insurer as of the date shown by the order of the court referred to in § 38.2-1507. The filing or recording of the order in any clerk's office in this Commonwealth shall give the same notice that a deed, bill of sale or other evidence of properly filed or recorded title have given.

§ 38.2-1509. Powers of Commission when authorized to rehabilitate or liquidate insurers by court order; disbursement of available assets to an association, etc.—A. Whenever the Commission is authorized by order of the Circuit Court of the City of Richmond to rehabilitate or liquidate any domestic insurer other than an insurer writing exclusively title, fidelity and surety, credit or ocean marine insurance, the Commission shall disburse the assets as they become available to an association. Disbursal shall not be made until an application has been filed with the Commission by an association for an insolvent insurer's available assets.

Drafting Note: "Association" has been defined previously.

B. The Commission shall disburse the assets of an insolvent insurer as they become available in the following manner:

1. Pay, after reserving for the payment of the costs and expenses of administration, according to the following priorities: (i) wages entitled to priority as provided in § 38.2-1514, (ii) claims of secured creditors with a perfected security interest not voidable under § 38.2-1513 to the extent of the value of their security, (iii) taxes owed to the United States and other debts owed to any person, including the United States, who by the laws of the United States are entitled to priority, (iv) claims of the associations for "covered claims" as defined in § 38.2-1603 and claims of other policyholders apportioned without preference, and (v) other creditors.

Drafting Note: Paragraph (2) is eliminated as it does not add anything to subsection B.

2. Equitably allocate disbursements to each of the entitled associations; and

3. Secure an agreement from each of the entitled associations requiring the return to the Commission of any assets previously disbursed to the association required to pay claims entitled to priority in paragraph 1 of this subsection. No bond shall be required of any entitled association; and

4. Require a full report to be made by the association to the Commission accounting for all assets disbursed to the association, all disbursements made from these assets, any interest earned on these assets and any other matter as the Commission may require.

C. The Commission shall provide for disbursements to the association in an amount estimated at least equal to the claim payments made or to be made by the association for which the association could assert a claim against the Commission. In addition, the Commission shall provide that if the assets available for disbursement do not equal or exceed the amount of claim payments made or to be made by the associations, then disbursements shall be in the amount of available assets.

D. The Commission shall notify the affected associations and the commissioners of insurance in the other states of any disbursement made according to this section. The notice shall be deemed given when sent by certified mail at least thirty days prior to disbursement.

§ 38.2-1510. Commission may appoint assistants in connection with rehabilitation or liquidation.—The Commission shall have power to appoint one or more special deputies as its agent and to employ the counsel, clerks, and assistants considered necessary to efficiently conduct the rehabilitation or liquidation. The Commission may delegate to its agent any of its powers which are necessary to carry out the rehabilitation or liquidation. The compensation of the special deputy commissioners, counsel, clerks and assistants, and all expenses relating to the rehabilitation or liquidation of any insurer shall be set by the Commission and upon certification by the Commission be paid out of the insurer's assets.

§ 38.2-1511. Borrowing on pledge of assets.—For the purpose of facilitating the delinquency proceeding of an insurer, the Commission, or a receiver other than the Commission with the approval of the court, may borrow money and execute, acknowledge, and deliver notes or other evidences of indebtedness and secure the repayment by mortgage, pledge, assignment, transfer in trust, or hypothecation of any or all of the property, real, personal or mixed, of the insurer. The Commission, or a receiver other than the Commission with the approval of the court, shall have power to take any action necessary and proper to consummate any loans and to provide for repayment. No note or other evidence of indebtedness made or executed by the receiver shall impose upon the receiver any liability except with respect to the assets and other property of the insurer.

Drafting Note: Because of the revised definition of "receiver" in § 38.2-1501, the change from "Commission or any such receiver" to the receiver is not a change in meaning.

§ 38.2-1512. Rights and liabilities fixed upon liquidation.—The rights and liabilities of an insurer and of its creditors, policyholders, stockholders, members, and all other persons interested in the property and assets of the insurer, shall be fixed as of the date of the entry of the order directing the liquidation of the insurer unless otherwise provided by law. The rights of claimants holding contingent claims on that date

shall be determined by this chapter.

§ 38.2-1513. Voidable transfers.—A. Any transfer of or lien upon the property of an insurer that is made or created within four months before the institution of delinquency proceedings under this chapter shall be voidable if (i) done with the intent of giving or enabling any creditor to obtain a greater percentage of payment of the debt than any other creditor of the same class and (ii) the creditor accepting the transfer has reasonable cause to believe that a preference will occur.

B. Every director, officer, employee, stockholder, member, subscriber, and other person acting on behalf of an insurer who is involved in any act described in subsection A of this section, and every person receiving property of an insurer as a result of this act, shall be personally liable and held accountable to the receiver.

C. A receiver in any proceeding under this chapter may avoid any transfer of or lien upon the property of an insurer that any creditor, stockholder, subscriber or member of the insurer might have avoided. The receiver may also recover the transferred property unless the person was a valid holder for value before the date of the institution of delinquency proceedings under this chapter. The property or its value may be recovered from anyone who has received it except as a valid holder for value as specified in this subsection.

§ 38.2-1514. Priority of claims for wages.—Before the payment of any other debt or claim, compensation shall be paid to employees other than officers of an insurer for services rendered within three months before the commencement of the delinquency proceedings. The payment shall not exceed $1,000 for each employee. At the discretion of the Commission, or a receiver other than the Commission with the approval of the court, payment may be made as soon as practicable. This priority shall be superior to any other similar priority authorized by law regarding wages or compensation of the employees.

Nothing in this section shall prohibit a receiver from allocating sufficient funds to cover the expenses of administration.

Drafting Note: Section 38.2-1514 (formerly § 38.1-138) has been re-written for clarity. Compensation limits have been changed to coincide with the NAIC model provisions.

§ 38.2-1515. Mutual debts or credits, how treated.—A. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, the credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection B of this section.

B. No offset shall be allowed in favor of any person where:

1. The obligation of the insurer to the person would not entitle him at the date of the entry of any rehabilitation or liquidation order to share as a claimant in the assets of the insurer;

2. The obligation of the insurer to the person was purchased by or transferred to the person with a view of its being used as an offset; or

3. The obligation of the person is to pay (i) an assessment levied against the members of a mutual insurer or the subscribers of a reciprocal insurer, or (ii) a balance upon a subscription to the capital stock of a stock insurer.

§ 38.2-1516. Receivers to file reports, etc., with Commission.—Each receiver appointed in delinquency proceedings shall file with the Commission annually a report of the affairs of the insurer in the form prescribed by the Commission. Each receiver shall file with the Commission copies of all reports, petitions, court orders, and other pertinent papers dealing with the delinquency proceeding.

§ 38.2-1517. What included in annual report of Commission.—The Commission shall include in its annual report the names of all insurers against which delinquency proceedings are pending under this chapter, and the names and addresses of any receivers of the insurers. The report shall show whether or not the insurers have resumed business or have been liquidated, and shall contain any other matter that will inform the policyholders, creditors, stockholders, members and the public of the current status of the proceeding regarding each insurer.

§ 38.2-1518. Rehabilitation or mutualization of companies.—If at any time the Commission acting as the receiver finds that it is in the best interests of the policyholders and creditors of a delinquent insurer that it be rehabilitated or mutualized, the Commission shall prepare a plan of rehabilitation or mutualization. If at any time a receiver , other than the Commission, of a delinquent insurer reports to the court that it is in the best interests of the policyholders and creditors of the insurer that it be rehabilitated or mutualized, the receiver shall submit a plan of rehabilitation or mutualization to the court for its approval. The plan may include a provision imposing liens upon the net equities of policyholders of the insurer, and in the case of life insurers, a provision imposing a moratorium upon the loan or cash surrender values of the policies for whatever period of time is necessary. A hearing on the plan shall be held and notice of the hearing given in a manner prescribed by either the Commission or the court. After the hearing, the plan may be approved, disapproved, or modified by the Commission or the court.

§ 38.2-1519. Termination of rehabilitation; when liquidation may be entered.—A. If either the Commission or the court determines that the purposes of the rehabilitation proceeding have been accomplished and that the insurer can safely and properly resume possession of its property and the

conduct of its business, an order may be entered terminating the rehabilitation proceeding and permitting the insurer to resume possession of its property and the management and conduct of its affairs. The order shall not be entered until a full hearing is held, subject to proper notice given in the manner prescribed by the Commission or the court.

B. If at any time it appears to either the Commission or the court that further efforts to rehabilitate the insurer would be useless, an order of liquidation may be entered.

§ 38.2-1520. Liquidation of alien insurers.—Proceedings in liquidation of the business of the United States branch of an alien insurer having trusteed assets in this Commonwealth may be instituted and conducted in the manner prescribed in this chapter for domestic insurers. However, only the assets of the business of the United States branch shall be included in the proceedings.

§ 38.2-1521. Conservation of assets of foreign or alien insurer; when liquidation may be entered.—A. Proceedings against a foreign or alien insurer for the conservation of the insurer's assets within this Commonwealth may be instituted and conducted in the manner prescribed in this chapter for delinquency proceedings against a domestic insurer on any one or more of the applicable grounds specified in § 38.2-1503. The order of conservation shall direct the receiver to take possession of the assets of the insurer within this Commonwealth and conserve the assets for the benefit of its policyholders and for any other purpose as the nature of the cause and the interests of its policyholders, creditors, members, stockholders or the public require.

B. If the laws of any other state or country provide for the conservation, liquidation and distribution of a foreign or alien insurer's assets to creditors, policyholders, and other entitled persons, then the receiver appointed in this Commonwealth to conserve the foreign or alien insurer's assets within this Commonwealth may proceed to liquidate the business of the insurer in this Commonwealth and distribute the assets to those entitled to them. In all other cases the rights, powers, and duties of the Commission or the receiver with respect to the assets of a foreign or alien insurer shall be ancillary to the rights, powers, and duties imposed upon any receiver or other person in charge of the property, business, and affairs of the insurer in its domiciliary state or country.

Title 38.2

CHAPTER 16.

Virginia Property and Casualty Insurance Guaranty Association.

1. The term "property and casualty" is added to the Association's name to differentiate it from the Virginia Life, Accident and Sickness Insurance Guaranty Association.

2. Section 38.2-1601 is amended to clarify that the coverage of the Guaranty Association applies only to member insurers.

3. In § 38.2-1601 captive insurance companies and home protection companies have been aded to the list of companies not eligible for membership. This change merely updates the code to current practices.

4. Section 38.2-1606 is amended to conform to the NAIC model with respect to filing claims with the liquidator or receiver of an insolvent insurer.

5. A provision is added to § 38.2-1606 to allow for the repayment of increased assessments made to certain insurers resulting from a defendent of assessments to other insurers. Repayment shall be made when the deferred assessment insurers bring their contributions up to date.

6. A new article is added to this chapter. This new article provides guidance to establishment of a safety fund for the Association. The article gives guidance to the Commission in administering § 38.2-225. Additional provisions are included on the priority use and repayment funds not derived from assessments. Of particular significance is the Commission's authority to direct funds derived from penalties to the safety fund. The establishment of the safety fund should allow the Association to handle insolvencies, particularly small insolvencies, more expediently.

CHAPTER 16.

VIRGINIA PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION.

Article 1.

Establishment and Operation of the Association.

§ 38.2-1600. Purpose.--The purpose of this chapter is to establish an association that shall provide prompt payment of covered claims to reduce financial loss to claimants or policyholders resulting from the insolvency of an insurer. This association shall assist in the detection and prevention of insurer insolvencies and shall apportion the cost of this protection among insurers.

§ 38.2-1601. Application.--A. This chapter shall apply to all classes of direct insurance written by member insurers except life, title, fidelity, surety, accident and sickness, mortgage guaranty, credit and ocean marine insurance.

B. This chapter shall not apply to any classes of insurance written by cooperative nonprofit life benefit companies, mutual assessment life, accident and sickness insurers, burial societies, fraternal benefit societies, captive insurers and home protection companies.

Drafting Note: The application of this Chapter is restricted to insurance written by a member. Certain non-member insurers could write coverages by this chapter but there is no intent that these coverages fall under the provisions of this chapter when written by a non-member. Mortgage guaranty insurance is excluded to conform with the practice. The exclusion of types of insurers in subsection B was moved from the definition of member insurers in § 38.2-1603. Captive insurance companies and home protection companies have been added to the list of companies not eligible for membership. This change merely updates the Code to current practices.

§ 38.2-1602. Liberal construction.-- This chapter shall be liberally construed to effect the purpose under § 38.2-1600, which shall constitute an aid and guide to interpretation.

§ 38.2-1603. Definitions.--As used in this chapter:

"Account" means any one of the three accounts created by § 38.2-1604.

"Association" means the Virginia Property and Casualty Insurance Guaranty Association created under § 38.2-1604.

"Covered claim" means an unpaid claim, including one for unearned premiums, which arises out of and is within the coverage and not in excess of the applicable limits of a policy covered by this chapter and issued by an insurer who has been declared to be an insolvent insurer. The claimant or insured shall be a resident of this Commonwealth at the time of the insured loss or the property from which the claim arises shall be permanently located in this Commonwealth. "Covered claim" shall not include any amount payable to a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.

Drafting Note: Reference to June 26, 1970 is obsolete and no longer needed.

"Insolvent insurer" means an insurer that is (i) licensed to transact the business of insurance in this Commonwealth either at the time the policy was issued or when the insured loss occurred and (ii) determined to be insolvent by a court of competent jurisdiction in this Commonwealth or the insurer's state of domicile.

"Member insurer" means any person who (i) writes any class of insurance to which this chapter applies under § 38.2-1601, including reciprocal insurance contracts, and (ii) is licensed to transact the business of insurance in this Commonwealth.

"Net direct written premiums" means direct gross premiums written in this Commonwealth on insurance policies applicable to this chapter, less return premiums and dividends paid or credited to policyholders on direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

§ 38.2-1604. Association created; members; divided into three accounts.-- The nonprofit unincorporated legal entity known as the Virginia Property and Casualty Insurance Guaranty Association, created by former § 38.1-761, shall continue in existence. All insurers defined as " member insurers " under § 38.2-1603 shall be and remain members of the Association as a condition of their license to transact the business of insurance in this Commonwealth. The Association shall perform its functions under a plan of operation established and approved under § 38.2-1607 and shall exercise its powers through a board of directors established under § 38.2-1605. For purposes of administration and assessment, the Association shall have three separate accounts: (i) the workers' compensation insurance account; (ii) the automobile insurance account; and (iii) the account for all other insurance to which this chapter applies.

§ 38.2-1605. Board of directors.--A. The board of directors of the Association shall consist of at least five but no more than nine persons serving terms specified in the plan of operation. The members of the board shall be elected by member insurers, giving consideration among other things to whether all types of member insurers are fairly represented. Vacancies on the board shall be filled for the remaining period of the term in the same manner as initial appointments.

B. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors.

§ 38.2-1606. Duties and powers of Association.--A. The Association shall:

1. Be obligated for the covered claims that existed prior to the determination of insolvency and which arose before the earliest of (i) ninety -one days after the determination of insolvency, (ii) the policy expiration date or (iii) the date the insured replaces or cancels the policy. This obligation shall include only that amount of each covered claim that (a) in the case of unearned premiums, is in excess of $50 but less than $300,000, and (b) in the case of all other covered claims, is less than $300,000. However, the Association shall pay the full amount of any covered claim arising out of a workers' compensation policy. In no event shall the Association be obligated to a policyholder or claimant for an amount in excess of the insolvent insurer's obligation for a covered claim. A covered claim shall not include any claim filed with the Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

Drafting Note: The changes conform with NAIC model and establish the court set date as a limit for the filing of a covered claim.

2. Be deemed the insurer to the extent of the insolvent insurer's obligation on the covered claims and to that extent shall have all the rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

3. Allocate claims paid and expenses incurred among the three accounts and assess member insurers separately for each account (i) the amounts necessary to pay the obligations of the Association under paragraph 1 of this subsection subsequent to an insolvency, (ii) the expenses of handling covered claims subsequent to an insolvency and (iii) other expenses authorized by this chapter. The assessments of each member insurer shall be based on the ratio of the net direct written premiums of the member insurer to the net direct written premiums of all member insurers. This ratio shall be determined using the premiums for the preceding calendar year on the classes of insurance in the account. Each member insurer shall be notified of the assessment at least thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two percent of that member insurer's net direct written premiums for the preceding calendar year on the classes of insurance in the account. If the sum of the maximum assessment and the assets of the account does not provide in any one year an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The Association may exempt or defer, in whole or in part, the assessment of any member insurer if payment of the assessment would cause the member insurer's financial statement to reflect an impairment of the insurer's minimum capital and surplus. Deferred assessments shall be paid when the payments shall not cause an impairment of minimum capital and surplus. These payments shall be refunded to those members receiving larger assessments by virtue of the deferment. Each member insurer may set off against any assessment, payments authorized by the Association and made on covered claims and expenses incurred in the payment of those claims. The offset shall be allowed only if the payments are chargeable to the account for which the assessment is made.

Drafting Note: The new language provides for repayment of assessments to those members that paid for the deferral.

4. Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims. The Association may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases and judgments may be properly contested.

5. Notify those persons as the Commission directs under paragraph 8 of this subsection.

6. Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to (i) the approval of the Commission, and (ii) acceptance by the designated insurer.

7. Reimburse each servicing facility for the Association's obligations paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association. The Association shall pay the other expenses authorized by this chapter.

8. Notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this chapter. Notification shall be sent by mail to the insureds' last known address. If the Association is unable to obtain the information required to mail the notice in a timely manner, the Association shall publish the notice in newspapers of general circulation likely to cover geographical areas occupied by the policyholders.

Drafting Note: Moved from paragraph 2(a) of existing § 38.1-765 with additional guidelines for use when notice must be published.

B. The Association may:

1. Employ or retain persons necessary to perform the duties of the Association.

2. Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

3. Sue or be sued.

4. Negotiate and become a party to those contracts necessary to carry out the purpose of this chapter.

5. Perform any other acts necessary or proper to achieve the purpose of this chapter.

6. Pay refunds to the member insurers in proportion to their contributions made to each account during the five years immediately preceding the date of the refund. The total refund shall be the amount by which the assets of the account are expected to exceed the liabilities for the coming year as determined by the board of directors.

§ 38.2-1607. Plan of operation.– A.1. The plan of operation and any amendments to it shall be submitted to the Commission by the Association and shall not become effective until approved by the Commission in writing. The Commission shall approve the plan or amendment to the plan if it complies with this chapter and assures the fair, reasonable, and equitable administration of the Association.

2. The plan of operation approved under former § 38.1-764 shall remain in effect until modified in accordance with paragraph 3 of this subsection.

3. If the Association fails to submit suitable amendments to the plan, the Commission shall, after notice and hearing, adopt and promulgate any reasonable rules that are necessary or advisable to effect this chapter. Those rules shall continue in force until modified by the Commission or superseded by a plan or amendments submitted by the Association and approved by the Commission.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

1. Establish the procedures for exercising the powers and duties of the Association under § 38.2-1606.

2. Establish procedures for handling assets of the Association.

3. Establish the amount and method of reimbursing members of the board of directors under § 38.2-1605.

4. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of those claims shall be periodically submitted to the Association or similar organizations in another state by the receiver or liquidator.

5. Establish regular places and times for meetings of the board of directors.

6. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors.

7. Provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commission within thirty days after the action or decision.

8. Establish the procedures for submitting to the Commission the names of elected members of the board of directors.

9. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under paragraph 3 of subsection A of § 38.2-1606 and paragraph 2 of subsection B of § 38.2-1606, shall be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. The corporation, association or organization shall be compensated for providing those and any other permissible services. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commission. The delegation may be made only to a corporation, association, or organization that extends protection which is substantially no less favorable or effective than that provided by this chapter.

§ 38.2-1608. Duties and powers of Commission; judicial review.–A. The Commission shall:

1. Notify the Association of the existence of an insolvent insurer within three days after it receives notice of the determination of the insolvency.

2. Upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer.

B. The Commission may:

Drafting Note: Moved to § 38.2-1606.

1. Suspend or revoke, after notice and hearing, the license to transact the business of insurance in this Commonwealth of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commission may levy a fine on any member insurer that fails to pay an assessment when due. The fine shall not exceed five percent of the unpaid assessment per month, except that no fine shall be less than $100 per month.

2. Revoke the designation of any servicing facility if it finds that claims are being handled unsatisfactorily.

Drafting Note: Judicial review is centralized under general provisions.

§ 38.2-1609. Insured's rights and liabilities; settlements binding on receiver or liquidator; priority of claims; statements to be filed with receiver or liquidator.—A. Any person recovering under this chapter shall be deemed to have assigned his rights under the policy to the Association to the extent of his recovery from the Association. Each insured or claimant seeking the protection of this chapter shall cooperate with the Association to the same extent as the person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except the causes of action the insolvent insurer would have had if those sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on an assessment plan, payments of claims by the Association shall not reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments previously made. However, the receiver, liquidator, or statutory successor shall under no circumstances levy an additional assessment against the insured, regardless of the terms of the policy.

B. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Association or a similar organization in another state. The court having jurisdiction shall grant those claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer. The expenses of the Association or a similar organization incurred in handling claims shall be accorded the same priority as the liquidator's expenses.

C. The Association shall preserve its rights to the assets of the insolvent insurer by periodically filing with the receiver or liquidator statements of the covered claims paid by the Association and estimates of anticipated claims on the Association.

§ 38.2-1610. Exhaustion of remedies under policy; claims recoverable from more than one association.—A. Any person having a claim against an insurer under any provision in an insurance policy, other than a policy of an insolvent insurer under which the claim is also covered, shall be required to first seek recovery under the policy covered by the insurer which is not insolvent. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under the insurance policy.

B. Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the state where the insured resides. However, if it is a first party claim for damage to property with a permanent location, the insured shall seek recovery first from the association of the state where the property is located. For a workers' compensation claim recovery shall first be sought from the association of the state where the claimant resides. Any recovery under this chapter shall be reduced by the amount of the recovery from any other insurance guaranty association or its equivalent.

§ 38.2-1611. Aids in detection and prevention of insurer insolvencies.—To aid in the detection and prevention of insurer insolvencies:

1. The Association's board of directors has the duty, upon a majority vote, to notify the Commission of any information indicating that a member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

2. The Association's board of directors, upon majority vote, may request that the Commission order an examination of any member insurer that the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of the request, the Commission shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners' examination or may be conducted by persons designated by the Commission. The cost of the examination shall be paid by the Association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commission from complying with paragraph 3 of this section.

The Commission shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commission, but it shall not be open to public inspection prior to the release of the examination report to the public.

3. It shall be the duty of the Commission to report to the board of directors when it has reasonable cause to believe that a member insurer, which has been examined or is being examined at the request of the board of directors, may be insolvent or in a financial condition hazardous to the policyholders or the public.

4. The board of directors may, upon majority vote, make reports and recommendations to the Commission upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Those reports and recommendations shall not be considered public documents.

5. The board of directors may, upon majority vote, make recommendations to the Commission for the detection and prevention of insurer insolvencies.

6. At the request of the Commission and at the conclusion of any insurer's insolvency in which the Association was obligated to pay covered claims, the board of directors shall prepare a report on the history and causes of the insolvency based on the information available to the Association. The report shall be submitted to the Commission.

§ 38.2-1612. Examination and regulation of Association by Commission; annual financial report.—The Association shall be subject to examination and regulation by the Commission. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the Commission.

§ 38.2-1613. Exemption from payment of fees and taxes.—The Association shall be exempt from payment of all fees and all taxes levied by this Commonwealth or any of its subdivisions except taxes levied on real or personal property.

§ 38.2-1614. Rates and premiums to be sufficient to cover assessments paid to Association.—The rates and premiums charged for insurance policies to which this chapter applies shall include an amount sufficient to cover the amounts paid to the Association by the member insurer less any amounts returned to the member insurer by the Association. The rates shall not be considered excessive because they contain an amount calculated to cover assessments paid by the member insurer.

§ 38.2-1615. No liability for action taken in good faith.—There shall be no liability on the part of and no cause of action shall arise against any member insurer, the Association or its agents or employees, the board of directors, or the Commission or its representatives for any action taken or statement made by them in good faith in the performance of their powers and duties under this chapter. The Association's board of directors shall not incur any civil liability for any statements made in good faith under this provision.

§ 38.2-1616. Stay of proceedings against insolvent insurer; setting aside judgment, etc.—All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this Commonwealth shall be stayed for sixty days from the date the insolvency is determined to permit proper defense by the Association of all pending causes of action. For any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the Association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that made the judgment, order, decision, verdict or finding and shall be permitted to defend against the claim on the merits.

§ 38.2-1617. Termination of operation of Association; expiration of chapter.—A. The Commission shall by order terminate the operation of the Association for any class of insurance covered by this chapter with respect to which it has found, after hearing, that there is in effect a statutory or voluntary plan which:

1. Is a permanent plan that is adequately funded or for which adequate funding is provided; and

2. Extends or will extend to the policyholders and residents of this Commonwealth protection and benefits with respect to insolvent insurers not substantially less favorable and effective to those policyholders and residents than the protection and benefits provided with respect to the classes of insurance under this chapter.

B. The Commission shall, by the same order, authorize discontinuance of future payments by insurers to the Association regarding the same classes of insurance. However, the assessments and payments shall continue, as necessary, to pay (i) covered claims of insurers determined to be insolvent prior to the order and (ii) the related expenses not covered by any other plan.

C. In the event the operation of the Association is terminated for all other classes of insurance within its scope, the Association shall, as soon as possible, distribute the balance of moneys and assets remaining. Distribution shall be made after the Association has settled all prior insurer insolvencies not covered by any other plan, including their related expenses. The distribution shall be made to the insurers that are then writing in this Commonwealth policies of the classes of insurance covered by this chapter and that had made payments to the Association. Distribution shall be made using a pro rata method based upon the aggregate of the payments made by the respective insurers during the five years immediately preceding the date of the order. Upon completion of the distribution for all of the classes of insurance covered by this chapter, this chapter shall be deemed to have expired.

ARTICLE 2.

Additional Funds Paid to Association.

Drafting Note: This article provides guidance to the establishment of a safety fund for the Association. The article gives guidance to the Commission in administering § 38.2-225. Additional provisions are included

on the priority use and repayment of other than assessment derived funds.

§ 38.2-1618. Purpose and applicability of article.– The purpose of this article is to provide directions and guidelines for the control and use of funds provided pursuant to § 38.2-225 or any other sources of funds not specified in Article 1 of this chapter.

§ 38.2-1619. Safety fund.–The Association shall maintain a separate asset account to be known as the safety fund. The safety fund shall be used to assist the Association in meeting the objectives specified in § 38.2-1600.

Drafting Note: The establishment of a separate asset safety account is necessary to assist the Association in handling catastrophic insolvencies.

§ 38.2-1620. Financing the safety fund, maximum amount, distribution of excess.–A. The safety fund, at the discretion of the Commission, shall receive penalty payments levied against member insurers made pursuant to subsection B of § 38.2-225 or any other payments approved by the Commission.

B. The Commission may approve the payment of funds to the Association provided the balance in the safety fund account does not exceed two percent of the total of all member insurer's net direct written premiums for classes of insurance covered by the accounts specified in § 38.2-1604.

C. Except as provided in subsection D of this section, investment income earned on assets held in the safety fund shall be credited to the safety fund.

D. In the event the safety fund balance exceeds three percent of the net written premium for all classes of insurance covered by the accounts specified in § 38.2-1604, at the discretion of the Commission the difference shall be paid to the state treasury to the credit of the Literary Fund or shall be subject to subsection F of § 38.2-1622.

E. In the event the fund is dissolved, remaining assets in the safety fund will be distributed to the state treasury to the credit of the Literary Fund.

Drafting Note: This section provides for the financing of the safety fund and provides direction to the Commission in implementing § 38.2-225. Penalty payments may be credited to the association until the balance exceeds 2% of the domestic premium assessment base. Investment income will remain in the account until the balance is 3% of the domestic premium assessment base. Excess balances may flow to the Literary Fund.

In 1984, the total assessable premium for all three accounts was $2.3 billion. Therefore, the Commission may direct that penalty payments levied against member insurers be allocated to the safety fund until the balance of the fund equals $46.5 million (2% of $2.3 billion). Investment income may be retained in the account until a balance of $70 million (3% of $2.3 billion) is achieved.

§ 38.2-1621. Investment of safety fund.–The assets of the safety fund may be invested in securities set forth in § 38.2-1415.

Drafting Note: The assets of the safety fund may be invested in government securities as set forth in § 38.2-1415.

§ 38.2-1622. Use of safety fund, repayment, etc.– A. The purpose of the safety fund is to provide for the payment of covered claims in the event the assessment limit specified in paragraph 3 of § 38.2-1606 is reached.

B. In the event the assets of the safety fund are needed to pay covered claims, these assets shall be loaned to the respective account specified in § 38.2-1604. This loan shall be the general obligation of the Association members and shall be evidenced by an agreement approved by the Commission.

C. Interest on this loan shall be compounded quarterly and be based upon the average of the ninety day treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin. This rate will be updated quarterly in order to conform with the market rates of interest.

D. This loan shall be repaid by levying assessments pursuant to paragraph 3 of § 38.2-1606 against the members for the account on whose behalf the loan was negotiated. Unless otherwise approved by the Commission, the loan shall be repaid within six months of its issuance. This assessment in conjunction with any other assessments levied, shall not exceed the limit specified in paragraph 3 of § 38.2-1606.

E. Subject to the approval of the Commission, assets of the safety fund may be loaned to any account specified in § 38.2-1604 even though the maximum assessment in paragraph 3 of § 38.2-1606 has not been levied if the directors of the Association determine that this action will minimize the cost to the association in paying covered claims.

F. Excess safety fund assets set forth in subsection D of § 38.2-1620 may be used to pay the Association's covered claims without the members incurring a liability to repay the safety fund.

Drafting Note: This section provides for the safety fund to be loaned to the account incorporating the covered claim. A market rate of interest will apply to this loan and the loan shall be repaid from future assessments. The loan, with exception, must be repaid within six months. When economically justifiable, the Association may borrow from the fund rather than levying an assessment. Normally, the safety fund should be used as a source of last resort. If the fund balance exceeds 2% of the assessable premium and at the discretion of the Commission the excess balances may be used to pay covered claims without obligating the insurers to repay the safety fund.

§ 38.2-1623. Association as a fiduciary.—In handling the assets of the safety fund, the Association shall be deemed a fiduciary for the Commonwealth.

Drafting Note: The assets in the safety fund are derived from the public by way of penalties and other non insurer sources. Consequently, the Association should be required to handle these funds in a fiduciary capacity on behalf of the public.

Title 38.2

CHAPTER 17.

Virginia Life, Accident and Sickness Insurance Guaranty Association.

1. Under existing language, policyholders insured by an insurer whose license to do business has been revoked may not be covered by the Guaranty Fund if an insolvency results after the revocation. Section 38.2-1025 has been changed to provide the Commission an alternative to license revocation.

2. In § 38.2-1704, investments by an insurer in evidences of indebtedness issued by the Association will qualify as Category 1 investments.

3. In § 38.2-1705, Association members will be charged a floating rate for assessments due but not paid.

4. Paragraph 4 of subsection A of § 38.2-1708 is deleted. It is unreasonable to expect the Association to review the IRIS (insurance regulation information system) reports. Review of those reports requires more time and resources than are normally available to the Association.

5. A new article is added to this chapter. This new article provides guidance to establishment of a safety fund for the Association. The article gives guidance to the Commission in administering § 38.2-225. Additional provisions are included on the priority use and repayment funds not derived from assessments. Of particular significance is the Commission's authority to direct funds derived from penalties to the safety fund. The establishment of the safety fund should allow the Association to handle insolvencies, particularly small insolvencies, more expediently.

CHAPTER 17.

VIRGINIA LIFE, ACCIDENT AND SICKNESS

INSURANCE GUARANTY ASSOCIATION.

ARTICLE 1.

Establishment and Operation of the Association.

Drafting Note: Short titles are not being used in this Title.

§ 38.2-1700. Purpose and applicability of article.—A. The purpose of this chapter is to protect, subject to certain limitations, policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, accident and sickness insurance policies, annuity contracts, and supplemental contracts against failure to fulfill contractual obligations due to the impairment or insolvency of the insurers issuing those policies or contracts. To provide this protection, (i) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, (ii) members of the Association are subject to assessments to provide funds to carry out the purpose of this chapter, and (iii) the Association is authorized to assist the Commission, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

B. This chapter shall apply to direct life insurance policies, accident and sickness insurance policies, annuity contracts, and contracts supplemental to life, accident and sickness insurance policies and annuity contracts issued by insurers licensed to transact insurance in this Commonwealth at any time.

Drafting Note: Currently, a question exists as to the obligation of the Association to honor liabilities of an insolvent insurer whose license had been revoked prior to the determination of insolvency. § 38.2-1025 has been modified to correct this problem by allowing the Commission to issue a restricted license when the provisions of § 38.2-1040 have not been met.

C. This chapter shall not apply to:

1. That portion or part of a variable life insurance or variable annuity contract not guaranteed by an insurer;

2. That portion or part of any policy or contract under which the risk is borne by the policyholder;

3. Any policy or contract, or part of a policy or contract assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued; or

4. Any policy or contract issued by cooperative nonprofit life benefit companies, mutual assessment life, accident and sickness insurance companies , burial societies, fraternal benefit societies, dental and optometric services plans and health services plans not subject to § 38.2-4213.

Drafting Note: 1. Title 32 has been repealed by prior legislation and its provisions have been moved to this title.

2. Only health services plans that have not been converted to nonagent plans will be exempt from membership.

§ 38.2-1701. Definitions.—As used in this chapter:

"Account" means any one of the three accounts created under § 38.2-1702.

"Association" means the Virginia Life, Accident and Sickness Insurance Guaranty Association created under § 38.2-1702.

Drafting Note: The definition of "Commission" appears at the beginning of the title.

"Contractual obligation" means any obligation under covered policies.

"Covered policy" means any policy or contract within the scope of this chapter under § 38.2-1700.

"Impaired insurer" means a solvent member insurer considered by the Commission to be potentially unable to fulfill its contractual obligations.

"Insolvent insurer" means a member insurer that becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction.

Drafting Note: Reference to dates in paragraphs (6) and (7) is no longer required.

"Member insurer" means any person licensed to write in this Commonwealth any class of insurance to which this chapter applies under § 38.2-1700.

"Premiums" means direct gross insurance premiums and annuity considerations received on covered policies, less any return of premiums, and considerations on covered policies, and dividends paid or

credited to policyholders on this business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers.

Drafting Note: The definition of "person" is deleted as it is included in the beginning of the title.

"Resident" means any person who resides in this Commonwealth at the time a member with contractual obligations is determined to be impaired or insolvent.

§ 38.2-1702. Association; creation; memberships; accounts; supervision.—A. The nonprofit legal entity to be known as the Virginia Life, Accident and Sickness Insurance Guaranty Association, created by former § 38.1-482.20, shall continue in existence. All member insurers shall continue to be members of the Association as a condition of their license to transact the business of insurance in this Commonwealth. The Association shall perform its functions under the plan of operation established and approved under § 38.2-1706 and shall exercise its powers through a board of directors established under §38.2-1703. For purposes of administration and assessment, the Association shall maintain three accounts: (i) the accident and sickness insurance account; (ii) the life insurance account; and (iii) the annuity account.

B. The Association shall come under the immediate supervision of the Commission and shall be subject to the applicable provisions of the insurance laws of this Commonwealth.

§ 38.2-1703. Board of directors of Association.—A. The board of directors of the Association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the Commission. Vacancies on the board shall be filled for the remainder of the term by a majority vote of the remaining board members, subject to the approval of the Commission.

Drafting Note: The deleted portion is no longer needed as the initial board has been established.

B. In approving selections or in appointing members to the board the Commission shall consider, among other things, whether all domestic and foreign member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board shall not be otherwise compensated by the Association for their services.

§ 38.2-1704. Powers and duties of Association.—In addition to the powers and duties enumerated in other sections of this chapter :

A. In the case of a impaired domestic insurer and subject to (i) conditions imposed by the Association other than those that impair the contractual obligations of the impaired insurer, (ii) approval by the impaired insurer and (iii) approval by the Commission, the Asociation may:

1. Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurer;

2. Provide moneys, pledges, notes, guarantees or other means required for compliance with paragraph 1 of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under that paragraph; and

3. Loan money to the impaired insurer.

B. In the case of an insolvent domestic insurer, the Association shall, subject to the approval of the Commission:

1. Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of the insolvent insurer;

2. Assure payment of the contractual obligations of the insolvent insurer; and

3. Provide moneys, pledges, notes, guarantees, or other means reasonably necessary to discharge its duties.

C. 1. In the case of an insolvent foreign or alien insurer, the Association shall, subject to the approval of the Commission:

a. Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of residents;

b. Assure payment of the contractual obligations of the insolvent insurer to residents; and

c. Provide moneys, pledges, notes, guarantees, or other means reasonably necessary to discharge its duties.

2. This subsection shall not apply where the Commission has determined that the foreign or alien insurer's domiciliary jurisdiction or state of entry provides protection by statute or regulation substantially similar to that provided by this chapter for residents of this Commonwealth.

D. 1. In carrying out its duties under subsections B and C of this section, the Association may request

that permanent policy liens or contract liens be imposed in connection with any guarantee, assumption, or reinsurance agreement, and those liens may be imposed if the court:

a. Finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the insolvent insurer's contractual obligations, or that economic or financial conditions are sufficiently adverse so that policy or contract liens are in the public interest; and

b. Approves the specific policy or contract liens to be used.

2. Before being obligated under subsections B and C of this section, the Association may request that temporary moratoriums or liens be imposed on payments of cash values and policy loans in addition to any contractual provisions for deferral of cash or policy loan values, and the temporary moratoriums and liens may be imposed if they are approved by the court.

E. If the Association fails to act as provided in subsections B and C of this section within a reasonable period of time, the Commission, on behalf of the Association, shall exercise the powers and duties of the Association under this chapter with respect to insolvent insurers.

F. Upon request, the Association may provide assistance and advice to the Commission concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

G. The Association shall have standing to appear before any court in this Commonwealth regarding all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the insolvent insurer and the determination of the covered policies and contractual obligations.

H. Any person receiving benefits under this chapter shall be deemed to have assigned the rights under the covered policy to the Association to the extent of the benefits received because of this chapter whether the benefits are payments of contractual obligations or continuation of coverage. The Association shall require an assignment to it of those rights by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition prior to the receipt of any rights or benefits conferred by this chapter upon that person. The Association shall be subrogated to those rights against the assets of any insolvent insurer. The subrogation rights of the Association under this subsection shall have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

I. The contractual obligations of the insolvent insurer for which the Association becomes or may become liable shall be equal to the contractual obligations that the insolvent insurer would have had in the absence of the insolvency unless those obligations are reduced as permitted by subsection D of this section. However, the aggregate liability of the Association shall not exceed $100,000 in cash values or $300,000 for all benefits, including cash values, with respect to any one life.

J. The Association may:

1. Enter into contracts necessary or proper to fulfill the provisions and purposes of this chapter.

2. Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under § 38.2-1705.

3. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the Association not in default shall be Category 1 investments, as defined in § 38.2-1401, for domestic insurers.

Drafting Note: In order to be consistent with Chapter 14, legal investments have been changed to Category 1 investments.

4. Employ or retain persons necessary to handle the financial transactions of the Association, and to perform other functions required by this chapter.

5. Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association.

6. Take legal action required to avoid payment of improper claims.

7. Exercise, for the purposes of this chapter and to the extent approved by the Commission, the powers of a domestic life or accident and sickness insurer, but in no case shall the Association issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer.

§ 38.2-1705. Assessments.—A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at any time and for any amounts as the board finds necessary. Assessments shall be due not less than thirty days after written notice has been given to the member insurers. Interest shall be compounded quarterly and be based upon the average of ninety day treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin. Interest will accrue on and after the due date.

Drafting Notes: A floating rate has been added to assure that there will be a positive incentive to pay the assessment when due.

Federal Reserve Bulletin will be properly noted as a publication title.

B. There shall be three classes of assessments as follows:

1. Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired or insolvent insurer.

2. Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under § 38.2-1704 with regard to an impaired or insolvent domestic insurer.

3. Class C assessments shall be made to the extent necessary to carry out the powers and duties of the Association under § 38.2-1704 with regard to an insolvent foreign or alien insurer.

C. 1. The amount of any Class A assessment shall be determined by the board and may be made on a basis other than pro rata. This assessment shall be credited against future insolvency assessments and shall not exceed fifty dollars per company in any one calendar year. The amount of any Class B or C assessment shall be allocated among accounts on the basis of the ratio of the premiums received by the impaired or insolvent insurer on the policies covered by each account to the premiums received by that insurer on all covered policies. The last calendar year preceding the assessment in which premiums were received by the impaired or insolvent insurer shall be used in determining this ratio.

2. Class B assessments for each account shall be made separately for each state in which the impaired or insolvent domestic insurer was authorized at any time to transact the business of insurance. The assessments shall be made on the basis of the ratio of the premiums received on business in that state by the impaired or insolvent insurer to the premiums received in all of those states by the impaired or insolvent insurer. The last calendar year preceding the assessment in which premiums were received by the insurer on policies covered by this account shall be used in determining this ratio. The assessments against member insurers shall be made on the basis of the ratio of the premiums received on business in each such state by each assessed member insurer on policies covered by each account to the premiums received on business in each state by all assessed member insurers. The last calendar year preceding the assessment shall be used in determining this ratio.

3. Class C assessments against member insurers for each account shall be made on the basis of the ratio of the premiums received on business in this Commonwealth by each assessed member insurer on policies covered by each account to the premiums received on business in this Commonwealth by all assessed member insurers. The calendar year preceding the assessment shall be used in determining this ratio.

4. Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to accomplish the purposes of this chapter. Classification of assessments under subsection B of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

D. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

E. The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed two percent of the member insurer's premiums received on the policies covered by the account in this Commonwealth during the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon as permitted by this chapter.

F. The board may refund to member insurers, in proportion to the contribution of each insurer to that account, the amount the assets of the account exceed the amount the board finds necessary to fulfill the Association's obligations during the coming year. In determining the refunds, assets accruing from net realized gains and income from investments shall be included. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses if refunds are impractical.

G. It shall be proper for any member insurer to consider the amount reasonably necessary to meet its Class A assessment obligations in determining its premium rates and policyowner dividends for any class of insurance covered by this chapter.

H. The Association shall issue to each insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution in a form prescribed by the Commission, for the amount of the assessment paid, excluding interest penalties. All outstanding certificates shall be of equal priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer on its financial statement as an asset. This shall be shown in a form, in an amount, and for a period of

time approved by the Commission.

Drafting Note: Reference to a requirement that a refund plan be established has been moved to § 38.2-1706.

§ 38.2-1706. Plan of operation.—A. 1. Neither the plan of operation nor any amendment to it shall become effective until submitted to and approved by the Commission. The Commission shall approve the plan or any amendment to it if it assures the fair, reasonable, and equitable administration of the Association.

2. The plan of operation approved under former § 38.1-482.24 shall remain in effect until modified in accordance with paragraph 3 of this subsection.

3. If the Association fails to submit suitable amendments to the plan, the Commission shall, after notice and hearing, adopt and promulgate reasonable rules that are necessary or advisable to effect this chapter. These rules shall continue in force until modified by the Commission or superseded by a plan or amendment submitted by the Association and approved by the Commission.

Drafting Note: The provision requiring the Association to submit a plan of operation has been deleted as the plan of operation has been approved.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

1. Establish procedures for handling assets of the Association.

2. Establish the amount and method of reimbursing members of the board of directors under §38.2-1703.

3. Establish regular places and times for meetings of the board of directors.

4. Establish procedures to keep records of all financial transactions of the Association, its agents, and the board of directors.

5. Establish the procedures for submitting to the Commission selections for the board of directors.

6. Establish any additional procedures for assessments under § 38.2-1705.

7. Establish a plan for equitable distribution of refunds to members.

8. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D. Except as provided by paragraph 3 of subsection A of § 38.2-1704 and § 38.2-1705, the plan of operation may provide that any or all powers and duties of the Association may be delegated to the corporation, association, or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commission, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this chapter.

§ 38.2-1707. Duties and powers of the Commission.—A. In addition to the duties and powers enumerated elsewhere in this chapter, the Commission shall:

1. Upon request of the board of directors, provide the Association with a statement of the premiums in the appropriate states for each member insurer.

2. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with this demand shall not excuse the Association from the performance of its powers and duties under this chapter.

3. Be appointed as the liquidator or rehabilitator in any liquidation or rehabilitation proceeding involving a domestic insurer. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commission shall be appointed conservator.

B. The Commission may suspend or revoke, after notice and hearing, the license to transact the business of insurance in this Commonwealth of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the Commission may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

C. Any action of the board of directors or the Association may be appealed to the Commission by any member insurer if the appeal is taken within thirty days of the action being appealed. Any final action or

order of the Commission shall be subject to judicial review in accordance with the provisions of §§ 12.1-39 through 12.1-41.

D. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

§ 38.2-1708. Detection and prevention of insolvencies.—A. To aid in the detection and prevention of insurer insolvencies, the Commission shall have the duty to:

1. Notify the insurance departments of all of the other states within thirty days of taking any of the following actions against a member insurer:

Drafting Note: The definition of "state" in Chapter 1 includes the deleted language.

a. Revocation of license;

b. Suspension of license;

c. Making any formal order that requires the insurer to (i) restrict its premium writing, (ii) obtain additional contributions to surplus, (iii) withdraw from the Commonwealth, (iv) reinsure all or any part of its business, or (v) increase its capital, surplus, or any other account for the security of policyholders or creditors.

2. Report to the board of directors when (i) any actions set forth in paragraph 1 of this subsection have been taken or (ii) a report has been received from any other insurance department indicating that an action has been taken in another state. The report to the board of directors shall (i) contain all significant details of the action taken or (ii) the report from the other insurance department.

3. Report to the board of directors when it has reasonable cause to believe that an insurer may be insolvent or in a financial condition hazardous to the policyholders or the public. The report may be based on a member insurer's financial examination, whether completed or in progress.

Drafting Note: It is unreasonable to expect the Association to review the IRIS (insurance regulation information system) reports. Review of those reports requires more time and resources than are normally available to the Association.

B. The Commission may seek the advice and recommendations of the board of directors concerning any matter affecting its duties and responsibilities regarding the financial condition of member insurers and insurers seeking admission to transact the business of insurance in this Commonwealth.

C. The board of directors may, upon majority vote, make reports and recommendations to the Commission upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or to the solvency of any insurer seeking to transact the business of insurance in this Commonwealth. These reports and recommendations shall not be considered public documents.

D. The board of directors shall have the duty, upon majority vote, to notify the Commission of any information indicating that a member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

E. The board of directors, upon majority vote, may request that the Commission order an examination of any member insurer that the board, in good faith, believes may be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of the request, the Commission shall begin the examination. The examination may be conducted as the National Association of Insurance Commissioners examination or may be conducted by persons the Commission designates. The cost of the examination shall be paid by the Association, and the examination report shall be treated like other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commission from complying with subsection A of this section. The Commission shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commission but it shall not be open to public inspection prior to the release of the examination report to the public.

F. The board of directors may, upon majority vote, make recommendations to the Commission for the detection and prevention of insurer insolvencies.

G. The board of directors shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commission containing all information it has in its possession relating to the history and causes of the insolvency.

H. The board shall cooperate with the board of directors of guaranty associations in other states in preparing a report on the history and causes for a member's insolvency, and may adopt by reference any report prepared by other associations.

§ 38.2-1709. Tax write-offs of certificates of contribution.—A. Unless a longer period has been allowed by the Commission, a member insurer shall have at its option the right to show a certificate of contribution as an asset in the form approved by the Commission pursuant to subsection H of § 38.2-1705 at percentages of the original face amount approved by the Commission for calendar years as follows:

100% for the calendar year of issuance;

80% for the first calendar year after the year of issuance;

60% for the second calendar year after the year of issuance;

40% for the third calendar year after the year of issuance;

20% for the fourth calendar year after the year of issuance.

B. The insurer may offset the amount of the certificate amortized in a calendar year as provided in subsection A of this section. This amount shall be deducted from the premium tax liability incurred on business transacted in this Commonwealth for that year. However, the Association shall diligently pursue all rights available to it to recover its expenditures made in the fulfillment of its responsibilities under this chapter. In the event the Commission determines after a hearing that the Association is not diligently pursuing available measures of recovery, participating insurers will not be able to offset amounts amortized during the period that the Commission determines that the Association has not been diligently pursuing available measures of recovery.

C. Any sums that have been (i) amortized by contributing insurers and offset against premium taxes as provided in subsection B of this section and (ii) subsequently refunded pursuant to subsection F of § 38.2-1705 shall be paid to the Commission and deposited with the State Treasurer for credit to the general fund of this Commonwealth.

D. The amount of any credit against premium taxes provided for in this section for an insurer shall be reduced by the amount of reduction in federal income taxes for any deduction claimed by the insurer for an assessment paid pursuant to this chapter.

§ 38.2-1710. Miscellaneous provisions.—A. Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved in carrying out its powers and duties under § 38.2-1704. Records of these negotiations or meetings shall be made public only upon (i) the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, (ii) the termination of the impairment or insolvency of the insurer, or (iii) the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under § 38.2-1711.

C. For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to subsection H of § 38.2-1704. All assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. For the purpose of this subsection, assets attributable to covered policies is that proportion of the assets which the reserves, that should have been established for these policies, bear to the reserves that should have been established for all insurance policies written by the impaired or insolvent insurer.

D. 1. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court, in making an equitable distribution of the ownership rights of the insolvent insurer, may take into consideration the contributions of the respective parties, including the Association, the shareholders and policyowners of the insolvent insurer, and any other party with a legitimate interest. In this determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

2. No distribution to any stockholders of an impaired or insolvent insurer shall be made until the total amount of valid claims have been fully recovered by the Association for funds expended in carrying out its powers and duties under § 38.2-1704.

E. 1. If an order for liquidation of an insurer domiciled in this Commonwealth has been entered, the receiver appointed under that order shall have a right to recover from any controlling affiliate on behalf of the insurer distributions, other than stock dividends, made at any time during the five years preceding the petition for liquidation or rehabilitation. This shall be subject to the limitations of paragraphs 2 through 4 of this subsection.

2. No dividend shall be recoverable if the insurer shows that the distribution was lawful and reasonable at the time of payment, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

3. Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

4. The maximum amount recoverable under this subsection shall be the amount in excess of all other available assets of the insolvent insurer needed to pay (i) the contractual obligations of the insolvent

insurer and (ii) the reasonable expenses of the Association incurred in connection with the performance of its duties for the insolvent insurer.

5. If any person liable under paragraph 3 of this subsection is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

§ 38.2-1711. Examination of the Association; annual report.–The Association shall be subject to examination and regulation by the Commission. The board of directors shall submit to the Commission, not later than each May 1, a financial report for the preceding calendar year in a form approved by the Commission and a report of its activities during the preceding calendar year.

§ 38.2-1712. Tax exemptions.–The Association shall be exempt from the payment of all fees and all taxes levied by this Commonwealth or any of its subdivisions, except taxes levied on real and personal property.

§ 38.2-1713. Immunity.–There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the Commission or its representatives, for any action taken by them in the performance of their powers and duties under this chapter.

§ 38.2-1714. Stay of proceedings; reopening default judgments.–All proceedings in which the insolvent insurer is a party in any court in this Commonwealth shall be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final. This will allow time for proper legal action by the Association on all matters germane to its powers and duties. The Association may apply to have the judgment under any decision, order, verdict, or finding based on default set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

§ 38.2-1715. Prohibition against advertising guaranty funds.–No person, including an insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the Association of this Commonwealth for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter.

ARTICLE 2.

Additional Funds Paid to the Association.

Drafting Note: This article provides guidance to the establishment of a safety fund for the Association. The article gives guidance to the Commission in administering § 38.2-225. Additional provisions are included on the priority use and repayment of other than assessment derived funds.

§ 38.2-1716. Purpose and applicability of article.– The purpose of this article is to provide directions and guidelines for the control and use of funds provided pursuant to § 38.2-225 or any other sources of funds not specified in Article 1 of this chapter.

§ 38.2-1717. Safety fund.–The Association shall maintain a separate asset account to be known as the safety fund for the purpose of meeting the Association's objectives as specified in § 38.2-1700.

Drafting Note: The establishment of a separate asset safety account is necessary if the Association is to be able to handle catastrophic insolvencies.

§ 38.2-1718. Financing the safety fund, maximum amount, distribution of excess.–A. The safety fund, at the discretion of the Commission, shall receive penalty payments levied against member insurers made pursuant to subsection B of § 38.2-225 or any other payments approved by the Commission.

B. The Commission may approve the payment of funds to the Association provided the balance in the safety fund account does not exceed two percent of the total of all member insurer's premium received in this Commonwealth for classes of insurance covered by the accounts specified in subsection A of § 38.2-1702.

C. Investment income earned on assets held in the safety fund shall be credited to the safety fund provided the balance of the safety fund does not exceed three percent of the total of all member insurer's premium received in this Commonwealth for classes of insurance covered by the accounts specified in subsection A of § 38.2-1702 unless otherwise determined by the Commission.

D. In the event the safety fund balance exceeds the amount specified in subsection C of this section, at the discretion of the Commission the difference shall be paid to the state treasury to the credit of the Literary Fund or shall be subject to subsection F of § 38.2-1720.

E. In the event the fund is dissolved, remaining assets in the safety fund will be distributed to the state treasury to the credit of the Literary Fund.

Drafting Note: This section provides for the financing of the safety fund and provides direction to the Commission in implementing § 38.2-225. Penalty payments may be credited to the Association until the

balance exceeds 2% of the domestic premium assessment base. Investment income will remain in the account until the balance is 3% of the domestic premium assessment base. Excess balances will flow to the literary fund.

In 1984, the total assessable premium for all three accounts was $3 billion. Therefore, the Commission may direct that penalty payments levied against member insurers be allocated to the safety fund until the balance of the fund equals $60 million (2% of $3 billion). Investment income may be retained in the account until a balance of $90 million (3% of 3 billion) is achieved. Placed in perspective, the Baldwin-United insolvency could have required members to be assessed an estimated $80 million. The Association's maximum assessment for this account would have been $14.5 million, leaving policyholders $6.5 million short.

§ 38.2-1719. Investment of safety fund.—The assets of the safety fund may be invested in securities set forth in § 38.2-1415.

Drafting Note: The assets of the safety fund may be invested in domestic government securities as set forth in § 38.2-1415.

§ 38.2-1720. Use of safety fund, repayment, etc.— A. The purpose of the safety fund is to provide for the payment of covered claims in the event the assessment limit specified in subsection E of § 38.2-1705 is reached.

B. In the event the assets of the safety fund are needed to pay covered claims, these assets shall be loaned to the respective account listed in subsection A of § 38.2-1702. This loan shall be the general obligation of the Association members and shall be evidenced by an agreement approved by the Commission.

C. Interest on this loan shall be compounded quarterly and be based upon the average of the ninety day treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin. This rate will be updated quarterly in order to conform with market rates of interest.

D. This loan shall be repaid by levying assessments against the members for the account on whose behalf the loan was negotiated. Unless otherwise approved by the Commission, the loan shall be repaid within six months of its issuance. This assessment in conjunction with any other assessments levied, shall not exceed the limit specified in subsection E of § 38.2-1705.

E. Subject to the approval of the Commission assets of the safety fund may be loaned to any account in subsection A of § 38.2-1702 even though the maximum assessment in subsection E of § 38.2-1705 has not been levied if the directors of the Association determine that this action will minimize the cost to the association in paying covered claims.

F. Excess safety fund assets set forth in subsection D of § 38.2-1718 may be used to pay the Association's covered claims without the members incurring a liability to repay the safety fund.

Drafting Note: This section provides for the safety fund to be loaned to the account incorporating the covered claim. A market rate of interest will apply to this loan and the loan shall be repaid from future assessments. The loan, with exception, must be repaid within six months. When economically justifiable, the Association may borrow from the fund rather than levying an assessment. Normally, the safety fund should be used as a source of last resort. If the fund balance exceeds 2% of the assessable premium and at the discretion of the Commission the excess balances may be used to pay covered claims without obligating the insurers to repay the safety fund.

§ 38.2-1721. Association as a fiduciary.—In handling the assets of the safety fund, the Association shall be deemed a fiduciary for the Commonwealth.

Drafting Note: The assets in the safety fund are derived from the public by way of penalties and other non insurer sources. Consequently, the Association should be required to handle these funds in a fiduciary capacity on behalf of the public.

Title 38.2

CHAPTER 18.

Insurance Agents.

1. The title of the chapter has been changed to Insurance Agents.

2. Proposed Chapters 38 (cooperative nonprofit life benefit companies) and 40 (burial societies) agents are now subject to full licensure requirements. The Commission will have the authority to waive these requirements. (proposed §38.2-1815)

3. Proposed Chapter 42 salesmen (The "Blues") and Chapter 43 salesmen (HMOs) are now considered health agents and subject to health licensure requirements. Health agent is defined (proposed §§ 38.2-1800 and 38.2-1815). Health agents will be required to pass a 25-hour study course.

4. Existing § 38.1-165.1 (Report of acts deemed larceny under §18.2-111) has been moved to this chapter as proposed § 38.2-1810.

5. Dental services agent, legal services agent and optometric services agent are being defined in proposed §38.2-1800 and added to proposed §38.2-1824.

6. The term "company representative" is being deleted throughout the chapter because it is no longer used.

7. Existing §38.1-356.1, Sale of accident airtrip insurance, is being moved to proposed §38.2-1807 because it appears more appropriate in this chapter.

8. In proposed § 38.2-1811, language is being deleted and moved to proposed § 38.2-206.

9. Existing §38.1-327.14 is being deleted and the uniform penalties section will apply.

10. Existing Articles 2 and 3 are being merged into one article that applies to both Property and Casualty Agents and Life and Health Agents.

    a) Existing §38.1-327.24 is being moved to proposed §38.2-1815.

    b) Existing §38.1-327.25 is being deleted and proposed §38.2-1817 will apply.

    c) Existing §38.1-327.28 is being deleted and proposed §38.2-1818 will apply.

    d) Existing §38.1-327. 29is being deleted and proposed §38.2-1819 will apply.

    e) Existing §38.1-327.30 is being deleted and proposed §38.2-1820 will apply.

    f) Existing §38.1-327.31 is being deleted and proposed §38.2-1821 will apply.

11. Existing §38.1-327.37 (proposed § 38.2-1826) is being amended to delete "office address". Residence is used elsewhere in the Code.

12. Existing §38.1-327.43 (proposed § 38.2-1831) A felony conviction was added to the list of offenses that can cause refusal to issue a license, or revocation.

13. Existing § 38.1-327.17C (proposed §38.2-1817) The examination for variable contracts will be the National Association of Security Dealers exam or other examination prescribed by the Commission.

14. In proposed § 38.2-1831, Refusal or revokation of license, the term "twisting" is separated from "rebating" and defined. "Twisting" has also been added to the corresponding section of the consultants article (proposed § 38.2-1843).

15. In proposed § 38.2-1814 mutual assessment property and casualty insurance agents will be required to meet examination and education requirements subject to the limitations of proposed § 38.2-2525.

16. In proposed § 38.2-1815, mutual assessment life and health agents will be required to meet examination and education requirements subject to the limitations of proposed § 38.2-3919.

17. The sections in Article 4, Licensing of Property and Casualty Consultants, are a result of 1985 legislation. Changes made in these sections are consistent with those in parallel sections for agents.

18. In § 38.2-1833, language has been added to specifically state that appointments are public information and are available for public inspection during normal business hours of the Commission.

CHAPTER 18

INSURANCE AGENTS.

Article 1.

Definitions and General Provisions.

§ 38.2-1800. Definitions.--As used in this chapter:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, or corporation licensed in this Commonwealth who is authorized by any company licensed in this Commonwealth to solicit, negotiate , or effect in its behalf contracts of insurance or annuity, and, if authorized by the company, may collect premiums on those contracts.

Drafting Note: The definition of agent has been modified to reflect the new licensing procedures that resulted from 1985 legislation.

"Assessment life and casualty insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit, negotiate, or effect life and casualty insurance as defined in Chapter 38 of this title for an insurer licensed in this Commonwealth.

Drafting Note: 1. "Assessment" is being deleted in line 3 to clarify that this definition applies to Chapter 38 agents.

2. The reference to existing Chapter 11 was deleted because mutual assessment life and health insurance agents have been given a separate definition later in this section.

"Burial insurance agent" means an agent who is authorized to solicit, negotiate, or effect burial insurance for an insurer licensed in this Commonwealth but only to the extent authorized in Chapter 40 of this title.

"Credit life and health insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit, negotiate, or effect credit life insurance and credit accident and sickness insurance for an insurer licensed in this Commonwealth, but only to the extent authorized in Chapter 37 of this title.

"Dental services agent" means an agent of a dental plan licensed in this Commonwealth who is authorized to solicit, negotiate or effect prepaid dental services contracts for dental plans as defined in Chapter 45 of this title.

Drafting Note: This definition is being added because we are proposing that they be a type of agent.

Drafting Note: Neither the term "excess" nor "rejected" life insurance business is used in this chapter or the Surplus Lines chapter. While "rejected business" is used in existing § 38.1-327.52, the modifications to that section (now proposed § 38.2-4806) have replaced that term with a new one. Therefore, the definitions of these terms have been deleted.

"Health agent" means an agent licensed in this Commonwealth who is authorized to solicit or procure applications for a corporation licensed in this Commonwealth under Chapter 42 of this title or for a health maintenance organization licensed in this Commonwealth under Chapter 43 of this title. Nothing in this chapter prohibits any person licensed in this Commonwealth as a life and health agent from also acting as a health agent.

As used in this section, "solicit or procure" includes selling or otherwise placing insurance, whether directly or indirectly, in this Commonwealth, and for which actions the person receives direct or indirect compensation in the form of commissions, fees or other inducements or benefits.

Drafting Note: This definition is being added because we are proposing that they be a type of agent. The definition of "solicit or procure" was moved here from the definition of "life and health insurance agent" for organizational purposes only. As suggested by the Code Commission, the changes in the definition of "solicit and procure" are being made to provide protection when an insured is not a resident of this Commonwealth.

"Legal services agent" means an agent of a legal services plan licensed in this Commonwealth who is authorized to solicit, negotiate or effect prepaid legal services contracts for legal services plans as defined in Chapter 44 of this title.

Drafting Note: This definition is being added because we are proposing that they be a type of agent.

"Life and health insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit or procure applications for life insurance, annuity contracts, and accident and sickness insurance as defined in §§ 38.2-102, 38.2-106 and 38.2-109, respectively, and for variable contracts as defined in §§ 38.2-105 and 38.2-107, if so qualified, for an insurer licensed in this Commonwealth. Except as otherwise provided, limitations or restrictions as to methods of compensation imposed by this title on agents shall not apply to life and health insurance agents. A resident of another state may not obtain a license or continue to be licensed as a life and health insurance agent in this Commonwealth unless he is so licensed and qualified in his state of residence.

"Mortgage guaranty insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit, negotiate, or effect mortgage guaranty insurance for an insurer licensed in this Commonwealth.

Drafting Note: "Mortgage guaranty insurance" is now being defined in Chapter 1 since the term is used in other chapters.

"Mortgage redemption insurance agent" means an employee of a lending institution, whether or not the institution accepts deposits from the public, who is an agent of an insurer licensed in this Commonwealth and who is authorized to solicit, negotiate, or effect mortgage redemption insurance and mortgage accident and sickness insurance. "Mortgage redemption insurance" means a nonrenewable, nonconvertible, decreasing term life insurance policy written in connection with a mortgage transaction for a period of time coinciding with the term of the mortgage. The initial sum shall not exceed the amount of the indebtedness outstanding at the time the insurance becomes effective, rounded up to the next $1,000.

"Mutual assessment life and health insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit, negotiate or effect mutual assessment life and accident and sickness insurance as defined in Chapter 39 of this title for an insurer licensed in this Commonwealth.

Drafting Note: This definition is being added because of the change in the name of proposed Chapter 39 (existing Chapter 11.1).

"Mutual assessment property and casualty insurance agent" means an agent of a mutual assessment property and casualty insurer licensed in this Commonwealth who is authorized to solicit, negotiate, or effect mutual assessment property and casualty insurance as authorized in Chapter 25 of this title.

"Ocean marine insurance agent" means an agent of an insurer who is authorized to solicit, negotiate, or effect those kinds of insurance classified in § 38.2-126, except those kinds specifically classified as inland marine insurance.

"Optometric services agent" means an agent of an optometric plan licensed in this Commonwealth who is authorized to solicit, negotiate or effect prepaid optometric services contracts for optometric plans as defined in Chapter 45 of this title.

Drafting Note: This definition is being added because we are proposing that they be a type of agent.

"Property and casualty insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit, negotiate, or effect insurance as defined in §§ 38.2-110 through 38.2-122, and §§ 38.2-124 through 38.2-134 for an insurer licensed in this Commonwealth.

"Resident" means (i) an individual domiciled and residing in Virginia; (ii) a partnership duly formed and recorded in Virginia ; or (iii) a corporation incorporated and existing under the laws of Virginia.

"Title insurance agent" means an agent licensed in this Commonwealth who is authorized to solicit, negotiate, or effect title insurance as is authorized in Chapter 46 of this title for a title insurer licensed in this Commonwealth.

"Travel accident insurance agent" means an individual at transportation terminal buildings, or a ticket-selling agent of a railroad, steamship company, air carrier, or public bus carrier, who acts as an agent in the sale of travel accident insurance to individuals.

"Travel baggage insurance agent" means the ticket-selling agent of a railroad or steamship company, air carrier, or public bus carrier who acts as an agent in the sale of travel baggage insurance to individuals.

"Variable contract agent" means an agent licensed in this Commonwealth to solicit, negotiate or effect variable contracts for an insurer licensed in this Commonwealth.

Drafting Note: The definition of variable contract agent is being added since it is a type of qualification already issued.

§ 38.2-1801. Person soliciting insurance deemed agent of insurer.–A person who is authorized by any insurer to solicit, negotiate or effect insurance or applications for insurance shall be held to be the agent of the insurer that issued the insurance solicited or applied for in any controversy between the insured or his beneficiary and the insurer.

§ 38.2-1802. Acting as agent for unlicensed insurer prohibited; penalties.–A. No person other than a licensed surplus lines broker shall solicit, negotiate, or effect contracts of insurance in this Commonwealth on behalf of any insurer which is not licensed to transact the business of insurance in this Commonwealth. Nothing in this section shall prohibit any person from obtaining insurance upon his own life or property from an unlicensed insurer.

B. Any person violating the provisions of this section shall be guilty upon conviction of a Class 1 misdemeanor and punished for each offense. In addition, any person violating this section shall be (i) liable on any claim against any unlicensed insurer that arises out of a contract or policy solicited, negotiated or effected by the person or which the person assisted in soliciting, negotiating or effecting, or (ii) punished as provided in § 38.2-218 and subject to revocation or suspension of his license, or (iii) subject to both (i) and (ii).

C. Nothing in this section shall apply to the solicitation, negotiation, or effecting of contracts of insurance on:

1. Vessels or craft, their cargo, freight, marine builder's risk, maritime protection and indemnity, ship

repairer's legal liability, tower's liability or other risks commonly insured under ocean marine insurance policies as distinguished from inland marine insurance policies, provided that a property and casualty or ocean marine insurance agent licensed in this Commonwealth solicits, negotiates or effects these classes of insurance on behalf of any insurer not licensed to transact the business of insurance in this Commonwealth ; or

2. The rolling stock and operating properties of railroads used in interstate commerce or of any liability or other risks incidental to their ownership, maintenance or operation.

§ 38.2-1803. Countersignature not required; splitting commissions.– There shall be no requirement that an agent who is a resident of this Commonwealth sign or countersign a policy of insurance covering a subject of insurance resident, located, or to be performed in this Commonwealth. However, if the laws or regulations of another state require a signature or countersignature by an agent resident in that state on a policy written by a nonresident agent or nonresident broker of that state, then any policy written by an agent resident of that state licensed as a nonresident agent in this Commonwealth covering a subject of insurance resident, located, or to be performed in this Commonwealth shall be signed or countersigned in writing by an agent resident in this Commonwealth. No policy shall be deemed invalid due to the absence of the required signature or countersignature. If the laws or regulations of another state require an agent or broker resident in that state, who so requests, to retain a portion of the commission paid on a like policy of insurance written, countersigned or delivered by the agent or broker in that state, then an equal pro rata portion of any commission on the policy of insurance shall be retained by the agent resident in this Commonwealth who signed or countersigned a policy of insurance written by a resident of that state licensed as a nonresident agent in this Commonwealth covering a subject of insurance resident, located, or to be performed in this Commonwealth.

§ 38.2-1804. Blank contracts.–No agent shall sign or allow an applicant to sign any incomplete or blank form pertaining to insurance in this Commonwealth.

§ 38.2-1805. Acceptance by industrial insurance agents of premiums in arrears; how advance premiums recorded.–A. No industrial insurance agent shall accept payment of premiums in arrears on any policy of life insurance or accident and sickness insurance on which the premiums are collected at least monthly that has lapsed and that the insured seeks to reinstate, unless the payment (i) at least equals the total of all premiums in arrears and (ii) entitles the policyholder to make immediate application for reinstatement of the policy.

B. Every advance premium paid to an agent on a life insurance policy or accident and sickness insurance policy on which the premiums are collected at least monthly shall be recorded in the receipt book of the insured and in the record book of the agent in exactly the same manner as current premiums are recorded. However, the failure to do so shall not invalidate the policy.

Drafting Note: The last sentence was deleted because revocation of license is included in proposed § 38.2-1831.

§ 38.2-1806. Interest with respect to credit extended or money lent for premiums on certain policies.–A. Any property and casualty insurance agent, mutual assessment property and casualty insurance agent, or ocean marine insurance agent licensed in this Commonwealth may charge interest on credit extended by the agent to the holder of any fire, casualty, surety or marine insurance policy, written or being serviced by or through such agent, for the premium due on such policy. The rate of interest shall not exceed one and one-half percent per month of the unpaid balance. However, the extension of credit or the making of the loan shall not be in conflict with the contract between the agent and the insurer that issues the policy.

B. A licensed insurance agent extending credit as authorized in this section shall not be required to comply with the provisions of Chapter 47 of this title with respect to the licensing of premium finance companies.

C. Notwithstanding the provisions of §§ 38.2-2114 and 38.2-2212, if any insured fails to discharge any of his obligations to an insurance agent when due in connection with the payment of any premium for a policy of insurance, that agent may request in writing that the insurer cancel such policy for nonpayment of premium. Within ten work days of the receipt of such written request, which shall also state the amount owed the agent by the policyholder, the insurer shall deliver or mail a written notice of cancellation to the named insured at the address shown in the policy and to any mortgagee or lienholder. This notice shall state the date on which the cancellation shall become effective. That date shall be established by giving at least the number of days notice prior to cancellation that are required by statute or the terms of the policy. Except for statutory requirements and contractual obligations, there shall be no liability on the part of the insurer for improper cancellation under this section if the insurer (i) in good faith relies upon the request of the agent and (ii) gives notice of cancellation in compliance with the provisions of this section.

D. The insurance agent shall have a lien on any return premium for the policy to the extent of the amount owed by the policyholder. Within thirty days of the mailing of the notice of cancellation, the insurer shall forward that amount to the agent and shall forward the remainder, if any, of the return premium to the policyholder.

Drafting Note: 1. Brokers have been deleted because they are not involved in this area.

2. Much of this section is the result of 1985 legislation which a) deleted the requirement in paragraph A that the extension of credit be for a period of less than 12 months and b) added paragraphs C and D.

§ 38.2-1807. Sale of accident airtrip insurance by means of vending machines.–Any insurer qualified to transact business in this Commonwealth and to write accident airtrip insurance may solicit applications for

and issue policies of accident airtrip insurance by means of mechanical vending machines in public airports. The machines shall be under the supervision of a licensed agent and the insurer shall comply with all the requirements prescribed by the Commission for the conduct of the business.

Drafting Note: This section has been moved from existing Chapter 8, Article 2 (§ 38.1-356.1). Subsections (b) and (c) of the existing section were deleted because they are not necessary with the general penalties and rules and regulations sections.

§ 38.2-1808. All agreements to be expressed in contract.—No agent for any insurer shall make any contract of insurance or agreement with respect to the insurance other than what is plainly expressed in the policy or contract issued.

§ 38.2-1809. Power of Commission to investigate affairs of persons engaged in insurance business; penalties for refusal to permit investigation.— The Commission shall have power to examine and investigate the business affairs of any person engaged or alleged to be engaged in the business of insurance in this Commonwealth, including all licensed agents, to determine whether the person has engaged or is engaging in any violation of this title. The Commission shall have the right to examine any paper, document or other material relating to the writing or alleged writing of insurance by any such person in this Commonwealth to determine whether the person is now or has been violating any of the provisions of this title. Any licensed agent, licensed property and casualty insurance consultant, or any person purporting to be a licensed agent or a licensed property and casualty insurance consultant, or any person whose actions have led any person to believe that he is a licensed agent or property or casualty insurance consultant, who refuses to permit the Commission or any of its employees or agents, including employees of the Bureau of Insurance, to make an examination or who fails or refuses to comply with the provisions of this section may, after notice and an opportunity to be heard, be subject to any of the penalties relating to agents or property and casualty insurance consultants licensed by the Commission provided in this title, including the suspension or revocation of his license.

Drafting Note: 1. The investigation by the Commission will be limited to the "business" affairs of those in the business of insurance.

2. 1985 legislation added insurance consultants to this section.

§ 38.2-1810. Report of acts deemed larceny under § 18.2-111; privileged communications; Commonwealth's attorney to be informed.—A. Whenever any insurer licensed to transact the business of insurance in this Commonwealth knows or has reasonable cause to believe that any licensed insurance agent or surplus lines broker of the insurer has committed any act of larceny as prescribed in § 18.2-111 with respect to any money, bill, note, check, order, draft or other property either belonging to the insurer or received by the agent or surplus lines broker on behalf of the insurer, it shall be the duty of the insurer within sixty days after acquiring the knowledge to file with the Commission a complete statement of the relevant facts and circumstances. Each statement shall be a privileged communication, and when made and filed shall not subject the insurer, or any individual representative of it that is making or filing the statement, to any liability whatsoever.

B. The Commission shall inform the Commonwealth's attorney of the appropriate county or city of each statement filed pursuant to subsection A of this section.

Drafting Note: Existing § 38.1-165.1 has been moved to this chapter. The term "broker" has been changed to "surplus lines broker," as "broker" is being deleted or clarified throughout the title. Also, the outdated cross-reference to the Criminal Code has been corrected. Minor editorial changes have been made.

§ 38.2-1811. Licensing of lending institutions and bank holding companies for certain classes of insurance.—A. As used in this section:

"Bank holding company" means and includes the definition of such terms as set forth in § 6.1-4 and in 12 USC 1841. If on or before the effective date of this section, a bank holding company has been granted an exemption by the Board of Governors of the Federal Reserve System pursuant to 12 USC 1843 (d), such bank holding company shall not be held to be a bank holding company within the meaning of 12 USC 1841.

"Lending institution" means any corporation, partnership, company or organization that accepts deposits from the public and lends money in this Commonwealth, including banks and savings and loan associations.

B. A lending institution, bank holding company or their subsidiaries or affiliates, including any officer or employee thereof, may engage in and be licensed for the sale of credit life insurance and credit accident and sickness insurance, mortgage redemption insurance, mortgage accident and sickness insurance, single interest insurance, title insurance, annuities purchased for the liquidation or partial liquidation of accounts accumulated in financial institutions, nonconvertible term life insurance rounded up to the next $1,000, and disability insurance rounded up to the next $100 of monthly payment, both directly limited to amount and duration of a credit transaction. Any other restrictions of the insurance laws pertaining to, engaging in, and being licensed for the sale of credit life and credit accident and sickness insurance, and any insurance insuring the lending institution, holding company or any subsidiary or affiliate of either shall apply.

C. The Commission, as authorized by § 38.2-223, may promulgate such rules and regulations as may be necessary to effect the purposes of this section which are to assist in maintaining the separation between lending institutions and the insurance business and to minimize the possibilities of unfair competitive practices by lending institutions and agents.

Drafting Note: The deleted language has been moved to proposed § 38.2-205 because it is more appropriately included in the General Provisions Chapter. No substantive changes have been made.

§ 38.2-1812. Payment and sharing commissions.—A. No insurer shall pay directly or indirectly any commission or other valuable consideration to any person for services as an agent or a surplus lines broker within this Commonwealth unless the person then holds a valid license as an agent, or valid license as surplus lines broker, for the class of insurance involved. No person other than a duly licensed and appointed agent or a surplus lines broker may accept any such commission or other valuable consideration. This provision shall not prevent the payment or receipt of renewal or other deferred commissions or compensation to or by any person if the person was so duly licensed and appointed, where the appointment was necessary, at the time of the transactions out of which arose the right to such renewals or deferred commissions or compensation.

B. No agent or surplus lines broker shall directly or indirectly share his commissions or other compensation received or to be received by him on account of a transaction under his license with any person not also then licensed under this chapter or Chapter 48 of this title, for the class of insurance involved in the transactions. No agent or surplus lines broker not then licensed and qualified for the same class of insurance shall receive any commission or other compensation. This provision shall not affect payment of the regular salaries due employees of the licensee.

Drafting Note: Since surplus lines brokers are licensed under the same chapter as agents in the existing Code but have been given a separate chapter in the proposed Code, reference to Chapter 48 (Surplus Lines) is added here for clarity.

§ 38.2-1813. Reporting and accounting for premiums.—All premiums, return premiums, or other funds received in any manner by an agent or a surplus lines broker shall be held in a fiduciary capacity. The agent or surplus lines broker shall, in the regular course of business, account for and pay the funds to the insured or his assignee, insurer, or agent entitled to the payment when due. However, nothing contained in this section shall be deemed to require any licensee to maintain a separate depository account, escrow or otherwise.

Drafting Note: Existing § 38.1-327.14 is being deleted in favor of the unified penalty section being added in Chapter 2.

Article 2.

Qualification of Property and Casualty Insurance Agents, Life and Health Insurance Agents and Health Agents.

§ 38.2-1814. License required of resident property and casualty insurance agent.— No individual who is a resident of this Commonwealth shall obtain a license as a property and casualty insurance agent from the Commission unless he has passed a written examination prescribed by the Commission. However, any individual may obtain a license as an agent for mortgage guaranty insurance, ocean marine insurance, title insurance, and travel baggage insurance sold by ticket-selling agents of a railroad or steamship company, air carrier, or public bus carrier without taking a written examination. Mutual assessment property and casualty insurance agents shall be licensed subject to the limitations of § 38.2-2525.

Drafting Note: 1. Due to 1985 legislation, agents will receive a license from the Commission instead of a certificate of qualification.

2. The change in lines 1 and 2 of the first sentence was made because a Virginia resident would have to be licensed here, regardless of his office location.

3. The term "baggage insurance" should be changed to "travel baggage insurance" to be consistent with proposed § 38.2-1800.

§ 38.2-1815. License required of resident life and health insurance agents and health agents.—No individual who is a resident of this Commonwealth shall obtain a license as a life and health insurance agent or health agent from the Commission unless he has passed a written examination prescribed by the Commission. However, any individual may obtain a license as a travel accident insurance agent, a mortgage redemption insurance agent, a credit life and health insurange agent, a dental services agent, an optometric services agent, or a legal services agent, without taking a written examination. Agents of an association referred to in § 38.2-3318 who will be limited to soliciting members of that association for burial association group life insurance certificates in amounts of $5,000 or less may also obtain a license without taking a written examination. Individuals who will act as agents only for cooperative nonprofit life benefit companies as defined in Chapter 38 of this title, or burial societies as defined in Chapter 40 of this title may be exempted from these examination requirements with the prior approval of the Commission. Mutual assessment life and health insurance agents shall be licensed subject to the limitations of § 38.2-3919.

Drafting Note: 1. This section was existing § 38.1-327.24.

2. Proposed Chapters 38 and 40 (currently Chapters 10 and 12) agents will now be subject to examination and education requirements with exemption subject to the prior approval of the Commission.

3. Mutual assessment life and health agents (proposed Chapter 39, existing Chapter 11.1) will be exempt from the licensing requirements when selling only the traditional lines. Proposed § 38.2-3919 is existing § 38.1-549.20.

§ 38.2-1816. Study course required; exception based upon employment experience.—A. Before applying to the Commission to take an examination for a license, each applicant shall have completed a forty-five-hour insurance study course approved by the Commission. However, applicants for a health agent license shall complete a twenty-five-hour insurance study course approved by the Commission.

B. An applicant shall apply to the Commission to take an examination for a license within one year after meeting the education requirement in subsection A of this section. The Commission, however, may waive this time limit in individual circumstances in accordance with such criteria as may be prescribed.

C. An applicant may apply to the Commission to take the examination for a license without taking the required study course if the applicant has attained equivalent knowledge through employment experience as determined by the Commission. The employment experience shall include no less than one year of full-time experience as an employee of an insurer, an insurance department, an insurance agency, or equivalent employment as determined by the Commission. The employment experience shall have involved the performance of responsible insurance duties in connection with the kind of insurance for which the applicant has applied for a license. The applicant shall have completed the employment experience requirement not more than one year before applying for a license.

Drafting Note: Health agents will only have to complete a 25-hour study course rather than the 45-hour course required for the life and health license.

§ 38.2-1817. Examination for license.—A. The Commission shall conduct examinations for licenses at least monthly at the times and places it prescribes. Each applicant shall pass a written examination prescribed by the Commission unless otherwise exempted. An applicant who fails an examination shall not be permitted to retake the examination for one month. If an applicant fails three times to pass the examination, the applicant must take or retake the study course approved by the Commission before the applicant may retake the examination.

B. An applicant who has been awarded the designation of Chartered Property and Casualty Underwriter shall be exempt from the education and examination requirements of this article for a property and casualty insurance license. An applicant who has been awarded the designation of Chartered Life Underwriter shall be exempt from the education and examination requirements for a life and health insurance license or a health license. However, the applicant shall not be exempt from the requirement to submit the application and pay the fee required by § 38.2-1819.

Drafting Note: CLUs will now be exempt from the education and examination requirements for a life and health license or a health license. The exemption was originally in § 38.1-327.25, which has been deleted.

C. No individual shall obtain a license for variable life insurance and variable annuity contracts unless he currently holds a life and health insurance agent's license and has passed the National Association of Security Dealers examination or other examination prescribed by the Commission.

Drafting Note: 1. Subsection C has been added for variable contracts.

2. Former § 38.1-327.18 was repealed by 1985 legislation.

§ 38.2-1818. Individual moving from another state or Canadian province.—An applicant who has moved into this Commonwealth from another state or a province of Canada and who (i) was a licensed property and casualty insurance agent, life and health insurance agent or health agent in the previous state or province within six months of the date of application and (ii) met education and examination requirements in the previous state or province similar to or in excess of those imposed by this article, shall be exempt from the requirements of §§ 38.2-1816 and 38.2-1817 if the other state or province grants the same exemption to an agent formerly residing in this Commonwealth. However, each of these applicants shall submit the application and pay the fee required by § 38.2-1819.

§ 38.2-1819. Application for examination; fee required; when fee forfeited.—Each applicant for an examination shall make a written application to the Commission, in the form and containing the information the Commission prescribes. Each applicant shall, at the time of applying to take the examination, pay a fee of fifteen dollars in a manner prescribed by the Commission. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance. An applicant may take the examination only after receiving written acknowledgement that the Commission has received the application and fee. If the applicant fails to take the examination within six months from the date his application is filed with the Commission, the fee prescribed in this section shall be forfeited and the application shall be considered withdrawn.

§ 38.2-1820. Issue of license.—Each applicant who is at least eighteen years of age and who has satisfied the Commission that he is of good character, has a good reputation for honesty, and has complied with the other requirements of this article is entitled to and shall receive a license in the form the Commission prescribes.

Drafting Note: As a result of 1985 legislation, the Commission will issue licenses instead of certificates of qualification.

§ 38.2-1821. Revocation, etc., of license revokes appointment.—If the Commission refuses to grant or revokes a license, any appointment of such licensee shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements of this article.

Drafting Note: Former § 38.1-327.23 was repealed by 1985 legislation.

Drafting Note: Subsection A of this section is being amended and moved to proposed § 38.2-1815. Subsection B is being deleted and proposed § 38.2-1816 will apply.

Drafting Note: 1. This section is being deleted and § 38.2-1817 will apply.

2. Former §§ 38.1-327.26 and 38.1-327.27 were repealed by 1985 legislation.

Drafting Note: This section is being deleted and proposed § 38.2-1818 will apply.

Drafting Note: This section is being deleted and proposed § 38.2-1819 will apply.

Drafting Note: This section is being deleted and proposed § 38.2-1820 will apply.

Drafting Note: 1. This section is being deleted and proposed § 38.2-1821 will apply.

2. Former § 38.1-327.32 was repealed by 1985 legislation.

Article 3.

Licensing of Agents.

§ 38.2-1822. License required of agents; individual acting for partnership or corporate licensee.—A. No person shall act, and no insurer or licensed agent shall knowingly permit a person to act, in this Commonwealth as an agent of an insurer licensed to transact the business of insurance in this Commonwealth without first obtaining a license in a manner and in a form prescribed by the Commission. As used in this section, "act as an agent" means soliciting, negotiating or effecting contracts of insurance or annuity on behalf of an insurer licensed in this Commonwealth. No person shall submit business to any joint underwriting association or any plan established under this title for the equitable distribution of risks among insurers unless the person holds a valid license to transact the kind of insurance involved.

B. No individual shall act for either a partnership or a corporation in the transaction of insurance unless he is licensed as an agent. The existence of the partnership or corporation shall be recorded pursuant to law, and the authority of the corporation to act as an insurance agent or agency shall be specifically set forth in this charter.

C. For a nonresident partnership or a nonresident corporation the foregoing requirements shall be attested to by the insurance department of the nonresident's state of domicile as set forth in § 38.2-1836.

Drafting Note: 1. The term "act as an agent" has been defined to clarify that anyone involved in this type of activity must be licensed.

2. Old subsection B providing that an agent who had a certificate of qualification could submit business to a licensed insurer prior to obtaining a license for the insurer has been repealed by 1985 legislation since the certificates are no longer used.

§ 38.2-1823. Penalty for acting for insurer, joint underwriting association, etc., when not licensed.—Any person submitting business, in violation of § 38.2-1822, while the person is not a holder of a valid agent's license to transact the kind of insurance involved shall be penalized a sum equal to the first year commission for the placement of that business and in addition shall be subject to the penalties prescribed in § 38.2-218.

§ 38.2-1824. Kinds of agents' licenses issued.—The Commission shall issue the following kinds of agents' licenses: life and health insurance agent, property and casualty insurance agent, assessment life and casualty insurance agent, burial insurance agent, credit life and health insurance agent, dental services agent, health agent, legal services agent, mortgage guaranty insurance agent, mortgage redemption insurance agent, mutual assessment property and casualty insurance agent, mutual assessment life and health insurance agent, ocean marine insurance agent, optometric services agent, title insurance agent, travel accident insurance agent, travel baggage insurance agent, and variable contract agent.

Drafting Note: 1. The reference to company representative is being deleted from this section as it is no longer used.

2. The terms health agent, dental services agent, legal services agent, optometric services agent, mutual assessment property and casualty insurance agent, mutual assessment life and health and variable contract agent are added.

§ 38.2-1825. Duration of license; annual renewal of agent's licenses.—A. A license issued to an agent shall authorize him to act as an agent until his license is otherwise terminated, suspended or revoked. An agent's license shall automatically terminate after a period of six months during which no appointment of such agent was in effect except for good cause shown to the Commission and payment of the prescribed fee.

B. An appointment issued to an agent by an insurer, unless terminated, suspended or revoked, shall authorize the appointee to act as an agent for that insurer and to be compensated therefor notwithstanding the provisions of §§ 38.2-1812 and 38.2-1823.

C. Upon the suspension or revocation of a license, the agent, or any person having possession of that license, shall immediately return it to the Commission.

Drafting Note: 1. This section was revised by 1985 legislation to be made consistent with the new agent licensing and appointment process.

2. "Termination" was deleted in subsection C because the Commission only needs to take action if a license is suspended or revoked.

§ 38.2-1826. Change of address, name.—Each agent shall report within thirty days to the Commission, and to every insurer that he represents, any change in his residence or name. Any agent who has moved his residence from this Commonwealth shall have his license immediately revoked.

Drafting Note: "Or office address" on line 2 was deleted. The revocation of license due to change in office address for property and casualty agents is being deleted.

§ 38.2-1827. License may include one or more classes of insurance.—Except as otherwise provided in this title, an agent's license issued to any person in this Commonwealth authorizes that person, if qualified, to solicit, negotiate, or effect any one or more of the classes of insurance (i) for which the agent is licensed to transact in this Commonwealth and (ii) with an insurer also licensed in this Commonwealth for

those classes of insurance.

§ 38.2-1828. Selling accident and sickness insurance.—Any individual who desires to solicit or procure applications for accident and sickness insurance as defined in § 38.2-109 shall obtain a life and health insurance agent's license. However, this requirement does not apply to (i) those individuals exempted from the examination and license requirements of § 38.2-1815 or (ii) those agents selling medical, hospital, surgical, funeral or weekly indemnity benefits as a part of a policy of motor vehicle or aircraft insurance.

§ 38.2-1829. Additional requirement to hold insurance license.—Each agent shall "engage actively in the insurance business." This means that during any given year the agent will write or place insurance for others having a total premium volume greater than the combined total premium volume of similar insurance written or placed by the agent upon his or its own property or risks, whether in an individual or in a fiduciary capacity, and if the agent is an individual, upon property or risks in connection with the business of his employer. For the purpose of this section, persons placing property for sale or rent with real estate agents shall not be deemed employers of the real estate agents, nor shall any public transportation company be deemed the employer of any ticket-selling agent who acts as an insurance agent only in the issuance of accident or travel baggage insurance policies primarily for the purpose of covering risks of travel.

Drafting Note: Former § 38.1-327.41 was repealed by 1985 legislation.

§ 38.2-1830. Temporary license; when issued.—A. A temporary license for life and health insurance agents or property and casualty insurance agents shall be issued by the Commission in the following circumstances:

1. Upon the death of an agent, to his personal representative, surviving spouse, employee, child or next of kin;

2. Upon the inability of an agent to act because of sickness, injury or mental incapacity, to his spouse, child, next of kin, employee or legal representative;

3. Upon the sale of the agent's business, to any person employed in the business. In the event no person is available and suitable for appointment, the Commission may appoint any other suitable person; or

4. To an applicant who is to be an agent of a combination insurer, and who will be assigned a debit and will actually collect the premiums on insurance contracts during the period of such temporary license. A " combination insurer" means an insurer selling industrial or ordinary life insurance or accident and sickness insurance on a debit, where the premiums are payable at least monthly directly by the owner of the policy or a person representing the owner to a representative of the insurer.

B. Before any temporary license is issued, the applicant shall file with the Commission a written application in the form and containing the information the Commission prescribes. No written examination shall be required of the applicant; however, no license shall be issued until the Commission is satisfied that the applicant is trustworthy and competent to be licensed. Only one temporary license shall be issued to any individual and that license shall be valid for ninety days. An individual holding a temporary license shall not be prevented from securing a license by meeting the applicable requirements for the license, nor shall a temporary license be required before an individual may obtain a license. The Commission, in its sole discretion and for good cause shown, may renew licenses granted under this section.

Drafting Note: Child of the agent has been added to this list of those eligible for a temporary license.

§ 38.2-1831. Refusal or revocation of license.—The Commission may refuse to issue an agent's license to any person and, in addition to or in lieu of a penalty imposed under § 38.2-218, may suspend or revoke the license of any licensee whenever it finds that the applicant or licensee:

1. Has misappropriated any insurance premium;

2. Has failed to apply any premium as directed by the holder or prospective holder of the contract of insurance;

3. Has violated any provisions of any law of this Commonwealth applicable to insurance and insurance agents;

4. Has been guilty of rebating;

5. Has been guilty of twisting the contracts of other insurers, where "twisting" means misrepresenting a policy for the purpose of inducing a policyholder to terminate an existing policy to take a new policy;

6. Has been guilty of misrepresenting the provisions of the contract he is selling, or the contracts of other insurers;

7. Has been guilty of fraudulent or dishonest practices;

8. If not exempted from the requirement of § 38.2-1829, has not been "actively engaged" in the insurance business during the preceding year as required by that section;

9. Has been convicted of a felony; or

10. Is not trustworthy or competent to solicit, negotiate or effect the kinds of insurance for which a license is applied for or held.

Drafting Note: 1. The refusal or revocation of a license has been qualified to be a penalty that is in addition to or in lieu of penalties imposed under § 38.2-218, for clarity purposes only.

2. For clarity purposes, "twisting" has been separated from "rebating" and given a definition.

3. Number 9 was added because of the serious nature of a felony conviction.

4. In number 10, "solicit, negotiate or effect" was added for consistency with the rest of the chapter.

§ 38.2-1832. Refusal to issue and revocation of license; hearing; appeal; new application.–If the Commission believes that any applicant for a license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. Except as provided in § 38.2-1042, the Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least ten days' notice in writing of the time and place of the hearing. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension, as the case may be . The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1826, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until after the time, not exceeding two years, the Commission prescribes in its order.

Drafting Note: 1. The addition of "the last known business address if the address of record is incorrect" was made because of problems experienced with revocation notices.

2. The right to appeal to the Virginia Supreme Court was deleted because of the unified appeals section in proposed Chapter 2.

§ 38.2-1833. Appointments of agents. –Every individual who holds a valid agent's license from this Commonwealth may solicit applications for insurance for any one or more of the classes of insurance for which he is licensed on behalf of an insurer (i) also licensed in this Commonwealth for those classes of insurance and (ii) with which the individual does not have a valid appointment on file with the Commission subject to the following requirements:

1. The insurer shall either reject such application or file with the Commission a written notice of appointment on a form acceptable to the Commission, within fifteen days from receipt by the insurer of the initial application for insurance from the agent.

2. The insurer shall mail to the agent within the same fifteen-day period a copy of the appointment form filed with the Commission. If the agent does not receive from the Commission a copy of the appointment within thirty days of mailing or delivering the first application to the insurer, then the agent shall discontinue any solicitation for that insurer until receipt of a copy of the appointment. Any such further solicitation prior to receipt of such appointment shall constitute a violation of this section and shall be penalized as prescribed in § 38.2-218.

3. The insurer submits to the Commission an appointment fee of seven dollars, which shall be collected by the Commission and paid directly into the state treasury and placed to the credit of the fund for the maintenance of the Bureau of Insurance.

4. Such appointments shall be public information and shall be available for public inspection during normal business hours of the Commission. The Commission may charge a reasonable fee to cover the costs incurred in providing this information.

Drafting Note: 1. This section is a result of 1985 legislation. Editorial modifications were made to make this consistent with proposed § 38.2-1827.

2. Paragraph 4 was added at the request of industry.

§ 38.2-1834. Duration of appointment; annual renewal of agent's appointment.–A. An appointment issued to an agent shall authorize the agent to act for the insurer during the time for which the appointing insurer is licensed to do business in this Commonwealth, unless such appointment is otherwise terminated, suspended, or revoked. Upon the termination, suspension or revocation of such appointment, the agent, or any other person having possession of the appointment, shall immediately return it to the Commission.

B. Prior to August 1 of each year, every insurer shall remit in a manner prescribed by the Commission a renewal appointment fee of seven dollars, which shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance.

C. Upon the termination of an agent by an insurer, the insurer shall immediately notify the agent and the Commission of that termination in a manner acceptable to the Commission, whereupon the agent's appointment to represent the insurer shall be terminated.

D. Any license in effect on January 1, 1986, shall be deemed to be an appointment for the unexpired term of that license. Certificates of qualifications issued prior to January 1, 1986, shall be deemed to be the license required by this chapter.

Drafting Note: This section is a result of 1985 legislation.

§ 38.2-1835. Failure to appoint.— Any insurer that accepts applications from an agent and does not appoint such agent as set forth in § 38.2-1833 shall be penalized as provided in § 38.2-218.

Drafting Note: This section is a result of 1985 legislation.

§ 38.2-1836. Licensing nonresidents; Clerk of the Commission to be appointed agent for service of process; reciprocal agreements with other states and Canadian provinces.—A. A person who is not a resident as defined in § 38.2-1800, but who is a resident of another state or a province of Canada, may obtain a license as set forth in § 38.2-1822 if the applicant first files with the Commission a certificate from the insurance department of the applicant's state or province of domicile setting forth (i) that the applicant is licensed in that state or province to solicit, negotiate or effect the kinds of insurance for which the license is being sought in this Commonwealth, (ii) that the applicant is conducting the business of insurance in that state or province in a satisfactory manner, (iii) if the applicant is a corporation, that it is authorized in its charter or other papers of incorporation to act as an insurance agent, and (iv) that the other state or province will issue a license to a similarly qualified applicant of this Commonwealth. In addition, an individual who proposes to become licensed under this section shall pass the written examination required of residents of this Commonwealth unless a reciprocal agreement waiving the examinations, pursuant to subsection D of this section, exists between this Commonwealth and the applicant's state or province of domicile.

B. For the purposes of this chapter, any person whose place of residence and place of business are in a city or town located partly within this Commonwealth and partly within another state may be considered as meeting the requirements as a resident of this Commonwealth, provided the other state has established by law or regulation similar requirements as to residence of these persons.

C. No agent's license shall be issued to any nonresident of this Commonwealth unless the nonresident executes a power of attorney appointing the Clerk of the Commission as the agent for service of process of the applicant in any action or proceeding arising in this Commonwealth out of or in connection with the exercise of the license. The appointment of an agent for service of process shall be irrevocable during the period within which a cause of action against the nonresident may arise out of nonresident transactions with respect to subjects of insurance in this Commonwealth. Service of process on the Clerk of the Commission shall conform to the provisions of Chapter 8 of this title.

D. The Commission may enter into a reciprocal agreement with an appropriate official of any other state or province of Canada waiving any written examination required by this chapter of any applicant who is a nonresident of this Commonwealth provided:

1. That a written examination is required of applicants for an agent's license in the other state or province; and

2. That the appropriate official of the other state or province certifies that the applicant holds a currently valid license in the other state or province and has either passed a written examination or was the holder of an agent's license prior to the time a written examination was required

Drafting Note: 1. The change in subsection C from Commissioner of Insurance to Clerk of the Commission was made because the clerk is the actual individual who acts as the agent for service of process.

2. Existing paragraph 3 was deleted because it repeats the requirement in the last part of paragraph 2.

Article 4.

Licensing of Property and Casualty Consultants.

§ 38.2-1837. Definitions.—As used in this article:

"Consultant" means any individual, partnership or corporation who acts as an independent contractor in relation to his client and for a fee or compensation, other than from an insurer or agent or surplus lines broker , advises or offers or purports to advise, as to property and casualty insurance as defined in §§ 38.2-110 through 38.2-122 and §§ 38.2-124 through 38.2-134, any person actively or prospectively insured. However, "consultant" shall not include:

1. Any licensed attorney acting in his professional capacity;

2. Any property and casualty insurance agent licensed in this Commonwealth except as provided in §§ 38.2-1839, 38.2-1840 and 38.2-1842;

3. A trust officer of a bank acting in the normal course of his employment;

4. Any actuary or certified public accountant who consults during the normal course of his business; and

5. Any person employed as a risk manager and who consults for his employer only.

Drafting Note: Property and casualty agents are included in the existing bond requirement section, § 38.1-327.64 (proposed § 38.2-1839) so that section has been added here in item 2 for easier reference.

§ 38.2-1838. License required of consultants.—A. Any person not licensed as an insurance agent or property and casualty insurance consultant who, in the Commonwealth, holds himself out to be an insurance advisor, consultant or insurance counselor or any person who uses any other designation or title likely to mislead the public, that he has particular insurance qualifications other than those for which he may otherwise be licensed or qualified shall be punished as provided in § 38.2-218 in addition to any other penalties specifically provided for in this chapter. As used in this section, "hold himself out to be an insurance advisor, consultant or insurance counselor" shall mean:

1. Representing that one's primary business is insurance consulting, excluding advice provided incidental to a primary noninsurance consulting business of such person providing the advice; or

2. Receiving, directly or indirectly, special and specific compensation for insurance advice.

B. To obtain a license a consultant shall:

1. Successfully complete a forty-five-hour property and casualty study course as required in § 38.2-1816; and

2. Successfully pass the property and casualty examination as required in § 38.2-1817.

C. Any individual who acts as a consultant for a partnership or a corporation shall be licensed as a consultant.

Drafting Note: Since existing 38.1-327.71 is being deleted in favor of the unified penalty section in proposed Chapter 2, the reference in the first paragraph has been modified to refer to that penalty section (proposed § 38.2-218).

§ 38.2-1839. Contract and bond required.—A. Any consultant or property and casualty agent acting as a consultant in this Commonwealth shall enter into a written contract with his client prior to any act as a consultant. The contract shall include, without limitation, the amount and basis of any consulting fee and the duration of employment.

B. Prior to the issuance of a consultant's license and thereafter for as long as the consultant's license remains in effect, the applicant shall file and keep in force a bond with the Commission. Prior to a property and casualty agent's acting as a consultant and thereafter for as long as he acts as a consultant, the agent shall file and keep in force a bond with the Commission. In both cases, the bond shall (i) be in favor of the Commonwealth in the penal sum of $25,000 with authorized corporate sureties approved by the Commission; (ii) be conditioned that the consultant or property and casualty agent acting as a consultant will conduct business in accordance with the provisions of this title; and (iii) not be terminated unless, at least thirty days prior, written notice of the termination is filed with the Commission.

§ 38.2-1840. Annual license fee.—The annual fee for the license shall be fifty dollars, which shall be paid in a manner prescribed by the Commission. Prior to August 1 of each year thereafter, every consultant shall renew his license in the manner prescribed by the Commission. All fees shall be collected by the Commission and paid into the state treasury for the maintenance of the Bureau of Insurance.

Drafting Note: The date has been changed to August 1 to be consistent with the date of renewing agent appointments.

§ 38.2-1841. Termination, suspension or revocation of license.—Upon the suspension or revocation of a consultant's license, the consultant or the person having possession of the license shall immediately return it to the Commission.

Before August 1 of each year, each consultant shall remit the fee prescribed in § 38.2-1840 for the renewal of the license, unless the license has been terminated, suspended or revoked on or before June 30 of that year.

Drafting Note: See the drafting note for § 38.2-1840.

§ 38.2-1842. Change of address, name.—Each consultant or any property and casualty agent acting as a consultant shall report within thirty days to the Commission any change in his residence or name. Any consultant or any property and casualty agent acting as a consultant who has moved his residence from this Commonwealth shall have his license immediately revoked.

Drafting Note: The requirement of reporting changes in office address has been deleted to be consistent with the change of address, name requirement for agents (proposed § 38.2-1826).

§ 38.2-1843. Refusal or revocation of license.—The Commission may refuse to issue a consultant's license and, in addition to or in lieu of a penalty under § 38.2-218, may suspend or revoke the license of any licensee whenever it finds such applicant or licensee:

1. Has violated any provisions of any law of this Commonwealth applicable to insurance;

2. Has misappropriated any funds held in a fiduciary capacity;

3. Has shared fees with persons not licensed as a consultant or exempted under this statute;

4. Has misrepresented the provisions of any insurance contract;

5. Has been guilty of twisting the contracts of other insurers where "twisting" means misrepresenting a

policy for the purpose of inducing a policyholder to terminate an existing policy to take a new policy;

6. Has committed fraudulent or dishonest practices; or

7. Is not trustworthy or is not competent to transact the insurance business for which a license is applied for or held.

Drafting Note: The changes to this section are consistent with the changes made to the section with similar provisions for agents (proposed § 38.2-1831).

§ 38.2-1844. Refusal to issue and revocation of license; hearing; appeal; new application.—If the Commission finds that any applicant for a license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least ten days' notice in writing of the time and place of the hearing. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension as the case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1842, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until after the time, not exceeding two years, the Commission prescribes in its order.

Drafting Note: See drafting note for proposed § 38.2-1832.

§ 38.2-1845. Licensing nonresidents.—A person who is not a resident as defined in § 38.2-1800, but who is a resident of another state or a province of Canada, may obtain a license as set forth in this article provided that the applicant first files with the Commission a certificate from the insurance department of the applicant's state or province of domicile setting forth:

1. That the applicant is licensed in that state or province as a property and casualty insurance consultant;

2. That the applicant is conducting the business of consulting in such state or province in a satisfactory manner;

3. That such other state or province will issue a license to a similarly qualified applicant of this Commonwealth. In addition, an individual who proposes to become licensed under this section shall pass a written examination as required of residents of this Commonwealth unless a reciprocal agreement waiving the examinations exists between this Commonwealth and the applicant's state or province of domicile; and

4. If the applicant is a corporation, that it is authorized in its charter or other papers of incorporation to act as a property and casualty insurance consultant.

Drafting Note: Existing § 38.1-327.71 is being deleted in favor of the unified penalty section being added in Chapter 2.

Title 38.2

CHAPTER 19.

Regulation of Rates Generally.

The changes made in this chapter are as follows:

1. In proposed § 38.2-1904, a new paragraph designated as A 3 relating to unfairly discriminatory rates has been added.

2. In proposed § 38.2-1904, the last portion of paragraph B 2 has been deleted because a proposed change in the Uninsured Motorist chapter has caused the deleted language to be inappropriate.

3. The revision of proposed § 38.2-1905 (existing § 38.1-279.33:1) is a clarification of the review procedure in subsection H of proposed § 38.2-2212 and current Bureau policy with the exception that the appeal period has been extended.

4. In § 38.2-1912, a provision has been added which requires the Commission to notify the insurer within thirty days if more information is required to evaluate a rate filing coming within the provisions of that section.

5. In § 38.2-1913, the duty of a rate service organization to notify the Commission of problems regarding information submission is deleted. This appears to be an operating problem of the rate service organization that they should handle internally.

6. A new subsection is added to proposed § 38.2-1918. The intent of this new subsection is to clarify that the Commission may approve the policy forms and endorsements used by insurers under a residual market facility (such as the Virginia Automobile Insurance Plan). This is not a substantive change from current practice.

   The Bureau also suggests that a parallel change be made to § 46.1-497 of the Motor Vehicle Code. Specifically, we suggest that the two existing paragraphs be labeled subsections A and B respectively and that a new subsection C be added. The new subsection should read as follows:

   > C. The State Corporation Commission may approve policy forms and endorsements for use by insurers with respect to insurance provided under this article. The provisions of this subsection shall take precedence over any conflicting provision of this code.

7. Existing § 38.1-279.48:1 has been moved to Chapter 3.

8. Existing § 38.1-279.49:1 has been moved to Chapter 21 (§ 38.2-2118).

9. In § 38.2-1927, the reference to the Criminal Code has been deleted since a violation of this section does not necessarily constitute perjury as defined in the Criminal Code.

CHAPTER 19.

REGULATION OF RATES GENERALLY.

§ 38.2-1900. Purposes of chapter.—A. This chapter shall be liberally construed to achieve the purposes stated in subsection B of this section.

B.—The purposes of this chapter are to:

1. Protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

2. Encourage independent action by insurers and reasonable price competition among insurers as the most effective way to produce rates that conform to the standards of paragraph 1;

3. Provide formal regulatory controls for use if independent action and price competition fail;

4. Authorize cooperative action among insurers in the rate making process, and regulate such cooperation in order to prevent practices that tend to create monopoly or to lessen or destroy competition;

5. Provide rates that are responsive to competitive market conditions and improve the availability of insurance in this Commonwealth; and

6. Regulate the business of insurance in a manner that will preclude application of federal antitrust laws.

§ 38.2-1901. Definitions.—As used in this chapter:

"Market segment" means any line or class of insurance or, if it is described in general terms, any subdivision of insurance or any class of risks or combination of classes.

"Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule, and any other information not otherwise inconsistent with the purposes of this chapter required by the Commission.

"Supporting data" includes:

1. The experience and judgement of the filer and, to the extent the filer wishes or the Commission requires, the experience and judgement of other insurers or rate service organizations;

2. The filer's interpretation of any statistical data relied upon;

3. Descriptions of the actuarial and statistical methods employed in setting the rates; and

4. Any other relevant information required by the Commission.

Drafting Note: The deleted definitions in § 38.2-1901 have been moved to Chapter 1 and are applied title-wide.

The definition of "supporting data" has been moved from existing § 38.1-279.40.

§ 38.2-1902. Scope of chapter.—A. Except as provided in subsection B of this section, this chapter applies to the classes of insurance defined in §§ 38.2-110 through 38.2-118, 38.2-120 through 38.2-122, 38.2-124 through 38.2-128 and 38.2-130 through 38.2-133.

Drafting Note: In order to improve clarity the proposed revision places all of the exclusions in subsection B. The proposed revision also reflects new definitions in Article 2 of Chapter 1.

B. This chapter does not apply to:

1. Workers' compensation insurance as defined in § 38.2-119;

2. Insurance on a specific risk as provided in § 38.2-1920;

3. Reinsurance, other than joint reinsurance , to the extent stated in § 38.2-1915;

4. Life insurance as defined in § 38.2-102;

5. Annuities as defined in §§ 38.2-106 and 38.2-107;

6. Accident and sickness insurance as defined in § 38.2-109;

7. Title insurance as defined in § 38.2-123;

8. Insurance of vessels or craft used primarily in a trade or business, their cargoes, marine builders' risks and marine protection and indemnity ;

9. Insurance against loss of or damage to hulls of aircraft, including their accessories and equipment,

or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance or use of aircraft;

10. Automobile bodily injury and property damage liability insurance issued to: (i) any motor carrier of property who is required to file such insurance with the Commission pursuant to § 56-299 or any amendment to that section; (ii) any petroleum tank truck carrier required by any rule or regulation of the Commission under § 56-338.36 to file such insurance with the Commission; or (iii) any motor carrier of property required by 49 U.S.C.A. § 315, or any rule or regulation prescribed by the Interstate Commerce Commission pursuant to 49 U.S.C.A. § 315, to file such insurance with the Interstate Commerce Commission;

11. Uninsured motorist coverage required by subsection A of § 38.2-2206;

12. Insurance written through the Virginia Automobile Insurance Plan;

13. Insurance provided pursuant to Chapter 27 of this title;

14. Home protection contracts as defined by § 38.2-2600 and their rates until such time as the Commission determines there is sufficient competition in the industry as provided by § 38.2-2608.

C. This chapter shall not apply to any class of insurance written (i) by any mutual assessment property and casualty insurance company organized and operating under the laws of this Commonwealth and doing business only in this Commonwealth, or (ii) by any mutual insurance company or association organized under the laws of this Commonwealth, conducting business only in this Commonwealth, and issuing only policies providing for perpetual insurance.

§ 38.2-1903. Exemptions.–The Commission may by rule exempt any person, class of persons, or market segment from any or all of the provisions of this chapter to the extent that it finds their application unnecessary to achieve the purposes of this chapter.

§ 38.2-1904. Rate standards.– A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory.

1. No rate shall be held to be excessive unless it is unreasonably high for the insurance provided and (i) a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies, or (ii) the rate will have the effect of destroying competition or creating a monopoly.

2. No rate shall be held inadequate unless it is unreasonably low for the insurance provided and (i) continued use of it would endanger solvency of the insurer, or (ii) the rate is unreasonably low for the insurance provided and use of the rate by the insurer has or, if continued, will have the effect of destroying competition or creating a monopoly.

3. No rate shall be unfairly discriminatory if a different rate is charged for the same coverage and (i) the rate differential is based on sound actuarial principles or (ii) is related to actual or reasonably anticipated experience.
Drafting Note: Paragraph 3 was added at the request of the industry.

B. 1. In determining whether rates comply with the standards of subsection A of this section, due consideration shall be given to (i) past and prospective loss experience within and outside this Commonwealth, (ii) conflagration or catastrophe hazards, (iii) a reasonable margin for underwriting profit and contingencies, (iv) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, (v) past and prospective expenses both countrywide and those specially applicable to this Commonwealth, (vi) investment income earned or realized by insurers both from their unearned premium and loss reserve funds, and (vii) all relevant factors within and outside this Commonwealth.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.
Drafting Note: The purpose of the uninsured motorists fund chapter has been amended to state that the purpose of the fund is to reduce the cost of the mandatory uninsured motorist coverage which is subject to the prior approval chapter. Therefore, the deleted language is no longer appropriate.

C. For the classes of insurance to which this chapter applies, including insurance against contingent, consequential and indirect losses as defined in § 38.2-133, (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or with respect to any subdivision or combination of insurance for which separate expense provisions are applicable, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference between risks that can be demonstrated to have a probable effect upon losses or expenses.

D. No insurer shall use any information pertaining to any motor vehicle conviction or accident to produce increased or surcharged rates above their filed manual rates for individual risks for a period longer than thirty-six months. This period shall begin no later than twelve months after the date of the

conviction or accident.

§ 38.2-1905. Motor vehicle insurer not to charge points unless accident caused by insured. A. No insurer may charge points to its insured under a safe driver insurance plan as a result of a motor vehicle accident unless the accident was caused either wholly or partially by the named insured, a resident of the same household, or other customary operator, except where the operator causing the accident is a principal operator insured under a separate policy. Any insurer charging points under any such plan shall notify the named insured in writing and in the same notification shall inform the named insured that he may appeal the decision of the insurer to the Commissioner if he feels he has been charged points without just cause.

B. An appeal of a point charge by the named insured shall be requested in writing within sixty days of receipt of the notice of any premium adjustment resulting from the point assignment. Upon receipt of the request, the Commissioner shall promptly initiate a review to determine whether the point charge is justified. The point charge shall remain in full force and effect until the Commissioner rules that the point charge be removed because it is not justified, or because it was not assigned in accord with the insurer's filed rating plan, and so notifies the insurer and the insured. Upon receipt of the ruling, the insurer shall promptly refund any premiums paid as a direct result of the point charge, and shall adjust future billings to reflect the removal of the point charge.

Drafting Note: In general, the revision of this section is a clarification of the review procedure in subsection H of proposed § 38.2-2212 and current Bureau policy with the exception that the appeal period has been extended. This change is suggested because the notifications required by this section and premium notices do not coincide. When an insured is notified that points are being assigned, the effect on premiums may not be disclosed.

§ 38.2-1906. Filing and use of rates.—A. Each authorized insurer and each rate service organization licensed under § 38.2-1914 that has been designated by any insurer for the filing of rates under § 38.2-1908 shall file with the Commission all rates and supplementary rate information and all changes and amendments to the rates and supplementary rate information made by it for use in this Commonwealth on or before the date they become effective.

Drafting Note: The cite to § 38.1-279.41 is incorrect. The cite should be to § 38.1-279.42. This error has been corrected in the renumbering process.

B. No insurer shall make or issue an insurance contract or policy of a class to which this chapter applies, except in accordance with the rate and supplementary rate information filings that are in effect for the insurer.

§ 38.2-1907. Filings open to inspection.—Each filing and all supplementary rate information filed under this chapter shall be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge for the copies. Where feasible, the Commission shall compile and make available to the public the lists of rates charged by insurers for or in connection with the insurance contracts or policies to which this chapter applies so as to inform the public of price competition among insurers.

§ 38.2-1908. Delegation of rate making and rate-filing obligation.—A. An insurer may establish rates and supplementary rate information for any market segment based on the factors in § 38.2-1904 or it may use rates and supplementary rate information prepared by a rate service organization, with average loss factors or expense factors determined by the rate service organization or with modification for its own expense and loss experience as the credibility of that experience allows.

—B. An insurer may discharge its obligations under subsection A of § 38.2-1906 by giving notice to the Commission that it uses rates and supplementary rate information prepared and filed with the Commission by a designated rate service organization of which it is a member or subscriber. Any information about modifications to the rate service organization's filing that is necessary to fully inform the Commission of the insurer's rates shall be filed with the Commission. The insurer's rates and supplementary rate information shall be those filed from time to time by the rate service organization, including any amendments to the rates and supplementary rate information, subject to modifications filed by the insurer.

§ 38.2-1909. Review of rates by Commission.—The Commission may investigate and determine, (i) upon its own motion, (ii) at the request of any citizen of this Commonwealth, or (iii) at the request of any insurer subject to this chapter, whether rates in this Commonwealth for the classes of insurance to which this chapter applies are excessive, inadequate or unfairly discriminatory. In any such investigation and determination the Commission shall give due consideration to those factors specified in § 38.2-1904.

§ 38.2-1910. Disapproval of rates. - A. If the Commission finds, after providing notice and opportunity to be heard, that a rate is not in compliance with § 38.2-1904, or is in violation of § 38.2-1916, the Commission shall order that use of the rate be discontinued for any policy issued or renewed after a date specified in the order. The order may provide for rate modifications. The order may also provide for refund of the excessive portion of premiums collected during a period not exceeding one year prior to the date of the order. Except as provided in subsection B of this section, the order shall be issued within thirty days after the close of the hearing or within another reasonable time extension fixed by the Commission.

B. Pending a hearing, the Commission may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the Commission has reasonable cause to believe that either: (i) a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies, (ii) the filed rate will have the effect of destroying competition or creating a monopoly, or (iii) use of the rate will endanger the solvency of the insurer. If the Commission

suspends a rate under this provision, it shall hold a hearing within fifteen business days after issuing the order suspending the rate unless the right to a hearing is waived by the insurer. In addition, the Commission shall make its determination and issue its order as to whether the rate shall be disapproved within fifteen business days after the close of the hearing.

C. At any hearing held under the provisions of subsection A or B of this section, the insurer shall have the burden of justifying the rate in question. All determinations of the Commission shall be on the basis of findings of fact and conclusions of law. If the Commission disapproves a rate, the disapproval shall take effect not less than fifteen days after its order and the last previous rate in effect for the insurer shall be reimposed for a period of one year unless the Commission approves a substitute or interim rate under the provisions of subsection D or E of this section.

D. For one year after the effective date of a disapproval order, no rate promulgated to replace a rate disapproved under the order may be used until it has been filed with the Commission and not disapproved within thirty days after filing.

E. Whenever an insurer has no legally effective rates as a result of the Commission's disapproval of rates or other act, the Commission shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties. The Commission may order that a specified portion of the premiums be placed in an escrow account approved by it. When new rates become legally effective, the Commission shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

§ 38.2-1911. Special restrictions on individual insurers.—A. The Commission may by order require that a particular insurer file any or all of its rates and supplementary rate information thirty days prior to their effective date, if the Commission finds, after providing notice and opportunity to be heard, that the protection of the interests of the insurer's policyholders and the public in this Commonwealth requires closer supervision of the insurer's rates because of the insurer's financial condition or repetitive filing of rates that are not in compliance with § 38.2-1904. The Commission may extend the waiting period of any filing for thirty additional days by written notice to the insurer before the first thirty-day period expires.

B. The filing shall be approved or disapproved during the waiting period or during its extension. If the filing is not disapproved before the expiration of the waiting period or of its extension, the filing shall be deemed to meet the requirements of this chapter, subject to the possibility of subsequent disapproval under § 38.2-1910.

C. Any insurer affected by an order entered under subsection A of this section may request a rehearing by the Commission after the expiration of twelve months from the date of the Commission's former order.

§ 38.2-1912. Delayed effect of rates.—A. If the Commission finds in any class, line, or subdivision of insurance, or in any rating class or rating territory that (i) competition is not an effective regulator of the rates charged, (ii) a substantial number of insurers are competing irresponsibly through the rates charged, or (iii) there are widespread violations of this chapter, it may promulgate a rule requiring that any subsequent changes in the rates or supplementary rate information for that class, line, subdivision, rating class or rating territory shall be filed with the Commission at least thirty days before they become effective. The Commission may extend the waiting period for thirty additional days by written notice to the filer before the first thirty-day period expires.

B. By this rule the Commission may require the filing of supporting data for any classes, lines or subdivisions of insurance, or classes of risks or combinations thereof it deems necessary for the proper functioning of the rate monitoring and regulating process.

C. A rule promulgated under this section shall expire no later than one year after issue. The Commission may renew the rule after a hearing and appropriate findings under this section.

D. If a filing is not accompanied by the information the Commission has required under subsection B of this section, the Commission shall within thirty days of the initial filing inform the insurer that the filing is not complete, and the filing shall be deemed to be made when the information is furnished.

Drafting Note: The word "may" has been changed to "shall" because the Commission should have an affirmative obligation to inform insurers when a filing is not considered completed.

The definition of "supporting data" has been moved to § 38.2-1901.

A provision has been added which requires the Commission to notify the insurer within 30 days if more information is required.

§ 38.2-1913. Operation and control of rate service organizations. —A. No rate service organization shall provide any service relating to the rates of any insurance subject to this chapter, and no insurer shall use the service of a rate service organization for such purposes unless the rate service organization has obtained a license under § 38.2-1914.

B. No rate service organization shall refuse to supply any services for which it is licensed in this Commonwealth to any insurer authorized to do business in this Commonwealth and offering to pay the fair and usual compensation for the services.

C. Any rate service organization subject to this chapter may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, other evidences of insurance, or evidences of the

cancellation of insurance, and may make reasonable rules governing their submission and the correction of any errors or omissions in them. This provision applies to the classes of insurance for which the rate service organization files rates pursuant to § 38.2-1908.

Drafting Note: The duty to notify the Commission of problems regarding information submission is deleted. This appears to be an operating problem of the rate service organization that they should handle internally.

§ 38.2-1914. Licensing of rate service organizations. —A. A rate service organization applying for a license as required by § 38.2-1913 shall include with its application:

1. A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

2. A list of its members and subscribers;

3. The name and address of one or more residents of this Commonwealth upon whom notices, process affecting it or orders of the Commission may be served;

4. A statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

5. Any other relevant information and documents that the Commission may require.

B. Each organization which has applied for a license under subsection A of this section shall promptly notify the Commission of every material change in the facts or in the documents on which its application was based.

C. If the Commission finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed, and that all requirements of law have been met, the Commission shall issue a license specifying the authorized activity of the applicant.

D. Licenses issued under subsection C of this section shall remain in effect until the licensee withdraws from the Commonwealth or until the license is suspended or revoked.

E. Any amendment to a document filed under paragraph 1 of subsection A of this section shall be filed promptly after it becomes effective. Failure to comply with this subsection shall be a ground for revocation of the license granted under subsection C of this section.

§ 38.2-1915. Joint underwriting or joint reinsurance organizations.—A. Each group, association or other organization of insurers that engages in joint underwriting or joint reinsurance for a class of insurance to which this chapter applies shall file with the Commission (i) a copy of its constitution, articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing its activities, all duly certified by the custodian of the originals of the copies, (ii) a list of its members, and (iii) the name and address of a resident of this Commonwealth upon whom notices or orders of the Commission or process may be served.

B. Each such organization of insurers shall notify the Commission promptly of every change in the information required to be filed by subsection A of this section.

C. Each group, association or other organization of insurers that engages in joint underwriting for a class of insurance to which this chapter applies shall be subject to this chapter. Each such organization of insurers that engages in joint reinsurance for a class of insurance to which this chapter applies shall be subject to §§ 38.2-1926, 38.2-1927, and 38.2-1928.

D. If, after providing notice and opportunity to be heard, the Commission finds that any activity or practice of any such organization of insurers is unfair, unreasonable or otherwise inconsistent with this chapter, it shall issue a written order (i) specifying in what respect the activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the activity or practice.

§ 38.2-1916. Certain conduct by insurers and rate service organizations prohibited.—A. As used in this section, the word "insurer" includes two or more insurers (i) under common management, or (ii) under common controlling ownership or under other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing or administration of their business and affairs as insurers.

B. No insurer or rate service organization shall:

1. Combine or conspire with any other person to monopolize or attempt to monopolize the business of insurance or any kind, subdivision or class of insurance;

2. Agree with any other insurer or rate service organization to charge or adhere to any rate, although insurers and rate service organizations may continue to exchange statistical information;

3. Make any agreement with any other insurer, rate service organization or other person to restrain trade unreasonably;

4. Make any agreement with any other insurer, rate service organization or other person that may substantially lessen competition in any kind, subdivision or class of insurance; or

5. Make any agreement with any other insurer or rate service organization to refuse to deal with any person in connection with the sale of insurance.

C. No insurer may acquire or retain any capital stock or assets of, or have any common management with, any other insurer if such acquisition, retention or common management substantially lessens competition in the business of insurance of any kind, subdivision or class thereof.

D. No rate service organization, or any of its members or subscribers, shall interfere with the right of any insurer to make its rates independently of the rate service organization or to charge rates different from the rates made by such rate service organization.

E. No rate service organization shall have or adopt any rule, exact any agreement, or engage in any program that would require any member, subscriber or other insurer to utilize some or all of its services, or to adhere to its rates, rating plans, rating systems, underwriting rules, or policy forms, or to prevent any insurer from acting independently.

Drafting Note: This section is deleted in light of the decision to use a comprehensive penalty section.

§ 38.2-1917. Injunctive relief.– Any person injured in his business or property by reason of any violation of § 38.2-1916 may maintain an action to enjoin the violation.

Drafting Note: The authority for the Commission to maintain an action to enjoin violations is being deleted here because that authority will be granted in a comprehensive injunction section for the whole title.

§ 38.2-1918. Agreements for equitable apportionment of insurance.–A. Nothing in this chapter shall prohibit the making of agreements among insurers for the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure it through ordinary methods. Insurers may agree among themselves on the use of reasonable rate modifications for such insurance. These agreements and rate modifications shall be subject to the approval of the Commission.

B. The Commission may approve policy forms and endorsements for use by such insurers with respect to insurance afforded such applicants.

Drafting Note: The intent of this new subsection is to clarify that the Commission may approve the policy forms and endorsements used by insurers under a residual market facility (such as the Virginia Automobile Insurance Plan). This is not a substantive change from current practice.

The Bureau also suggests that a parallel change be made to § 46.1-497 of the Motor Vehicle Code. Specifically, we suggest that the two existing paragraphs be labeled subsections A and B respectively and that a new subsection C be added. The new subsection should read as follows:

"C. The State Corporation Commission may approve policy forms and endorsements for use by insurers with respect to insurance provided under this article."

§ 38.2-1919. Collection of experience data; uniformity; compilations available to insurers and rate service organizations.–A. The Commission may promulgate reasonable rules and statistical plans for each of the rating systems on file with it, which may be modified from time to time. These rules and plans shall be used by each insurer in the recording and reporting of its loss and countrywide expense experience, so that the experience of all insurers may be made available, at least annually, in the form and detail necessary to aid the Commission in determining whether rating systems comply with the standards set forth in § 38.2-1904. The rules and plans may also provide for the recording and reporting of expense experience items that are specially applicable to this Commonwealth and cannot be determined by prorating the countrywide experience.

B. In promulgating the rules and plans the Commission shall give due consideration (i) to the rating systems on file with it and (ii) to the rules and to the form of the plans used for rating systems in other states so that the rules and plans may be as uniform as is practicable among the several states.

C. The Commission may designate one or more rate service organizations or other agencies to assist it in gathering the experience data and making compilations of it. These compilations shall be made available, subject to reasonable rules promulgated by the Commission, to insurers and rate service organizations. Any rate service organization designated by the Commission shall retain the experience data and compilations of the experience data in the format and detail required by the applicable statistical plan and shall submit this information to the Commission upon request.

§ 38.2-1920. Excess rate for a specific risk.–Subject to the Commission's approval, a rate in excess of that provided by an applicable filing may be used for a specific risk upon the filing of (i) written application of the insurer stating its reasons for the increased rate and (ii) the written consent of the insured or prospective insured.

Drafting Note: This section has been expanded and moved to Chapter 3 (§ 38.2-317).

§ 38.2-1921. Combination policies.–The Commission may approve for use in this Commonwealth policies

or forms for writing at divisible or indivisible rates and premiums any combination of the classes of insurance set forth in subsection A of § 38.2-1902, except insurance on or with respect to operating properties of railroads. The rates and premiums for combination policies, whether divisible or indivisible, shall be subject to this chapter.

Drafting Note: This section has been moved to Chapter 21 (§ 38.2-2118). There are a number of different replacement cost endorsements available with different minimum coverage requirements. The replacement section is intended to make the notice requirement more flexible to meet the differences in the endorsements.

§ 38.2-1922. No rule prohibiting or regulating payment of dividends, etc., to be adopted.—No rate service organization subject to this chapter shall adopt any rule prohibiting or regulating the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

§ 38.2-1923. Person aggrieved by application of rating system to be heard; appeal to Commission.—Each rate service organization and each insurer subject to this chapter that makes its own rates shall provide within this Commonwealth reasonable means for any person aggrieved by the application of its rating system to be heard in person or by an authorized representative on his written request. Any person who makes the written request shall be entitled to review the manner in which the rating system has been applied to the insurance afforded him. If the rate service organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any person affected by the action of the rate service organization or the insurer on the request may, within thirty days after written notice of the action, appeal to the Commission. The Commission may affirm or reverse the action after a hearing held upon not less than ten days' written notice to the applicant and to the rate service organization or insurer.

§ 38.2-1924. Cooperation among rate service organizations, or among rate service organizations and insurers, authorized; review by Commission.—Cooperation among rate service organizations or among rate service organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized if the filings resulting from such cooperation are subject to all the provisions of this chapter applying to filings generally. The Commission may review such cooperative activities and practices. If, after providing notice and opportunity to be heard, it finds that any cooperative activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, the Commission shall issue a written order (i) specifying in what respects the cooperative activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the cooperative activity or practice.

§ 38.2-1925. Examination of rate service organizations and joint underwriting and joint reinsurance organizations. - A. Whenever the Commission considers it necessary to be informed about any matter related to the enforcement of the insurance laws, it may examine the affairs and condition of any rate service organization under subsection A of § 38.2-1913 and of any joint underwriting or joint reinsurance organization under § 38.2-1915.

B. So far as reasonably necessary for any examination under subsection A of this section, the Commission may examine the accounts, records, documents or evidence of transactions, so far as they relate to the examinee, of any (i) officer, (ii) manager, (iii) general agent, (iv) employee, (v) person who has executive authority over or is in charge of any segment of the examinee's affairs, (vi) person controlling or having a contract under which he has the right to control the examinee whether exclusively or with others, (vii) person who is under the control of the examinee, or (viii) person who is under the control of a person who controls or has a right to control the examinee whether exclusively or with others.

C. On demand every examinee under subsection A of this section shall make available to the Commission for examination any of its own accounts, records, documents or evidences of transactions and any of those of the persons listed in subsection B of this section.

D. The Commission may examine every licensed rate service organization at intervals established by the Commission.

E. 1. Instead of all or part of an examination under subsections A and B of this section, or in addition to it, the Commission may order an independent audit by certified public accountants or actuarial evaluation by actuaries approved by it of any person subject to the examination requirement. Any accountant or actuary selected shall be subject to standards respecting conflicts of interest used by the Commission. Any audit or evaluation under this subsection shall be subject to subsections H through O of this section, so far as appropriate.

2. Instead of all or part of an examination under this section, the Commission may accept the report of an audit already made by certified public accountants or actuarial evaluation by actuaries approved by it, or the report of an examination made by the insurance department of another state.

G. An examination may cover comprehensively all aspects of the examinee's affairs and condition. The Commission shall determine the exact nature and scope of each examination, and in doing so shall take into account all relevant factors, including but not limited to (i) the length of time the examinee has been operating, (ii) the length of time it has been licensed in this Commonwealth, (iii) the nature of the services provided, (iv) the nature of the accounting records available and (v) the nature of examinations performed elsewhere.

H. For each examination under this section, the Commission shall issue an order stating the scope of

the examination and designating the examiner in charge. On demand a copy of the order shall be exhibited to the examinee.

I. Any examiner authorized by the Commission shall, so far as necessary for the purposes of the examination, have access at all reasonable hours to the premises and to any books, records, files, securities, documents of property of the examinee and to those of persons under subsection B of this section so far as they relate to the affairs of the examinee.

J. The officers, employees and agents of the examinee and of persons under subsection B of this section shall comply with every reasonable request of the examiners for assistance in any matter relating to the examination. No person shall obstruct or interfere with the examination in any way other than by legal process.

K. If the Commission finds the accounts or records to be inadequate for proper examination of the condition and affairs of the examinee or improperly kept or posted, it may employ experts to rewrite, post or balance them at the expense of the examinee.

L. The examiner in charge of an examination shall make a proposed report of the examination that shall include the information and analysis as is ordered in subsection H of this section, together with the examiner's recommendations. At the discretion of the examiner in charge, preparation of the proposed report may include conferences with the examinee or its representatives. The proposed report shall remain confidential until filed under subsection M of this section.

M. The Commission shall serve a copy of the proposed report upon the examinee. Within twenty days after service, the examinee may serve upon the Commission a written demand for a hearing on the contents of the report. If a hearing is demanded the Commission shall give notice and hold a hearing, and on demand by the examinee the hearing shall be informal and private. The Commission shall adopt the report with any necessary modifications and file it for public inspection, or it may order a new examination within either (i) sixty days after the hearing or (ii) if no hearing is demanded, sixty days after the last day on which the examinee might have demanded a hearing.

N. The Commission shall forward a copy of the examination report to the examinee immediately upon adoption, except that if the proposed report is adopted without change, the Commission need only so notify the examinee.

O. The examinee shall furnish copies of the adopted report to each member of its board of directors or other governing board.

P. The Commission may furnish, without cost or at a price to be determined by it, a copy of the adopted report to the insurance commissioner of any jurisdiction in which the examinee is licensed and to any other interested person in this Commonwealth or elsewhere.

Q. In any proceeding by or against the examinee or any officer or agent of the examinee, the examination report as adopted by the Commission shall be admissible as evidence of the facts stated in the examination report. In any proceeding by or against the examinee the facts asserted in any report properly admitted in evidence shall be presumed to be true in the absence of contrary evidence.

R. The reasonable costs of an examination under this section shall be paid by the examinee except as provided in subsection U of this section. The costs shall include the salary and expenses of each examiner and any other expenses directly apportioned to the examination.

S. The amount payable under subsection R of this section shall become due ten days after the examinee has been served a detailed account of the costs.

T. The Commission may require any examinee, before or during an examination, to deposit with the State Treasurer any deposits the Commission considers necessary to pay the cost of the examination. Any deposit and any payment made under subsections R and S of this section shall be credited to the special fund of the Bureau of Insurance.

U. On the examinee's request or on its own motion, the Commission may pay all or part of the costs of an examination whenever it finds that, because of the frequency of examinations or other factors, imposition of the costs would place an unreasonable burden on the examinee. The Commission shall include in its annual report information about any instance in which it applied this subsection.

V. Deposits and payments under subsections R through U of this section shall not be considered to be a tax or license fee within the meaning of any law. If any other state charges a per diem fee for examination of examinees domiciled in this Commonwealth, any examinee domiciled in that other state shall pay the same fee when examined by the Commission.

§ 38.2-1926. Action of Commission upon request for hearing on order or decision made without a hearing.—A. Any person aggrieved by an order or a decision of the Commission made under this chapter without a hearing may, within thirty days after notice of the order or decision, make a written request to the Commission for a hearing on that order or decision. Within a reasonable time after the request the Commission, after having given not less than ten days' written notice of the time and place of hearing, shall hear the person aggrieved by the order or decision. Within a reasonable time after the hearing the Commission shall affirm, reverse or modify its previous action, specifying its reasons for the affirmation,

reversal or modification.

B. Pending the hearing and decision on its previous action, the Commission may suspend or postpone the effective date of the order or decision to which the hearing relates.

§ 38.2-1927. Withholding information; giving false or misleading information.--No person shall willfully withhold information from or knowingly give false or misleading information to (i) the Commission, (ii) any statistical agency designated by the Commission, (iii) any rate service organization or (iv) any insurer, if that information will affect the rates or premiums subject to this chapter.

Drafting Note: Reference to the Criminal Code has been deleted since a violation of this section does not necessarily constitute perjury as defined in the Criminal Code.

§ 38.2-1928. Violations of chapter.-- The issuance, procurement or negotiation of a single policy of insurance shall be deemed a separate violation.

Drafting Note: This change is intended to accord with the decision to adopt one comprehensive penalty section. Only the second sentence will be retained in this section.

Drafting Note: This section is not necessary because a proposed title-wide section will be included in Chapter 2, which specifies appeal rights.

Title 38.2

CHAPTER 20

Regulation of Rates for Certain Types of Insurance.

1. The only major change proposed for this chapter is the addition of a deemer provision in proposed § 38.2-2006. Also, under the proposed revisions to this section, the Commission will be obligated to inform a filer within 30 days if the filing does not contain all of the necessary information.

2. In § 38.2-2009 the phrase "unfairly discriminatory" has been deleted from subsection B because uniform percentage deviations are required. If the rating system itself is not unfairly discriminatory, uniform percentage deviations from that rating system will not be unfairly discriminatory. The word "excessive" has also been deleted because deviations must be downward.

3. A new subsection is added to § 38.2-2015. The intent of this new subsection is to clarify that the Commission may approve the policy forms and endorsements used by insurers under a residual market facility (such as the Virginia Automobile Insurance Plan). This is not a substantive change from current practice.

   The Bureau also suggests that a parallel change be made to § 46.1-497 of the Motor Vehicle Code. Specifically, we suggest that the two existing paragraphs be labeled subsections A and B respectively and that a new subsection C be added. The new subsection should read as follows:

   > C. The State Corporation Commission may approve policy forms and endorsements for use by insurers with respect to insurance provided under this article. The provisions of this subsection shall take precedence over any conflicting provision of this code.

4. In § 38.2-2021, the duty of rate service organizations to notify the Commission of problems regarding information submission is deleted. This appears to be an operating problem of the rate service organization that they should handle internally.

CHAPTER 20.

REGULATION OF RATES FOR CERTAIN TYPES OF INSURANCE.

Article 1.

General Provisions.

§ 38.2-2000. Purposes of chapter.—A. The purposes of this chapter are to protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory insurance rates, and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this chapter. Nothing n in this chapter is intended to (i) prohibit or discourage reasonable competition, or (ii) prohibit or encourage uniformity in insurance rates, rating systems and rating plans or practices, except to the extent necessary to accomplish the purposes mentioned above.

B. This chapter shall be liberally interpreted to effect the purposes of this chapter.

Drafting Note: This definition will be included in the general definitions portion of the revised Chapter 1 (§ 38.2-100).

§ 38.2-2001. Insurance to which chapter applies.— This chapter applies only to (i) the class of insurance defined in § 38.2-119, (ii) the coverages provided in the Virginia Automobile Insurance Plan, (iii) the coverages provided pursuant to Chapter 27 of this title, (iv) uninsured motorist coverage as required by subsection A of § 38.2-2206, and (v) home protection contracts as defined by § 38.2-2600.

§ 38.2-2002. Joint underwriting and joint reinsurance.—A.1. Each group, association or other organization of insurers that engages in joint underwriting or joint reinsurance for the insurance to which this chapter applies shall file with the Commission (i) a copy of its constitution, its articles of incorporation, agreement or association, and a copy of its bylaws, rules and regulations governing its activities, all duly certified by the custodian of the originals of the copies, (ii) a list of its members, and (iii) the name and address of a resident of this Commonwealth upon whom notices or orders of the Commission or process may be served.

2. Each such organization of insurers shall notify the Commission promptly of every change in the information required to be filed by this subsection.

3. This subsection shall not apply to the Virginia Automobile Insurance Plan and the Virginia Property Insurance Association.

B. Each group, association or other organization of insurers that engages in joint underwriting for the insurance to which this chapter applies shall be subject to this chapter. Each such organization of insurers that engages in joint reinsurance for the insurance to which this chapter applies shall be subject to § 38.2-2026.

C. If, after providing notice and opportunity to be heard, the Commission finds any activity or practice of any such organization of insurers to be unfair, unreasonable or otherwise inconsistent with this chapter, it shall issue a written order (i) specifying in what respect the activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the activity or practice.

Drafting Note: 1. Proposed subsection A is taken from existing § 38.1-279.43 (proposed § 38.2-1915) with editorial changes. It is an attempt to provide regulatory consistency between Chapters 19 and 20. The provisions of subsection A will not apply to the V.P.I.A. or the V.A.I.P. since they are addressed in other areas of the Code.

2. In subsection B, § 38.2-2026 is existing § 38.1-276; existing §§ 38.1-278 and 38.1-279 have been deleted because of the proposed title-wide penalties and appeals sections in Chapter 2.

Article 2.

Rate Filings and Making of Rates.

§ 38.2-2003. Rate filings by insurer; supporting information.—Each insurer writing in this Commonwealth a class of insurance to which this chapter applies shall file with the Commission every manual of classifications, minimum rate, class rate, rating schedule, rating plan, rating rule, and every modification of any of the foregoing that it proposes to use. Every filing shall indicate the character and extent of coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports the filing, and the Commission does not have sufficient information to determine whether the filing meets the requirements of this chapter, the Commission may require the insurer to furnish the information upon which it supports the filing. A filing and any supporting information shall be a public record. For the purposes of this section, a group or fleet of insurers operating under the same general management may be considered an insurer.

§ 38.2-2004. Filings by rate service organization.—An insurer may satisfy its obligation to make the rate filings required in § 38.2-2003 by becoming a member of or a subscriber to a rate service organization that makes such filings and that is licensed pursuant to § 38.2-1914, and by authorizing the Commission to

accept the filings on its behalf. Filings made by rate service organizations shall meet the requirements of § 38.2-2003. No insurer shall be required to become a member of or a subscriber to any rate service organization.

Drafting Note: It would appear to be proper to specify that rate service organizations must satisfy the same supporting information requirements as insurers.

Drafting Note: This section is not necessary.

§ 38.2-2005. Provisions governing making of rates.—A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory.

B. 1. In making rates for the classes of insurance to which this chapter applies, due consideration shall be given to (i) past and prospective loss experience within and outside this Commonwealth, (ii) conflagration or catastrophe hazards, (iii) a reasonable margin for underwriting profit and contingencies, (iv) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, (v) past and prospective expenses both countrywide and those specially applicable to this Commonwealth, (vi) investment income earned or realized by insurers from their unearned premium and loss reserve funds, and (vii) all relevant factors within and outside this Commonwealth.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

3. In the case of uninsured motorist coverage required by subsection A of § 38.2-2206, consideration shall be given to all sums distributed by the Commission from the Uninsured Motorists Fund in accordance with the provisions of Chapter 30 of this title.

C. For the classes of insurance to which this chapter applies (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or for any subdivision or combination of insurance for which separate expense provisions apply, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

D. All rates, rating schedules or rating plans and every manual of classifications, rules and rates, including every modification thereof, approved by the Commission under this chapter, shall be used until a change is approved by the Commission.

§ 38.2-2006. Approval by Commission prerequisite to use of filing.—A. Except as provided in § 38.2-2010, no filing shall become effective, be applied, or be used in this Commonwealth until it has been approved by the Commission. However, a rate produced in accordance with a rating schedule or rating plan, previously approved by the Commission, may be used pending the approval.

B. A filing shall be deemed to meet the requirements of this chapter and to become effective unless disapproved by the Commission within thirty days of the time that the filing was made. However, the Commission may extend the waiting period for thirty additional days by written notice to the filer before the first thirty-day period expires.

C. If a filing is not accompanied by the information necessary for the Commission to determine if the requirements of § 38.2-2005 are satisfied, the Commission shall so inform the filer within thirty days of the initial filing. The filing shall be deemed to be made when the necessary information is furnished.

D. The provisions of subsection B of this section shall be suspended when the Commission has ordered a hearing to be held under the provisions of § 38.2-2007.

Drafting Note: A "deemer provision" has been added to this section to allow insurers to use a rate filing after a specified period of time if the Commission has not acted on that filing. Also, under the proposed revisions, the Commission shall be obligated to inform a filer within 30 days if the filing does not contain all of the necessary information.

§ 38.2-2007. Commission to determine if notice of filing to be published; hearing; approval or disapproval.—A. When a filing has been made with the Commission, the Commission shall determine whether publication of notice of the filing is necessary. If the Commission determines that such publication is required, the notice shall be published in the form and for the time prescribed by the Commission, not to exceed once a week for four consecutive weeks, in a newspaper or newspapers of general circulation published in the Commonwealth.

B. Prior to publication or upon completion of publication, the Commission shall determine whether a hearing should be held before acting upon the filing. If the Commission determines that a hearing should be held, it shall order one to be held within a reasonable time, but not less than ten days after issuing the order setting the hearing. The Commission shall notify the person making the filing and any other person it deems interested in the filing of the hearing.

C. Upon determination that publication of notice of a filing is unnecessary, upon completion of any

required publication when no hearing is ordered, or upon completion of a hearing, the Commission shall (i) approve the filing as submitted or with any modifications deemed appropriate by the Commission, or (ii) disapprove the filing. If a filing is approved with modifications, or is disapproved, the order of such approval or disapproval shall state the reasons for the decision.

§ 38.2-2008. Review of rates by Commission.--The Commission may investigate and determine, (i) upon its own motion, (ii) at the request of any citizen of this Commonwealth, or (iii) at the request of any insurer subject to this chapter, whether rates in this Commonwealth for the insurance to which this chapter applies are excessive, inadequate or unfairly discriminatory. In accordance with its findings, the Commission may order changes in the rates that are fair and equitable to all interested parties. In any investigation and determination, the Commission shall give due consideration to those factors specified in subsection B of § 38.2-2005.

Drafting Note: Section 38.1-255.1 adds nothing to the authority already granted in § 38.1-255.

§ 38.2-2009. Deviations.--

Drafting Note: This statement is unnecessary. Proposed subsection D of § 38.2-2005 provides the substance of this statement.

A. For the classes of insurance defined in § 38.2-119, any insurer or licensed group self-insurance association may apply to the Commission for permission to use a uniform percentage decrease deviation to be applied to the premiums produced by the applicable rating system for all of the risks written by it. The application shall specify the basis for the deviation and shall be accompanied by all of the supporting data upon which the application relies. In considering the application for permission to use a uniform percentage decrease deviation, the Commission shall give consideration to all available statistics and the principles of rate making as provided in this article.

B. 1. The Commission shall issue an order permitting the uniform percentage decrease deviation for an insurer or licensed group self-insurance association to be used if it is found to be justified. The Commission shall issue an order denying the application if it finds that the requested deviation would result in premiums that are inadequate.

2. Each deviation approved in accordance with this section shall be effective for one year from the date of such approval, unless terminated sooner with the approval of or by the Commission.

Drafting Note: The phrase "unfairly discriminatory" has been deleted from subsection B because uniform percentage deviations are required. If the rating system itself is not unfairly discriminatory, uniform percentage deviations from that rating system will not be unfairly discriminatory. Pursuant to a prior decision of the Code Commission, the word "excessive" has also been deleted because deviations must be downward.

§ 38.2-2010. Suspension or modification of requirement for filing.-- The Commission, by order, may suspend or modify the filing requirement of this chapter for any kind of insurance or subdivision or combination of insurance, or for classes of risks, where the rates for the insurance cannot practicably be filed before they are used. The order shall be made known to insurers and rate service organizations affected by it. The Commission may make any examination it deems advisable to determine whether any rates affected by the order meet the standards set out in subsection A of § 38.2-2005.

§ 38.2-2011. Interchange of rating data and information.--To promote uniform administration of rate regulatory laws, the Commission and each insurer and each rate service organization subject to this chapter may (i) exchange information and experience data with insurance supervisory officials, insurers, and rate service organizations in other states, and (ii) consult with them regarding rate making and the application of rating schedules and rating plans. Reasonable rules and plans may be promulgated by the Commission for the interchange of data necessary for the application of rating plans.

§ 38.2-2012. Collection of experience data; uniformity; compilations available to insurers and rate service organizations.--A. The Commission may promulgate reasonable rules and statistical plans for each of the rating systems on file with it, which may be modified from time to time. These rules and plans shall be used by each insurer in the recording and reporting of its loss and countrywide expense experience, so that the experience of all insurers may be made available, at least annually, in the form and detail as may be necessary to aid the Commission in determining whether rating systems comply with the standards set forth in subsection A of § 38.2-2005. The rules and plans may also provide for the recording and reporting of expense experience items that are specially applicable to this Commonwealth and cannot be determined by prorating the countrywide expense experience.

B. In promulgating the rules and plans, the Commission shall give due consideration to (i) the rating systems on file with it and (ii) the rules and the form of the plans used for rating systems in other states so that the rules and plans may be as uniform as practicable among the several states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it or on its behalf.

C. The Commission may designate one or more rate service organizations or other agencies to assist it in gathering the experience data and making compilations of it. The compilations shall be made available, subject to reasonable rules promulgated by the Commission, to insurers and rate service organizations.

§ 38.2-2013. Excess rate for specific risk.--Subject to the Commission's approval, a rate in excess of that provided by an applicable filing may be used for a specific risk upon the filing of (i) written application of an insurer stating its reasons for the increased rate, accompanied by (ii) the written consent of the insured

or prospective insured.

§ 38.2-2014. Contract or policy to accord with filings.—No insurer shall make or issue an insurance policy or contract to which this chapter applies, except in accordance with the filings that are in effect for that insurer, or in accordance with an applicable provision in §§ 38.2-2009, 38.2-2010 or 38.2-2013.

Drafting Note: Proposed § 38.2-2006 (existing § 38.1-253) does not provide an exemption from using the filed and approved rates. Existing §§ 38.1-256 and 38.1-257 have been repealed by prior legislation. It appears that inclusion of proposed § 38.2-2009 (existing § 38.1-255.2) is necessary as this section allows the issuance of a policy at a rate different from the applicable filing.

§ 38.2-2015 Agreements for equitable apportionment of insurance; reasonable performance standards.—A. Agreements among insurers may be made for the equitable apportionment among them of insurance that may be afforded applicants who are in good faith entitled to insurance but who are unable to procure it through ordinary methods. Insurers may agree among themselves on the use of reasonable rate modifications for the insurance. The agreements and rate modifications shall be subject to the approval of the Commission.

B. The Commission may require that the agreements contain reasonable performance standards for insurers or agents, or both, with respect to insurance afforded such applicants. The performance standards may contain, but shall not be limited to : (i) original applications, (ii) premium payments, (iii) policy issuance, (iv) policy changes, (v) return premium, (vi) return commission and (vii) administrative procedures for monitoring compliance with the standards.

C. The Commission may approve policy forms and endorsements for use by such insurers with respect to insurance afforded such applicants.

Drafting Note: The intent of this new subsection is to clarify that the Commission may approve the policy forms and endorsements used by insurers under a residual market facility (such as the Virginia Automobile Insurance Plan). This is not a substantive change from current practice.

The Bureau also suggests that a parallel change be made to § 46.1-497 of the Motor Vehicle Code. Specifically, we suggest that the two existing paragraphs be labeled subsections A and B respectively and that a new subsection C be added. The new subsection should read as follows:

"C. The State Corporation Commission may approve policy forms and endorsements for use by insurers with respect to insurance provided under this article."

Drafting Note: The penalty section for this chapter is being deleted. Therefore, the last sentence of this section should also be deleted. Even if the penalty section were to be retained, the last sentence is unnecessary and any violation of this chapter is punishable according to the provisions of the penalty section.

Drafting Note: Existing § 38.1-174 (proposed § 38.2-1317) provides the authority granted in this section.

§ 38.2-2016 Information regarding rates to be furnished insured.—Each rate service organization and each insurer subject to this chapter that makes its own rates shall furnish to any insured affected by those rates, or to the authorized representative of the insured, all pertinent information regarding the rate within a reasonable time after receiving a written request for the information.

§ 38.2-2017. No rule prohibiting or regulating payment of dividends, etc., to be adopted.—No rate service organization subject to this chapter shall adopt any rule prohibiting or regulating the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

§ 38.2-2018. Person aggrieved by application of rating system to be heard; appeal to Commission.—Each rate service organization and each insurer subject to this chapter that makes its own rates shall provide within this Commonwealth reasonable means whereby any person aggrieved by the application of its rating system may, after written request, be heard in person or by an authorized representative to review the manner in which the rating system has been applied to the insurance afforded him. If the rate service organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any person affected by the action of the rate service organization or the insurer on such request may, within thirty days after written notice of the action, appeal to the Commission. The Commission may affirm or reverse the action after a hearing held upon not less than ten days' written notice to the applicant and to the rate service organization or insurer.

§ 38.2-2019. Cooperation among rate service organizations, or among rate service organizations and insurers, authorized; review by Commission.—Cooperation among rate service organizations or among rate service organizations and insurers in rate making or in other matters within the scope of this chapter is authorized if the filings resulting from the cooperation are subject to all the provisions of this chapter that are applicable to filings generally. The Commission may review cooperative activities and practices. If, after providing notice and opportunity to be heard, it finds that any activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, it shall issue an order (i) specifying in what respects the activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the activity or practice.

§ 38.2-2020. Rate service organization may procure actuarial, technical or other services.—Any rate service organization subject to this chapter may subscribe for or purchase actuarial, technical or other services if these services are available without discrimination to all members of and subscribers to the rate

service organization.

§ 38.2-2021. Examination of policies or other evidences of insurance.—Any rate service organization subject to this chapter for the classes of insurance for which it files rates may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements or other evidences of insurance, or evidences of the cancellation of insurance, and may make reasonable rules governing their submission and the correction of any errors or omissions in them.

Drafting Note: The duty to notify the Commission of problems regarding information submission is deleted. This appears to be an operating problem of the rate service organization that they should handle internally.

Article 3.

Advisory Organizations.

§ 38.2-2022. Advisory organizations defined.—For the purpose of this article, "advisory organization" means any group, association or other organization of insurers, located within or outside this Commonwealth, that assists insurers who make their own filings or rate service organizations in rate making, by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but that does not make filings under this chapter for the kind of insurance involved.

§ 38.2-2023. What to be filed with Commission by advisory organization.—Each advisory organization shall file with the Commission:

1. A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules and regulations governing its activities;

2. A list of its members; and

3. The name and address of a resident of this Commonwealth upon whom may be served notices or orders of the Commission or process issued at its direction.

§ 38.2-2024 Unfair acts or practices of advisory organization.—If after a hearing the Commission finds that the furnishing of information or assistance by any advisory organization involves any act or practice that is unfair, unreasonable or otherwise inconsistent with this chapter, the Commission may issue a written order (i) specifying in what respects the act or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the act or practice.

§ 38.2-2025. Statistics or recommendations by advisory organization not complying with this article or order of Commission.—No insurer that makes its own filings nor any rate service organization shall support its filings by statistics or adopt rate making recommendations furnished to it by an advisory organization that has not complied with (i) the provisions of this article or (ii) any order of the Commission entered under § 38.2-2024, involving such statistics or recommendations. If the Commission finds any insurer or rate service organization to be in violation of this section it may issue an order requiring the discontinuance of the violation.

Article 4.

Hearings, Offenses and Penalties.

§ 38.2-2026. Action of Commission upon request for hearing on order or decision made without a hearing.—A. Any person aggrieved by an order or a decision of the Commission made under this chapter without a hearing may, within thirty days after notice of the order or decision, make a written request to the Commission for a hearing on the order or decision. Within a reasonable time after the request the Commission, after having given at least ten days ' written notice of the time and place of hearing, shall hear the person aggrieved by the order or decision. Within a reasonable time after the hearing the Commission shall affirm, reverse or modify its previous action, specifying its reasons for the affirmation, reversal or modification.

B. Pending the hearing and decision on its previous action, the Commission may suspend or postpone the effective date of the order or decision to which the hearing relates.

§ 38.2-2027. Withholding information; giving false or misleading information.—No person shall willfully withhold information from or knowingly give false or misleading information to (i) the Commission, (ii) any statistical agency designated by the Commission, (iii) any rate service organization or (iv) any insurer that will affect the rates or premiums subject to this chapter.

Drafting Note: This section has been deleted in accordance with the decision to adopt one comprehensive penalty section.

Drafting Note: This section is not necessary. A section will be included in the Chapter 2 general provisions specifying appeal rights.

Title 38.2

CHAPTER 21.

Fire Insurance Policies.

1. With the addition of a new section limiting the scope of the chapter to fire insurance policies, and fire insurance policies in combination with other coverages, the specification of applicability to such policies found in many sections may be deleted.

2. In proposed § 38.2-2104 the standard insuring agreement is amended such that policy inception and expiration times are 12:01 AM rather than noon. The standard insuring agreement is now being modified by endorsement to accomplish this change. This change is simply intended to codify current practice.

3. In proposed §§ 38.2-2113 and 38.2-2114 a one year records retention period has been proposed.

4. Anti-discrimination provisions have been added to proposed § 38.2-2114 and under proposed § 38.2-2115. These are similar to the provisions found in proposed Chapter 22 which have to do with automobile insurance.

CHAPTER 21.

FIRE INSURANCE POLICIES.

§ 38.2-2100. Application of chapter.—This chapter applies only to contracts or policies of fire insurance, and contracts or policies of fire insurance in combination with other insurance coverages.

Drafting Note: This chapter applies only to fire insurance policies and fire insurance policies in combination with other coverages. It would appear consistent with other chapters to specify this limitation in a specific section.

§ 38.2-2101. Policies shall conform to provisions of this chapter.—No insurance policy or contract on any property in this Commonwealth shall be issued or delivered in this Commonwealth unless the policy or contract meets the requirements of this chapter.

Drafting Note: The specification of "fire insurance policy" is deleted in this and subsequent sections because the proposed new section to this chapter specifies the limited scope of application.

§ 38.2-2102. Excluding loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination.—The standard policy of fire insurance prescribed by this chapter shall not cover loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination, whether resulting directly or indirectly from a peril insured under the policy. Insurers issuing the standard policy of fire insurance are authorized to affix to the policy or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination, whether resulting directly or indirectly from a peril insured under the policy. However, an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination may be attached to the standard policy of fire insurance.

§ 38.2-2103. Information to be printed on policy.—There shall be prominently printed on every policy issued on property in this Commonwealth (i) the name of the insurer issuing the policy, (ii) the location of the home office of the insurer, and (iii) a statement specifying whether the insurer is a stock company, a mutual company, a reciprocal insurer, or other form of insurer. If the policy is jointly issued by more than one insurer, the information shall be included for each insurer.

Drafting Note: The phrase "combination policy" has been replaced with the word "jointly" because of concerns that the current language may be mistaken for a fire insurance policy issued in combination with other coverages. A similar change is made in proposed § 38.2-2116.

§ 38.2-2104. Standard insuring agreement for fire insurance policies.—A. Each policy shall provide space for listing amounts of insurance, rates, and premiums for the coverages provided in the policy and endorsements attached to the policy , and shall show the location of the agency and the name and location of the insurer issuing the policy. Except as provided in § 38.2-2107, each policy shall contain the following insuring agreement:

In consideration of the provisions and stipulations herein or added hereto and of the premium above specified, this Company for the term of

. . . . . .

..... At 12:01 A.M..... ..... At 12:01 A.M. from..... (Standard Time) to... . ... (Standard Time) at location of property involved, to an amount not exceeding the amount(s) above specified, does insure. .. .. and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all direct loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy, except as hereinafter provided, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

B. No change shall be made in the sequence of the words and paragraphs of the insuring agreement except that additional matter relating to the coverage provided under the policy and supplemental contracts or extended coverage endorsements may be inserted following any paragraph. The additional matter shall not be inconsistent or in conflict with the standard provisions for policies set out in this chapter, and shall conform with other applicable laws relating to the regulation of fire insurance.

C. For the purpose of more accurate identification of the subject matter or more accurate reference to other provisions, substitutions may be made in the standard insuring agreement for the words "above specified," "hereinafter," or other similar terms; but no substitution shall be made if the purpose and intent of the contract is changed by the substitution.

Drafting Note: The first paragraph is amended to state that the policy shall show the location of the agency or insurer actually issuing the policy. Currently, only the agency location is required. As direct writers, who have no true agents, are quite prevalent, it would seem proper that insurers should be added.

Proposed § 38.2-2107 allows for the use of simplified and readable policies in lieu of the standard insuring agreement that is specified in this section as mandatory language. This exception should be noted in this section. As this section is currently written, it is not readily apparent that there is an exception to the standard insuring agreement.

The standard insuring agreement is amended such that policy inception and expiration times are 12:01 AM rather than noon. The standard insuring agreement is now being modified by endorsement to accomplish this change. This change is simply intended to codify current practice.

The last paragraph has been taken from proposed § 38.2-2106 as this provision only applies to this section now.

§ 38.2-2105. Standard provisions, conditions, stipulations and agreements for such policies.—A. Except as provided in § 38.2-2107, each policy shall contain the following provisions, conditions, stipulations, and agreements:

Drafting Note: The first paragraph is being amended to include a cite to proposed § 38.2-2107. This is consistent with the suggested change to proposed § 38.2-2104. As proposed § 38.2-2105 is currently written, it is not readily apparent that there is an exception from the standard fire policy.

Concealment, fraud. This entire policy shall be void, if whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property. This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included. This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting in actual or immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other Insurance. Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring

(a) While the hazard is increased by any means within the control or knowledge of the insured; or

(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or

(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Other perils or subjects. Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement by writing hereon or added hereto.

Added provisions. The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions. No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy. This policy shall be cancelled at any time at the request of insured, in which case

this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be cancelled at any time by this Company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations. If loss hereunder is made payable in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a ten days' written notice of cancellation.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interest and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability. This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs. The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, and furnish a complete inventory of the destroyed or damaged property setting forth for each item, or by category if itemization is not reasonably practicable, the amount of loss claimed. The Company may, in addition, require the insured to furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within sixty days after the loss, unless such time is extended in writing by this Company, the insured shall render to this Company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the

descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal. In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally; provided, however, if the written demand is made by this Company, then the insured shall be reimbursed by this Company for the reasonable cost of the insured's appraiser and the insured's portion of the cost of the umpire.

Company's options. It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment. There can be no abandonment to this Company of any property.

When loss payable. The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.

Suit. No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within two years next after inception of the loss.

Subrogation. This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

B. No change shall be made in the sequence of the words and paragraphs of the standard provisions, conditions, stipulations and agreements prescribed by this section, or in the arrangement of the words into lines. The numbers given the lines in the standard form and the catch words placed at the beginning of the paragraphs shall be retained.

§ 38.2-2106. Standard form for execution of policies.—Except as provided in § 38.2-2107, each policy shall contain the following clause, which shall be used in executing and attesting the policy:

IN WITNESS WHEREOF, this Company has executed and
attested these
presents

Immediately following the execution clause a space shall be left for the signature of the officer or officers of the company authorized to sign the policy.

Drafting Note: The countersignature requirement for agents is deleted because it has been repealed by prior legislation.

The last paragraph has been moved to proposed § 38.2-2104. It is no longer needed here since the language contained in the countersignature requirement has been deleted.

§ 38.2-2107. Commission may establish guidelines for filing readable fire insurance policy forms.—The Commission may establish guidelines for the filing of simplified and readable policies of insurance. An insurer may issue a simplified and readable policy of insurance that deviates in language from the standard policy form provided for in §§ 38.2-2104, 38.2-2105 and 38.2-2106 if the deviating policy form is (i) in no respect less favorable to the insured than the standard policy form, and is (ii) approved by the Commission prior to issuance.

§ 38.2-2108. Standards for content of fire insurance policies.—A. The Commission may establish standards for the content of any policy or any rider, endorsement or other supplemental agreement or provision for use in connection with any policy written to insure owner-occupied dwellings which is to be issued or delivered in this Commonwealth.

B. Following adoption of the standards of content and notwithstanding the provisions of §§ 38.2-2104, 38.2-2105 and 38.2-2106, no insurer shall issue or renew any policy or any rider, endorsement, or other supplemental agreement or provision for use in connection with any policy written to insure owner-occupied dwellings unless the policy form has been filed with the Commission. The Commission shall determine whether the policy form meets the standards of content and is in compliance with any other statutory requirements.

C. Nothing in this section prevents an insurer from issuing policies with coverages, terms and conditions which are broader and more favorable to the insured than the standards established by the Commission. The language, style and format of the coverages, terms and conditions shall be consistent with the language, style and format of the entire policy form.

Drafting Note: The language relating to "rules and regulations" is deleted as there will be a title-wide rules and regulations section.

§ 38.2-2109. Execution of policies.— The policy shall be executed by the proper officers of the insurer or insurers, whose signatures on the policy may be in facsimile.

Drafting Note: The countersignature requirement is deleted as it has already been repealed by prior legislation.

§ 38.2-2110. Other matter permitted in the policy.—The policy may contain information on the insurer, its officers and agents, the agent issuing the policy, the amount of insurance for each peril covered, the premium for each peril, and any other relevant matter not inconsistent or in conflict with the standard provisions for policies prescribed by this chapter.

§ 38.2-2111. Special regulations to be added to policy.—If the policy is issued by any insurer having special regulations for the payment of assessments by the insured, the regulations shall be printed upon and made a part of the policy. If the policy is issued by an insurer having other regulations appropriate to or required by its form of organization, those other regulations shall be either (i) written or printed upon the policy or (ii) attached to the policy by endorsement.

§ 38.2-2112. Temporary insurance contracts; duration; what deemed to include.—A. Oral or written binders or other temporary insurance contracts may be made and used for a period not exceeding sixty days pending the issuance of the policy, and shall be deemed to include all agreements and provisions set out in §§ 38.2-2104 and 38.2-2105 and all applicable endorsements designated in the temporary insurance contract. Unless otherwise expressly provided, the contract shall be deemed to include the usual provisions, stipulations and agreements which are commonly used in this Commonwealth in effecting the insurance.

B. No temporary insurance contract shall include any provision or agreement which is inconsistent with or waives any provision, stipulation, agreement or condition required by §§ 38.2-2104 or 38.2-2105. However, the cancellation provision and the provision fixing the hour of inception may be superseded by the express terms of the temporary insurance contract.

§ 38.2-2113. Mailing of notice of cancellation or refusal to renew.—A. No written notice of cancellation or refusal to renew a policy written to insure owner-occupied dwellings shall be effective when mailed by an insurer unless:

1. a. It is sent by registered or certified mail , or

b. At the time of mailing the insurer obtains a written receipt from the United States Postal Service showing the name and address of the insured stated in the policy;

2. The insurer retains a duplicate copy of the notice of cancellation or refusal to renew ; and

3. At the time of mailing the insurer endorses upon the duplicate copy of the notice a certificate showing that the duplicate is a copy of the notice that was sent to the insured (i) by registered or certified mail, or (ii) by regular mail for which the postal receipt was obtained.

B. This section shall not apply to policies written through the Virginia Property Insurance Association or any other residual market facility established pursuant to Chapter 27 of this title.

C. If the terms of the policy require the notice of cancellation or refusal to renew to be given to any lienholder, then the insurer shall also retain a duplicate copy of the lienholder's notice endorsed in the manner required by this section. If the notices sent to the insured and the lienholder are part of the same form, the insurer may retain a single duplicate copy upon which is endorsed the appropriate certificate for both the insured and the lienholder. The registered, certified or regular mail postal receipt and duplicate copy of the notice shall be retained by the insurer for at least one year from the date of termination.

Drafting Note: The substitution of "residual market" for "insurance placement" is necessary to accord with suggested revisions of Chapter 27.

The changes made to this section are intended to accord with changes made to proposed § 38.2-2208.

§ 38.2-2114. Grounds and procedure for termination of policy; contents of notice; review by Commissioner; exceptions; immunity from liability.—A. Notwithstanding the provisions of § 38.2-2105, no policy or contract written to insure owner-occupied dwellings shall be cancelled by an insurer unless written notice is mailed or delivered to the named insured at the address stated in the policy, and cancellation is for one of the following reasons:

1. Failure to pay the premium when due;

2. Conviction of a crime arising out of acts increasing the probability that a peril insured against will occur;

Drafting Note: Perils are the things insured against (i.e., fire). Hazards are conditions that increase the probability that a peril will occur (i.e., storage of flammable liquids).

3. Discovery of fraud or material misrepresentation;

4. Willful or reckless acts or omissions increasing the probability that a peril insured against will occur as determined from a physical inspection of the insured premises; or

5. Physical changes in the property which result in the property becoming uninsurable as determined from a physical inspection of the insured premises.

B. No policy or contract written to insure owner-occupied dwellings shall be terminated by an insurer by refusal to renew except at the expiration of the stated policy period or term and unless the insurer or its agent acting on behalf of the insurer mails or delivers to the named insured, at the address stated in the policy, written notice of the insurer's refusal to renew the policy or contract.

C. A written notice of cancellation of or refusal to renew a policy or contract written to insure owner-occupied dwellings shall:

1. State the date that the insurer proposes to terminate the policy or contract, which shall be at least thirty days after mailing or delivering to the named insured the notice of cancellation or refusal to renew. However, when the policy is being terminated for the reason set forth in paragraph 1 of subsection A of this section, the date that the insurer proposes to terminate the policy may be less than thirty days but at least ten days from the date of mailing or delivery;

2. State the specific reason for terminating the policy or contract and provide for the notification required by the provisions of §§ 38.2-608 and 38.2-609 and subsection B of § 38.2-610. However, those notification requirements shall not apply when the policy is being cancelled or not renewed for the reason set forth in paragraph 1 of subsection A of this section;

3. Advise the insured that within ten days of receipt of the notice of termination he may request in writing that the Commissioner review the action of the insurer in terminating the policy or contract;

4. Advise the insured of his possible eligibility for fire insurance coverage through the Virginia Property Insurance Association; and

5. Be in a type size authorized by § 38.2-311.

D. Within ten days of receipt of the notice of termination any insured or his attorney shall be entitled to request in writing to the Commissioner that he review the action of the insurer in terminating a policy or contract written to insure owner-occupied dwellings. Upon receipt of the request, the Commissioner shall promptly initiate a review to determine whether the insurer's cancellation or refusal to renew complies

with the requirements of this section and of § 38.2-2113, if sent by mail. The policy shall remain in full force and effect during the pendency of the review by the Commissioner except where the cancellation or refusal to renew is for reason of nonpayment of premium, in which case the policy shall terminate as of the date stated in the notice. Where the Commissioner finds from the review that the cancellation or refusal to renew has not complied with the requirements of this section or of § 38.2-2113, if sent by mail, he shall immediately notify the insurer, the insured, and any other person to whom notice of cancellation or refusal to renew was required to be given by the terms of the policy that the cancellation or refusal to renew is not effective. Nothing in this section authorizes the Commissioner to substitute his judgment as to underwriting for that of the insurer.

Drafting Note: "Commissioner" has not been replaced with "Commission" because this appears to be one of the few instances where a direct appeal to the Commissioner is intended.

E. Nothing in this section shall apply:

1. To any policy written to insure owner-occupied dwellings that has been in effect for less than ninety days when the notice of termination is mailed or delivered to the insured, unless it is a renewal policy;

2. If the insurer or its agent acting on behalf of the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate or other evidence of renewal, or has otherwise manifested its willingness to renew in writing to the insured. The written manifestation shall include the name of a proposed insurer, the expiration date of the policy, the type of insurance coverage and information regarding the estimated renewal premium;

3. If the named insured has notified the insurer or its agent in writing that he wishes the policy to be cancelled, or that he does not wish the policy to be renewed, or if, prior to the date of expiration, he fails to accept the offer of the insurer to renew the policy; or

4. To any contract or policy written through the Virginia Property Insurance Association or any residual market facility established pursuant to Chapter 27 of this title.

F. Each insurer shall maintain, for at least one year, records of cancellation and refusal to renew and copies of every notice or statement referred to in subsection E of this section that it sends to any of its insureds.

G. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his subordinates; any insurer, its authorized representative, its agents, its employees; or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew, for any statement made by any of them in complying with this section or for providing information pertaining to the cancellation or refusal to renew.

H. Nothing in this section requires an insurer to renew a policy written to insure owner-occupied dwellings, if the insured does not conform to the occupational or membership requirements of an insurer who limits its writings to an occupation or membership of an organization.

I. No insurer or agent shall refuse to renew a policy written to insure an owner-occupied dwelling, solely because of the age, sex, residence, race, color, creed, national origin, ancestry, marital status or lawful occupation, including the military service, of anyone who is insured. However, nothing in this subsection shall require any insurer to renew a policy for an insured where the insured's occupation has changed so as to materially increase the risk. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

Drafting Note: The provision that specifies the number of days' notice of termination that the insurer must give has been moved to subsection C. Paragraphs 1 and 2 of subsection C have been broadened to include a provision for nonpayment of premium, which codifies current practice.

Subsection F has been added to put retention requirements in this section and to conform the time to similar sections of this chapter.

Subsection I has been added to prohibit nonrenewal based on age, sex, residence, race, color, etc., just as this is prohibited in proposed § 38.2-2212 for auto insurance.

Subsection (f) has been deleted as there is a title-wide severability clause that will apply to all provisions within the Code.

§ 38.2-2115. Discrimination in issuance of fire insurance. —No insurer or agent shall refuse to issue a policy solely because of any one or more of the following factors: the age, sex, residence, race, color, creed, national origin, ancestry, marital status or lawful occupation, including the military service, of the person seeking insurance. Nothing in this section prohibits any insurer from limiting the issuance of policies to those who are residents of this Commonwealth, nor does it prohibit any insurer from limiting the issuance of policies only to persons engaging in or who have engaged in a particular profession or occupation, or who are members of a particular religious sect. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

Drafting Note: This is an anti-discrimination (age, sex, residence, race, and etc.) section. It is very similar to proposed § 38.2-2213, which relates to anti-discrimination in the issuance of automobile insurance. Since there is an anti-discrimination section for automobile insurance, it appears consistent to have an anti-discrimination section for fire insurance also.

§ 38.2-2116. Policies issued by two or more insurers.— A. With the consent of the Commission, two or more licensed insurers may jointly issue a policy, using a distinctive title that is prominently printed on the policy followed by the names and the home office addresses of the insurers obligated under the policy. The

policy shall be executed by the proper officers of each insurer. Before issuance, the form and any terms of the policy that are in addition to the standard provisions set out in §§ 38.2-2104 and 38.2-2105 shall be approved by the Commission. The terms of the policy shall not be inconsistent with the standard provisions, and shall be placed under a separate title headed as follows: "Provisions specially applicable to this jointly issued policy." The special provisions shall contain in substance that:

1. The insurers executing the policy are severally liable for the full amount of any loss or damage according to the terms of the policy or for specified percentages or amounts of any loss or damage aggregating the full amount of insurance under the policy; and

2. Service of process upon, or notice of proof of loss required by the policy and given to any of the insurers executing the policy, shall be deemed to be service upon or notice to all such insurers.

B. The unearned premium reserve on each policy shall be allocated to each insurer on the basis of each insurer's pro rata share of the face amount of the policy, except to the extent that the risk is transferred under a valid contract of reinsurance.

Drafting Note: This section has been amended to clarify the allocation method of unearned premium reserves. The intent of this section is to allocate on the basis of each insurer's share of the face amount of the policy.

§ 38.2-2117. Approval of forms or provisions for additional coverage.—The Commission may approve and authorize the use of appropriate forms or provisions contained in supplemental contracts or extended coverage endorsements used in connection with policies on property in this Commonwealth to provide coverage for one or more perils in addition to the perils covered by the standard insuring agreement and standard provisions prescribed in this chapter.

§ 38.2-2118. Required statement on insurance policies for owner-occupied dwellings.—Each insurer writing insurance on owner-occupied dwellings and appurtenant structures with a replacement cost provision under the provisions of Chapter 19 of this title shall give each applicant for insurance a statement summarizing: (i) any minimum coverage requirement necessary for the replacement cost provision to be fully effective, and (ii) the effect on claim payment of not meeting the minimum coverage requirement.

Drafting Note: This section replaces § 38.1-279.49:1. It has been revised to make the notice requirement more flexible to meet the differences in endorsements currently available.

§ 38.2-2119. Approval of forms or provisions for certain risks.—The Commission may approve and authorize the use of appropriate forms or provisions for supplemental contracts or extended coverage endorsements where the insured may be indemnified for (i) the difference between the actual cash value of the property at the time of loss and the cost of repair or replacement of the property on the same site with new materials of like kind and quality, within a reasonable time after the loss, and without deduction for depreciation, (ii) additional cost or loss by reason of any ordinance or law in force at the time of loss which necessitates the demolition of any portion of the insured property, (iii) any increased cost of repair or replacement by reason of any ordinance or law regulating construction or repair of the insured building, and (iv) loss from interruption of business, untenantability, or termination of leasehold interest because of damage to or destruction of the property described in the policy. These forms or provisions shall apply to coverage provided to an insured having any interest in an insured building or structure which is a part of the building described in the policy, including service equipment for the building.

§ 38.2-2120. Optional coverage to be offered with homeowner's policy.—Any insurer who issues or delivers a homeowner's insurance policy in this Commonwealth shall offer as an option a provision insuring against loss caused or resulting from water which backs up through sewers or drains.

Drafting Note: This section was formally numbered § 38.1-335.2.

§ 38.2-2121. When courts may appoint umpires.—Whenever appraisers selected under the standard provisions for fire insurance policies set out in § 38.2-2105 fail for fifteen days to agree upon a person to serve as umpire, the insured or the insurer may apply in writing, for the appointment of an umpire, to the judge of the circuit court of the county or city in which the damaged or destroyed property was located at the time of loss. If the application is filed by the insured, a copy of the application shall first be delivered to a resident agent of the insurer. If the application is filed by the insurer, a copy of the application shall first be delivered to the insured. Upon showing, by affidavit or otherwise, the failure or neglect of the appraisers to agree upon and select an umpire within the time specified in the policy, the judge shall immediately appoint a competent and disinterested person to serve as umpire in determining the amount of loss or damage sustained.

§ 38.2-2122. Appraisers and umpire to be citizens of Virginia; oath to be taken.—Whenever any appraisal is to be made under the standard provisions of a policy for loss or damage to property, the appraisers and the umpire shall be citizens and actual residents of this Commonwealth unless otherwise agreed to in writing by the insured and the insurer. Each appraiser and umpire shall, before acting as such, take an oath that he is not directly or indirectly in the employment of the insured, the insurer or any other insurer, that he is not related to the insured or any officer of the insurer, and that he will faithfully discharge the duties imposed upon him.

Drafting Note: Underwriting agencies no longer exist in this Commonwealth. Therefore all sections addressing this type of entity have been deleted.

§ 38.2-2123. Chapter not applicable to certain mutual insurers.— This chapter shall not apply to mutual assessment property and casualty insurers, or to mutual insurers and associations organized under the laws of this Commonwealth, conducting business only in this Commonwealth, and issuing only policies providing

for perpetual insurance.

Drafting Note: The last sentence is deleted as it is not necessary with the new section added to the beginning of this chapter.

Drafting Note: This section is deleted as a comprehensive penalty section has been added.

Title 38.2

CHAPTER 22.

Liability Insurance Policies.

1. There are 17 subsections to the existing §38.1-381. It would appear reasonable to separate §38.1-381 into four independent sections. We have, therefore, grouped this section into the following new sections:

§ 38.2-2204. Subsections (a) through (a2) have become one section entitled Liability insurance on motor vehicles, aircraft and watercraft; standard provisions; "omnibus clause".

§ 38.2-2205. Subsections (a3) and (a4) have become a new section entitled Liability insurance on motor vehicles; standard provisions; applicability of other valid and collectible insurance.

§ 38.2-2206. Subsections (b) through (j) have become a new section entitled Uninsured motorist insurance coverage.

§ 38.2-2207. Subsection (i) has become a separate section as this provision is not specifically tied to the other provisions in § 38.1-381.

2. The terms "motor vehicle insurance policies" and "automobile insurance policies" are currently used interchangeably. The revised draft uses only the term "motor vehicle insurance".

3. Existing § 38.1-381.1 (proposed § 38.2-2208) has been amended to require a one year retention period for these notices. Also, a notice provision for lienholders has been included for consistency with § 38.2-2113.

4. In existing § 38.1-381.5 (proposed § 38.2-2212), subsection F.1 a provision has been added which requires the insurer to retain for one year a copy of each written manifestation of its willingness to renew.

5. Existing § 38.1-381.7 (proposed § 38.2-2214) has been revised to require that a rate classification statement be provided upon renewal only if there is a change in the insured's classification. The intent is to reduce the number of required notices.

CHAPTER 22.

LIABILITY INSURANCE POLICIES.

§ 38.2-2200. Required provisions as to insolvency or bankruptcy, and as to when action maintained against insurer.—No policy or contract insuring or indemnifying against liability for injury to or the death of any person, or for injury to or destruction of property, shall be issued or delivered in this Commonwealth unless it contains in substance the following provisions or other provisions that are at least equally favorable to the insured and to judgment creditors:

1. That the insolvency or bankruptcy of the insured, or the insolvency of the insured's estate, shall not relieve the insurer of any of its obligations under the policy or contract.

2. That if execution on a judgment against the insured or his personal representative is returned unsatisfied in an action brought to recover damages for injury sustained or for loss or damage incurred during the life of the policy or contract, then an action may be maintained against the insurer under the terms of the policy or contract for the amount of the judgment not exceeding the amount of the applicable limit of coverage under the policy or contract.

Drafting Note: The word "idemnifying" is added to clarify that contracts providing only first party indemnification rather that third party payments are subject to the required provisions.

§ 38.2-2201. Optional provisions as to injuries to named insured, his family and persons occupying insured motor vehicle.—A. Upon request of an insured, each insurer licensed in this Commonwealth issuing or delivering any policy or contract of bodily injury or property damage liability insurance covering liability arising from the ownership, maintenance or use of any motor vehicle shall provide on payment of the premium, as a minimum coverage (i) to persons occupying the insured motor vehicle; and (ii) to the named insured and, while resident of the named insured's household, the spouse and relatives of the named insured while occupying, or while not occupying a motor vehicle through being struck by, any motor vehicle , the following health care and disability benefits for each accident:

1. All reasonable and necessary expenses for medical, chiropractic, hospital, dental, surgical, ambulance, prosthetic and rehabilitation services, and funeral expenses, resulting from the accident and incurred within one year after the date of the accident, up to $2,000 per person; and

2. If the person is usually engaged in a remunerative occupation, an amount equal to the loss of income incurred after the date of the accident resulting from injuries received in the accident up to $100 per week during the period from the first workday lost as a result of the accident up to the date the person is able to return to his usual occupation. However, the period shall not extend beyond one year from the date of the accident.

B. The insured has the option of purchasing either or both of the coverages set forth in paragraphs 1 and 2 of subsection A of this section. Either or both of the coverages, as well as any other medical expense coverage under any policy of automobile liability insurance, shall be payable notwithstanding the failure or refusal of the named insured or other person entitled to the coverage to give notice to the insurer of an accident as soon as practicable under the terms of the policy, except where the failure or refusal prejudices the insurer in establishing the validity of the claim.

C. In any policy of personal automobile insurance in which the insured has purchased coverage under subsection A of this section, every insurer providing such coverage arising from the ownership, maintenance or use of no more than four motor vehicles shall be liable to pay up to the maximum policy limit available on every motor vehicle insured under that coverage if the health care or disability expenses and costs mentioned in subsection A of this section exceed the limits of coverage for any one motor vehicle so insured.

Drafting Note: The change in the second paragraph of subsection A of § 38.2-2201 is intended to clarify existing interpretation of the law.

§ 38.2-2202. Required notice of optional coverage available.—A. No original premium notice for insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be issued or delivered unless it contains on the front of the premium notice or unless there is enclosed with the premium notice, in boldface type, the following statement:

IMPORTANT NOTICE

IN ADDITION TO THE MINIMUM INSURANCE REQUIRED BY LAW , YOU MAY PURCHASE ADDITIONAL INSURANCE COVERAGE FOR THE NAMED INSURED AND FOR HIS RELATIVES WHO ARE MEMBERS OF HIS HOUSEHOLD WHILE OCCUPYING, OR WHILE NOT OCCUPYING THROUGH BEING STRUCK BY, ANY MOTOR VEHICLE AND FOR OCCUPANTS OF THE INSURED MOTOR VEHICLE. THE FOLLOWING HEALTH CARE AND DISABILITY BENEFITS ARE AVAILABLE FOR EACH ACCIDENT:

(A) PAYMENT OF UP TO $2,000 PER PERSON FOR ALL REASONABLE AND NECESSARY EXPENSES FOR MEDICAL, CHIROPRACTIC, HOSPITAL, DENTAL, SURGICAL, AMBULANCE, PROSTHETIC AND REHABILITATION SERVICES, AND FUNERAL EXPENSES RESULTING FROM THE ACCIDENT AND INCURRED WITHIN ONE YEAR AFTER THE DATE OF THE ACCIDENT; AND

(B) AN AMOUNT EQUAL TO THE LOSS OF INCOME UP TO $100 PER WEEK IF THE INJURED

PERSON IS ENGAGED IN AN OCCUPATION FOR WHICH HE RECEIVES COMPENSATION, FROM THE FIRST WORKDAY LOST AS A RESULT OF THE ACCIDENT UP TO THE DATE THE PERSON IS ABLE TO RETURN TO HIS USUAL OCCUPATION. SUCH PAYMENTS ARE LIMITED TO A PERIOD EXTENDING ONE YEAR FROM THE DATE OF THE ACCIDENT.

IF YOU DESIRE TO PURCHASE EITHER OR BOTH OF THESE COVERAGES AT AN ADDITIONAL PREMIUM, YOU MAY DO SO BY CONTACTING THE AGENT OR COMPANY THAT ISSUED YOUR POLICY. -

The insurer issuing the premium notice shall inform the insured by any reasonable means of communication of the approximate premium for the additional coverage.

B. No new policy or original premium notice of insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be issued or delivered unless it contains the following statement printed in boldface type, or unless the statement is attached to the front of or is enclosed with the policy or premium notice:

IMPORTANT NOTICE

IN ADDITION TO THE INSURANCE COVERAGE REQUIRED BY LAW TO PROTECT YOU AGAINST A LOSS CAUSED BY AN UNINSURED MOTORIST,

IF YOU HAVE PURCHASED LIABILITY INSURANCE COVERAGE THAT IS HIGHER THAN THAT REQUIRED BY LAW TO PROTECT YOU AGAINST LIABILITY ARISING OUT OF THE OWNERSHIP, MAINTENANCE, OR USE OF THE MOTOR VEHICLES COVERED BY THIS POLICY, AND YOU HAVE NOT ALREADY PURCHASED UNINSURED MOTORIST INSURANCE COVERAGE EQUAL TO YOUR LIABILITY INSURANCE COVERAGE

1. YOUR UNINSURED AND UNDERINSURED MOTORIST INSURANCE COVERAGE HAS INCREASED TO THE LIMITS OF YOUR LIABILITY COVERAGE AND THIS INCREASE WILL COST YOU AN EXTRA PREMIUM CHARGE AND

2. YOUR TOTAL PREMIUM CHARGE FOR YOUR MOTOR VEHICLE INSURANCE COVERAGE WILL INCREASE IF YOU DO NOT NOTIFY YOUR AGENT OR INSURER OF YOUR DESIRE TO REDUCE COVERAGE WITHIN 20 DAYS OF THE MAILING OF THE POLICY OR THE PREMIUM NOTICE, AS THE CASE MAY BE.

3. IF THIS IS A NEW POLICY AND YOU HAVE ALREADY SIGNED A WRITTEN REJECTION OF SUCH HIGHER LIMITS IN CONNECTION WITH IT, PARAGRAPHS 1 AND 2 OF THIS NOTICE DO NOT APPLY.

Drafting Note: This notice should be right and left justified when type is reset.

References to renewal policies have been deleted as they are no longer necessary. All policies have been renewed at least once since January 1, 1983.

After twenty days, the insurer shall be relieved of the obligation imposed by this subsection to attach or imprint the foregoing statement to any subsequently delivered renewal policy, extension certificate, other written statement of coverage continuance, or to any subsequently mailed premium notice.

§ 38.2-2203. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.—Notwithstanding any provision of any policy or contract of bodily injury liability insurance, when the policy or contract provides for reimbursement for any service that may be legally performed by a person licensed in this Commonwealth for the practice of chiropractic, reimbursement under the policy shall not be denied because the service is rendered by a licensed chiropractor.

§ 38.2-2204. Liability insurance on motor vehicles, aircraft and watercraft; standard provisions; "omnibus clause".—A. No policy or contract of bodily injury or property damage liability insurance, covering liability arising from the ownership, maintenance , or use of any motor vehicle, aircraft, or private pleasure watercraft, shall be issued or delivered in this Commonwealth to the owner of such vehicle, aircraft or watercraft, or shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle, aircraft, or private pleasure watercraft that is principally garaged, docked, or used in this Commonwealth, unless the policy contains a provision insuring the named insured, and any other person using or responsible for the use of the motor vehicle, aircraft, or private pleasure watercraft with the expressed or implied consent of the named insured, against liability for death or injury sustained, or loss or damage incurred within the coverage of the policy or contract as a result of negligence in the operation or use of such vehicle, aircraft, or watercraft by the named insured or by any such person. Each such policy or contract of liability insurance, or endorsement to the policy or contract, insuring private passenger automobiles, aircraft, or private pleasure watercraft principally garaged, docked, or used in this Commonwealth, that has as the named insured an individual or husband and wife and that includes, with respect to any liability insurance provided by the policy, contract or endorsement for use of a nonowned automobile, aircraft or private pleasure watercraft, any provision requiring permission or consent of the owner of such automobile, aircraft, or private pleasure watercraft for the insurance to apply, shall be construed to include permission or consent of the custodian in the provision requiring permission or consent of the owner.

B. For aircraft liability insurance, such policy or contract may contain the exclusions listed in § 38.2-2227. Notwithstanding the provisions of this section or any other provisions of law, no policy or

contract shall require pilot experience greater than that prescribed by the Federal Aviation Administration, except for pilots operating air taxis, or pilots operating aircraft applying chemicals, seed, or fertilizer.

C. No policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle shall be issued or delivered in this Commonwealth to the owner of such vehicle or shall be issued or delivered by an insurer licensed in this Commonwealth upon any motor vehicle principally garaged or used in this Commonwealth without an endorsement or provision insuring the named insured, and any other person using or responsible for the use of the motor vehicle with the expressed or implied consent of the named insured, against liability for death or injury sustained, or loss or damage incurred within the coverage of the policy or contract as a result of negligence in the operation or use of the motor vehicle by the named insured or by any other such person. This provision shall apply notwithstanding the failure or refusal of the named insured or such other person to cooperate with the insurer under the terms of the policy. If the failure or refusal to cooperate prejudices the insurer in the defense of an action for damages arising from the operation or use of such insured motor vehicle, then the endorsement or provision shall be void. If an insurer has actual notice of a motion for judgment or complaint having been served on an insured, the mere failure of the insured to turn the motion or complaint over to the insurer shall not be a defense to the insurer, nor void the endorsement or provision, nor in any way relieve the insurer of its obligations to the insured, provided the insured otherwise cooperates and in no way prejudices the insurer.

D. Any endorsement, provision or rider attached to or included in any such policy of insurance which purports or seeks to limit or reduce the coverage afforded by the provisions required by this section shall be void.

Drafting Note: Existing § 38.1-381 has been divided into four new sections to improve readability. Subsections (a) through (a2) are now numbered § 38.2-2204.

§ 38.2-2205. Liability insurance on motor vehicles; standard provisions; applicability of other valid and collectible insurance.—A. 1. Each policy or contract of bodily injury or property damage liability insurance which provides insurance to a named insured in connection with the business of selling, leasing, repairing, servicing, storing or parking motor vehicles, against liability arising from the ownership, maintenance , or use of any motor vehicle incident thereto shall contain a provision that the insurance coverage applicable to those motor vehicles shall not be applicable to a person other than the named insured and his employees in the course of their employment if there is any other valid and collectible insurance applicable to the same loss covering the other person under a policy with limits at least equal to the financial responsibility requirements specified in § 46.1-504. Such provision shall apply to motor vehicles which are either for the purpose of demonstrating to the other person as a prospective purchaser, or which are loaned or leased to the other person as a convenience during the repairing or servicing of a motor vehicle for the other person, or leased to the other person for a period of six months or more.

2. If the other valid and collectible insurance has limits less than the financial responsibility requirements specified in § 46.1-504, then the coverage afforded a person other than the named insured and his employees in the course of their employment shall be applicable to the extent necessary to equal the financial responsibility requirements specified in § 46.1-504.

3. If there is no other valid and collectible insurance available, the coverage under such policy afforded a person, other than the named insured and his employees in the course of their employment, shall be applicable, but the amount recoverable in such case shall not exceed the financial responsibility requirements specified in § 46.1-504.

B. 1. Any policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle shall exclude coverage to persons other than (i) the named insured, or (ii) directors, stockholders, partners, agents, or employees of the named insured, or (iii) residents of the household of either (i) or (ii), while those persons are employed or otherwise engaged in the business of selling, repairing, servicing, storing, or parking motor vehicles if there is any other valid or collectible insurance applicable to the same loss covering the persons under a policy with limits at least equal to the financial responsibility requirements specified in § 46.1-504.

2. If the other valid and collectible insurance has limits less than the financial responsibility requirements specified in § 46.1-504, then the coverage afforded a person other than the named insured while that person is employed or otherwise engaged in the business of selling, repairing, servicing, storing, or parking motor vehicles shall be applicable to the extent necessary to equal the financial responsibility requirements specified in § 46.1-504.

3. If there is no other valid and collectible insurance available, the coverage afforded a person other than the named insured while that person is employed or otherwise engaged in the business of selling, repairing, servicing, storing, or parking motor vehicles shall apply, but the amount recoverable shall not exceed the financial responsibility requirements specified in § 46.1-504.

Drafting Note: Subsections (a3) and (a4) of existing § 38.1-381 have become a new section numbered 38.2-2205.

§ 38.2-2206. Uninsured motorist insurance coverage. —A. Except as provided in subsection J of this section, no policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle shall be issued or delivered in this Commonwealth to the owner of such vehicle or shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle principally garaged or used in this Commonwealth unless it contains an endorsement or provisions undertaking to pay the insured all sums that he is legally entitled to recover as

damages from the owner or operator of an uninsured motor vehicle, within limits not less than the requirements of § 46.1-1 (8). Those limits shall equal but not exceed the limits of the liability insurance provided by the policy, unless the insured rejects the additional uninsured motorist insurance coverage by notifying the insurer as provided in subsection B of § 38.2-2202. Where the insured contracts for higher limits, the endorsement or provisions for those limits shall obligate the insurer to make payment for bodily injury or property damage caused by the operation or use of an underinsured motor vehicle to the extent the vehicle is underinsured, as defined in subsection B of this section. The endorsement or provisions shall also provide for at least $10,000 coverage for damage or destruction of the property of the insured in any one accident but may provide an exclusion of the first $200 of the loss or damage where the loss or damage is a result of any one accident involving an unidentifiable owner or operator of an uninsured motor vehicle.

B. As used in this section, the term "bodily injury" includes death resulting from bodily injury.

"Insured" as used in subsections A, D, G, and H of this section means the named insured and, while resident of the same household, the spouse of the named insured, and relatives of either, while in a motor vehicle or otherwise, and any person who uses the motor vehicle to which the policy applies, with the expressed or implied consent of the named insured, and a guest in the motor vehicle to which the policy applies or the personal representative of any of the above.

"Uninsured motor vehicle" means a motor vehicle for which (i) there is no bodily injury liability insurance and property damage liability insurance in the amounts specified by § 46.1-1 (8), (ii) there is such insurance but the insurer writing the insurance denies coverage for any reason whatsoever, including failure or refusal of the insured to cooperate with the insurer, (iii) there is no bond or deposit of money or securities in lieu of such insurance, or (iv) the owner of the motor vehicle has not qualified as a self-insurer under the provisions of § 46.1-395. A motor vehicle shall be deemed uninsured if its owner or operator is unknown.

A motor vehicle is " underinsured " when, and to the extent that, the total amount of bodily injury and property damage coverage applicable to the operation or use of the motor vehicle, including all bonds or deposits of money or securities made pursuant to Article 6 (§ 46.1-467 et seq.) of Chapter 6 of Title 46.1, is less than the total amount of uninsured motorist coverage afforded any person injured as a result of the operation or use of the vehicle.

Recovery under the endorsement or provisions shall be subject to the conditions set forth in this section.

C. There shall be a rebuttable presumption that a motor vehicle is uninsured if the Commissioner of the Department of Motor Vehicles certifies that, from the records of the Department of Motor Vehicles, it appears that : (i) there is no bodily injury liability insurance and property damage liability insurance in the amounts specified by § 46.1-1 (8) covering the owner or operator of the motor vehicle; or (ii) no bond has been given or cash or securities delivered in lieu of the insurance; or (iii) the owner or operator of the motor vehicle has not qualified as a self-insurer in accordance with the provisions of § 46.1-395.

D. If the owner or operator of any motor vehicle that causes bodily injury or property damage to the insured is unknown, and if the damage or injury results from an accident where there has been no contact between that motor vehicle and the motor vehicle occupied by the insured, or where there has been no contact with the person of the insured if the insured was not occupying a motor vehicle, then for the insured to recover under the endorsement required by subsection A of this section, the accident shall be reported promptly to either (i) the insurer, (ii) the Department of Motor Vehicles on a form prescribed by the Department, or (iii) a law-enforcement officer having jurisdiction in the county or city in which the accident occurred. If it is not reasonably practicable to make the report promptly, the report shall be made as soon as reasonably practicable under the circumstances.

E. If the owner or operator of any vehicle causing injury or damages is unknown, an action may be instituted against the unknown defendant as "John Doe" and service of process may be made by delivering a copy of the motion for judgment or other pleadings to the clerk of the court in which the action is brought. Service upon the insurer issuing the policy shall be made as prescribed by law as though the insurer were a party defendant. The insurer shall have the right to file pleadings and take other action allowable by law in the name of John Doe.

F. If any action is instituted against the owner or operator of an uninsured or underinsured motor vehicle by any insured intending to rely on the uninsured or underinsured coverage provision or endorsement of this policy under which the insured is making a claim, then the insured shall serve a copy of the process upon this insurer in the manner prescribed by law, as though the insurer were a party defendant. The provisions of § 8.01-288 shall not be applicable to the service of process required in this subsection. The insurer shall then have the right to file pleadings and take other action allowable by law in the name of the owner or operator of the uninsured or underinsured motor vehicle or in its own name. Nothing in this subsection shall prevent the owner or operator of the uninsured motor vehicle from employing counsel of his own choice and taking any action in his own interest in connection with the proceeding.

G. Any insurer paying a claim under the endorsement or provisions required by subsection A of this section shall be subrogated to the rights of the insured to whom the claim was paid against the person causing the injury, death, or damage and that person's insurer, although it may deny coverage for any reason, to the extent that payment was made. The bringing of an action against the unknown owner or

operator as John Doe or the conclusion of such an action shall not bar the insured, from bringing an action against the owner or operator proceeded against as John Doe, or against the owner's or operator's insurer denying coverage for any reason, if the identity of the owner or operator who caused the injury or damages becomes known. Any recovery against the owner or operator, or the insurer of the owner or operator shall be paid to the insurer of the injured party to the extent that the insurer paid the named insured in the action brought against the owner or operator as John Doe. However, the insurer shall pay its proportionate part of all reasonable costs and expenses incurred in connection with the action, including reasonable attorney's fees. Nothing in an endorsement or provisions made under this subsection nor any other provision of law shall prevent the joining in an action against John Doe of the owner or operator of the motor vehicle causing the injury as a party defendant and the joinder is hereby specifically authorized.

H. No endorsement or provisions providing the coverage required by subsection A of this section shall require arbitration of any claim arising under the endorsement or provisions, nor may anything be required of the insured except the establishment of legal liability, nor shall the insured be restricted or prevented in any manner from employing legal counsel or instituting legal proceedings.

I. The provisions of subsections A and B of § 38.2-2204 and the provisions of subsection A of this section shall not apply to any policy of insurance to the extent that it covers the liability of an employer under any workers' compensation law, or to the extent that it covers liability to which the Federal Tort Claims Act applies. No provision or application of this section shall limit the liability of an insurer of motor vehicles to an employee or other insured under this section who is injured by an uninsured motor vehicle.

J. Policies of insurance whose primary purpose is to provide coverage in excess of other valid and collectible insurance or qualified self insurance may include uninsured motorist coverage as provided in subsection A of this section. Insurers issuing or providing liability policies that are of an excess or umbrella type or which provide liability coverage incidental to a policy and not related to a specifically insured motor vehicle, shall not be required to offer, provide or make available to those policies uninsured or underinsured motor vehicle coverage as defined in subsection A of this section.

Drafting Note: Subsections (b) through (j) of existing § 38.1-381 have become a new section dealing with uninsured motorist insurance coverage.

§ 38.2-2207. No policy to exclude coverage to employee. –No policy of insurance shall exclude coverage to an employee of the insured in any controversy arising between employees even though one employee shall be awarded compensation as provided in Title 65.1.

Drafting Note: Subsection (i) of existing § 38.1-381 has become a separate section as this provision is not specifically tied to the other provisions in existing § 38.1-381.

§ 38.2-2208. Notices of cancellation of or refusal to renew motor vehicle insurance policies.–A. No written notice of cancellation or refusal to renew that is mailed by an insurer to an insured in accordance with the provisions of a motor vehicle insurance policy shall be effective unless:

1. a. It is sent by registered or certified mail, or

b. At the time of mailing the insurer obtains a written receipt from the United States Postal Service showing the name and address of the insured stated in the policy;

2. The insurer retains a duplicate copy of the notice of cancellation or refusal to renew; and

3. At the time of mailing the insurer endorses upon the duplicate copy of the notice a certificate showing that the duplicate is a copy of the notice that was sent to the insured (i) by registered or certified mail, or (ii) by regular mail for which the postal receipt was obtained.

B. If the terms of the policy require the notice of cancellation or refusal to renew to be given to any lienholder, then the insurer shall also retain a duplicate copy of the lienholder's notice endorsed in the manner required by this section. If the notices sent to the insured and the lienholder are part of the same form, the insurer may retain a single duplicate copy upon which is endorsed the appropriate certificate for both the insured and the lienholder. The registered, certified or regular mail postal receipt and the duplicate copy of the notice shall be retained by the insurer for at least one year from the date of termination.

Drafting Note: This section has been amended to require a one year retention period for these notices. Also, a notice provision for lienholders has been included for consistency with proposed § 38.2-2113.

§ 38.2-2209. Motor vehicle liability medical benefit insurer not to retain right of subrogation to recover from third party.– No policy or contract of bodily injury or property damage liability insurance that contains any representation by an insurer to pay all reasonable medical expenses incurred for bodily injury caused by accident to the insured or any relative or other person coming within the provisions of the policy, shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle then principally garaged or principally used in this Commonwealth, if the insurer retains the right of subrogation to recover amounts paid on behalf of an injured person under the provision of the policy from any third party.

§ 38.2-2210. Warning concerning cancellation to appear on application for motor vehicle liability insurance.–Any application for the original issuance of a policy of insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle as defined in § 38.2-2212 shall have the following statement printed on or attached to the first page of the application form, in red boldface type : READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF

ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

This section shall not apply to the renewal of any policy of insurance.

§ 38.2-2211. Motor vehicle liability insurer not to receive credit for other medical expense insurance.—No policy or contract of bodily injury or property damage liability insurance that contains any representation by an insurer to pay all reasonable medical expenses incurred for bodily injury caused by accident to the insured, relative or any other person coming within the provisions of the policy, shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle then principally garaged or principally used in this Commonwealth, if the policy provides for credit against the medical expense coverage for any other medical expense insurance to which the injured person may be entitled. Nothing in this section allows the injured person to collect more than his actual medical expenses as a result of an accident from any one or any combination of all policies providing motor vehicle medical payment coverage applicable to the accident.

§ 38.2-2212. Grounds and procedure for cancellation of or refusal to renew motor vehicle insurance policies; review by Commissioner.—A. The following definitions shall apply to this section:

"Cancellation" or "to cancel" means a termination of a policy during the policy period.

"Insurer" means any insurance company, association, or exchange licensed to transact motor vehicle insurance in this Commonwealth.

"Policy of motor vehicle insurance" or "policy" means a policy or contract for bodily injury or property damage liability insurance issued or delivered in this Commonwealth covering liability arising from the ownership, maintenance, or use of any motor vehicle, insuring as the named insured one individual or husband and wife who are residents of the same household, and under which the insured vehicle designated in the policy is either:

a. A motor vehicle of a private passenger, station wagon, or motorcycle type that is not used comercially, rented to others, or used as a public or livery conveyance where the terms "public or livery conveyance" do not include car pools, or

b. Any other four-wheel motor vehicle with a load capacity of 1500 pounds or less which is not used in the occupation, profession, or business, other than farming, of the insured, or as a public or livery conveyance, or rented to others. The term "policy of motor vehicle insurance" or "policy" does not include (i) any policy issued through the Virginia Automobile Insurance Plan, (ii) any policy insuring more than four motor vehicles, (iii) any policy covering the operation of a garage, sales agency, repair shop, service station, or public parking place, (iv) any policy providing insurance only on an excess basis, or (v) any other contract providing insurance to the named insured even though the contract may incidentally provide insurance on motor vehicles.

"Renewal" or "to renew" means (i) the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, providing types and limits of coverage at least equal to those contained in the policy being superseded, or (ii) the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy. Each renewal shall conform with the requirements of the manual rules and rating program currently filed by the insurer with the Commission. Except as provided in subsection K of this section, any policy with a policy period or term of less than twelve months or any policy with no fixed expiration date shall for the purpose of this section be considered as if written for successive policy periods or terms of six months from the original effective date.

Drafting Note: The definitions have been put in alphabetical order.

B. This section shall apply only to that portion of a policy of motor vehicle insurance providing the coverage required by §§ 38.2-2204, 38.2-2205 and 38.2-2206.

C. No insurer or agent shall refuse to renew a motor vehicle insurance policy solely because of the age, sex, residence, race, color, creed, national origin, ancestry, marital status, or lawful occupation, including the military service, of anyone who is insured. However, nothing in this section shall require any insurer to renew a policy for an insured where the insured's occupation has changed so as to materially increase the risk. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

D. No insurer shall cancel a policy except for one or more of the following reasons:

1. The named insured or any other operator who either resides in the same household or customarily operates a motor vehicle insured under the policy has had his driver's license suspended or revoked during the policy period or, if the policy is a renewal, during its policy period or the ninety days immediately preceding the last anniversary of the effective date.

2. The named insured fails to pay the premium for the policy or any installment of the premium, whether payable to the insurer or its agent either directly or indirectly under any premium finance plan or extension of credit.

E. No cancellation or refusal to renew by an insurer of a policy of motor vehicle insurance shall be effective unless the insurer delivers or mails to the named insured at the address shown in the policy a written notice of the cancellation or refusal to renew. The notice shall:

1. Be in a type size authorized under § 38.2-311;

2. State the effective date of the cancellation or refusal to renew. The effective date of cancellation or refusal to renew shall be at least forty-five days after mailing or delivering to the insured the notice of cancellation or notice of refusal to renew. However, when the policy is being canceled or not renewed for the reason set forth in paragraph 2 of subsection D of this section the effective date may be less than forty-five days but at least fifteen days from the date of mailing or delivery;

3. State the specific reason of the insurer for cancellation or refusal to renew and provide for the notification required by §§ 38.2-608, 38.2-609, and subsection B of § 38.2-610. However, those notification requirements shall not apply when the policy is being canceled or not renewed for the reason set forth in paragraph 2 of subsection D of this section;

4. Inform the insured of his right to request in writing within fifteen days of the receipt of the notice that the Commissioner review the action of the insurer;

Drafting Note: The word "Commissioner" has not been changed to "Commission" in this section because the appeal is to be directed to the Commissioner of Insurance.

5. Inform the insured of the possible availability of other insurance which may be obtained through his agent, through another insurer, or through the Virginia Automobile Insurance Plan; and

6. If sent by mail, comply with the provisions of § 38.2-2208.

Nothing in this subsection prohibits any insurer or agent from including in the notice of cancellation or refusal to renew, any additional disclosure statements required by state or federal laws, or any additional information relating to the availability of other insurance.

F. Nothing in this section shall apply:

1. If the insurer or its agent acting on behalf of the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate , or other evidence of renewal, or has manifested its willingness to renew in writing to the insured. The written manifestation shall include the name of a proposed insurer, the expiration date of the policy, the type of insurance coverage, and information regarding the estimated renewal premium. The insurer shall retain a copy of each written manifestation for a period of at least one year from the expiration date of any policy that is not renewed.

2. If the named insured, or his duly constituted attorney-in-fact, has notified in writing the insurer or its agent that he wishes the policy to be canceled or that he does not wish the policy to be renewed, or if prior to the date of expiration he fails to accept the offer of the insurer to renew the policy; or

3. To any motor vehicle insurance policy which has been in effect less than sixty days when the termination notice is mailed or delivered to the insured, unless it is a renewal policy.

G. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his subordinates; any insurer, its authorized representatives, its agents, or its employees; or any person furnishing to the insurer information as to reasons for cancellation or refusal to renew, for any statement made by any of them in complying with this section or for providing information pertaining to the cancellation or refusal to renew. For the purposes of this section, no insurer shall be required to furnish a notice of cancellation or refusal to renew to anyone other than the named insured, any person designated by the named insured, any other person to whom such notice is required to be given by the terms of the policy and the Commissioner.

H. Within fifteen days of receipt of the notice of cancellation or refusal to renew, any insured or his attorney shall be entitled to request in writing to the Commissioner that he review the action of the insurer in cancelling or refusing to renew the policy of the insured. Upon receipt of the request, the Commissioner shall promptly begin a review to determine whether the insurer's cancellation or refusal to renew complies with the requirements of this section and of § 38.2-2208 if the notice was sent by mail. The policy shall remain in full force and effect during the pendency of the review by the Commissioner except where the cancellation or refusal to renew is for the reason set forth in paragraph 2 of subsection D of this section, in which case the policy shall terminate as of the effective date stated in the notice. Where the Commissioner finds from the review that the cancellation or refusal to renew has not complied with the requirements of this section or of § 38.2-2208, he shall immediately notify the insurer, the insured and any other person to whom such notice was required to be given by the terms of the policy that the cancellation or refusal to renew is not effective. Nothing in this section authorizes the Commissioner to substitute his judgment as to underwriting for that of the insurer. Where the Commissioner finds in favor of the insured, the Commission in its discretion may award the insured reasonable attorneys' fees.

I. Each insurer shall maintain for at least one year, records of cancellation and refusal to renew and copies of every notice or statement referred to in subsection E of this section that it sends to any of its insureds.

J. The provisions of this section shall not apply to any insurer that limits the issuance of policies of

motor vehicle liability insurance to one class or group of persons engaged in any one particular profession, trade, occupation, or business. Nothing in this section requires an insurer to renew a policy of motor vehicle insurance if the insured does not conform to the occupational or membership requirements of an insurer who limits its writings to an occupation or membership of an organization. No insurer is required to renew a policy if the insured becomes a nonresident of Virginia.

Drafting Note: Subsection K of existing 38.1-381.5 is deleted because there will be a severability clause that is applicable to the entire insurance code.

K. Notwithstanding any other provision of this section, a motor vehicle insurance policy with a policy period or term of five months or less may expire at its expiration date when the insurer has manifested in writing its willingness to renew the policy for at least thirty days and has mailed the written manifestation to the insured at least fifteen days before the expiration date of the policy. The written manifestation shall include the name of the proposed insurer, the expiration date of the policy, the type of insurance coverage, and the estimated renewal premium. The insurer shall retain a copy of the written manifestation for at least one year from the expiration date of any policy that is not renewed.

Drafting Note: The two-year records retention period has been changed to one year to accord with the revisions in other sections.

§ 38.2-2213. Discrimination in issuance of motor vehicle insurance.—No insurer or agent shall refuse to issue a motor vehicle insurance policy as defined in § 38.2-2212 solely because of any one or more of the following factors: the age, sex, residence, race, color, creed, national origin, ancestry, marital status, or lawful occupation, including the military service, of the person seeking the coverage. Nothing in this section prohibits any insurer from limiting the issuance of motor vehicle insurance policies to those who are residents of this Commonwealth nor does this section prohibit any insurer from limiting the issuance of motor vehicle insurance policies only to persons engaging in or who have engaged in a particular profession or occupation, or who are members of a particular religious sect. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

§ 38.2-2214. Statement defining rate classifications to be provided by insurer to insured.—Any insurer issuing motor vehicle insurance policies as defined in § 38.2-2212, including those policies assigned to any insurer by the Virginia Automobile Insurance Plan, shall provide the named insured with a statement defining his rate classifications. This statement shall be provided at the time of issuance or at the time of renewal if there has been a change in the named insured's rate classification. The statement shall not be considered a part of the policy and shall not be deemed a warranty or representation by the insurer to the insured.

The Commission shall approve the form of the statement prior to its use.

Drafting Note: This section has been revised to require that a rate classification statement be provided upon renewal only if there is a change in the insured's classification. The intent is to reduce the number of required notices.

§ 38.2-2215. Failure to issue or failure to renew motor vehicle liability insurance on the basis of a motor vehicle's age prohibited. —No insurer or agent shall refuse to issue or fail to renew a policy of motor vehicle liability insurance solely because of the age of the motor vehicle to be insured, provided the motor vehicle is licensed.

§ 38.2-2216. Medical benefit offset against liability or uninsured motorist coverage prohibited. - No policy or contract of bodily injury liability insurance which contains any representation by an insurer to pay medical expenses incurred for bodily injuries caused by an accident to the insured or any relative or any other person coming under the provisions of the policy, shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle then principally garaged or principally used in this Commonwealth, if the policy contains any provision reducing the amount of damages covered under the liability or uninsured motorist coverages of the policy by the amount of payments made by the insurer under the medical expense or other medical payments coverage of the policy.

§ 38.2-2217. Reduction in rates for certain persons fifty-five years of age and older.—A. Any schedule of rates, rate classifications or rating plans for motor vehicle insurance as defined in § 38.2-2212 filed with the Commission shall provide for an appropriate reduction in premium charges for those insured persons who are fifty-five years of age and older and who qualify as provided in this subsection. Only those insured persons who have successfully completed a motor vehicle accident prevention course approved by the Department of Motor Vehicles shall qualify for a three-year period after the completion of the course for the reduction in rates. No reduction in premiums shall be allowed for a self-instructed course or for any course that does not provide actual classroom instruction for a minimum number of hours as determined by the Department of Motor Vehicles.

B. The Commission and the Department of Motor Vehicles may promulgate rules and regulations which will assist them in carrying out the provisions of this section.

C. All insurers writing motor vehicle insurance in Virginia as defined in § 38.2-2212 shall allow an appropriate reduction in premium charges to all eligible persons subject to the provisions of this section.

D. Upon successfully completing the approved course, the course's sponsor shall issue to each participant a certificate approved by the Department of Motor Vehicles which shall be evidence of qualification for the reduction in premium charges.

E. Each participant shall take an approved course every three years in order to continue to be eligible

for the reduction in premium charges.

F. Nothing in this section prevents an insurer from offering appropriately reduced rates based solely on age to an insured person over the age of fifty-five years.

§ 38.2-2218. Adoption of standard forms for motor vehicle insurance.– The Commission shall prepare a standard form whenever it believes that any form of policy or any form of rider, endorsement, or other supplemental agreement or provision, for use in connection with any contract of motor vehicle insurance to be issued or delivered upon any motor vehicle principally garaged or principally used in this Commonwealth, is so extensively used that a standard form is desirable. The Commission shall file a copy of the standard form in its office and shall provide by order that, at least thirty days after the order, the form shall become a standard form for use by all insurers unless objection to the proposed form is filed with the Commission within twenty days after the entry of the order. The Commission shall mail a copy of its order to all insurers licensed to transact the class of insurance to which the form is applicable, and to all rate service and advisory organizations representing those insurers.

§ 38.2-2219. Hearing on objections to the form.–If any insurer or rate service organization affected by an order entered pursuant to § 38.2-2218 files objections to a proposed standard form within the time prescribed in the Commission's order, the Commission shall rescind the order and shall notify all insurers and rate service organizations affected by the order that on a day specified in the notice, which shall be at least thirty days from the date on which the objections are received, it will hold a public hearing on the adoption of the proposed form, and that at the hearing any person interested may appear and be heard. After the hearing the Commission may by order confirm or amend the proposed form and set a day, at least thirty days after the entry of the order, when the approved form shall become a standard form for use by all insurers. The Commission may by like order refuse to adopt the proposed form.

§ 38.2-2220. Use of form after adoption. - Except as provided in § 38.2-2223, after any standard form is adopted by the Commission, no insurer shall use any form covering substantially the same provisions contained in the standard form unless it is in the precise language of the form filed and adopted by the Commission.

§ 38.2-2221. Amendment of standard form. - The Commission may amend the provisions of any standard form in the manner provided in this chapter for the adoption of a new standard form.

§ 38.2-2222. Withdrawal of form.– Whenever the Commission believes there is no further necessity for requiring the use of any standard form adopted under the provisions of this chapter, it may, by order entered of record, withdraw the form, and thereafter its use shall not be required.

§ 38.2-2223. Variations of, or additions to, form.–For the word "company" appearing in any standard form, there may be substituted a more accurate descriptive term for the type of insurer. Additional provisions, other than those in the standard form, or coverages more favorable than those in the standard form, may be used with a standard form by any insurer with the approval of the Commission. However, the Commission shall first determine that the more favorable coverage or the additional provisions are not in conflict or inconsistent with the standard form, the laws of this Commonwealth or any rules and regulations adopted by the Commission. The approval and determination by the Commission shall be evidenced by an order entered of record.

§ 38.2-2224. Commission to establish guidelines for filing readable motor vehicle insurance policy forms. –The Commission may establish guidelines for the filing of simplified and readable motor vehicle insurance policy forms that are acceptable for issuance. Notwithstanding the provisions of §§ 38.2-2218 through 38.2-2223, an insurer may issue a motor vehicle insurance policy that deviates in language, but not in substance or coverage, from the standard policy form provided for in §§ 38.2-2218 through 38.2-2223, if the deviating policy form is (i) in no respect less favorable to the insured than the standard form, and (ii) approved by the Commission prior to issuance.

§ 38.2-2225. Sending copies of orders to companies affected.–A copy of each order entered by the Commission in accordance with the provisions of this chapter shall be sent to every insurer and rate service organization affected by the order.

Drafting Note: Section 38.1-389 is deleted as there is a centralized penalty section.

§ 38.2-2226. Insurer to give notice to claimant of intention to rely on certain defenses and of execution of nonwaiver of rights agreement.–Whenever any insurer on a policy of liability insurance discovers a breach of the terms or conditions of the insurance contract by the insured and the insurer intends to rely on the breach in defense of liability for any claim within the terms of the policy, the insurer shall notify the claimant or the claimant's counsel of record of its intention to rely on the breach as a defense. Notification shall be given within twenty days after discovery by the insurer or any of its agents of the breach or of the claim, whichever is later. Whenever a nonwaiver of rights or similar agreement is executed by the insurer and the insured, notice of the nonwaiver of rights shall be given to the claimant or the claimant's counsel of record within ten days after that agreement is executed. Failure to serve the notice within ten days will result in a waiver of the defense to the extent of the claim by operation of law.

§ 38.2-2227. Aircraft liability policy not to deny coverage for violation of federal or civil regulations, etc.; permitted exclusions or conditions.–No insurance policy issued or delivered in this Commonwealth covering loss, expense, or liability arising out of the loss, maintenance, or use of an aircraft shall act to exclude or deny coverage because the aircraft is operated in violation of federal or civil regulations or any state or local ordinance. This section does not prohibit the use of specific exclusions or conditions in any

policy that relates to any of the following:

1. Certification of an aircraft in a stated category by the Federal Aviation Administration;

2. Certification of a pilot in a stated category by the Federal Aviation Administration;

3. Establishing requirements for pilot experience; or

4. Restricting the use of the aircraft to the purposes stated in the policy.

§ 38.2-2228. Certain medical malpractice claims to be reported to Commissioner; duty of Commissioner; annual report; statistical summary.–All medical malpractice claims settled or adjudicated to final judgment against a person, corporation, firm, or entity providing health care and any such claim closed without payment during each calendar year shall be reported annually to the Commissioner by the insurer of the health care provider or, if there is no insurer, by the health care provider. The reports shall not identify the parties.

The report to the Commissioner shall state the following in a format prescribed by him:

1. Nature of the claim and damages asserted;

2. Principal medical and legal issues;

3. Attorney's fees and expenses incurred in connection with the claim or defense to the extent these amounts are known;

4. The amount of the settlement or judgment;

5. The specialty of each health care provider; and

6. Any other pertinent and relevant information which the Commissioner may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. Each annual report shall be a matter of public record.

CHAPTER 23.

LEGAL SERVICES INSURANCE.

§ 38.1-2300. Conditions; permitted contracts; approval.—A. Legal services insurance may be offered in this Commonwealth subject to the following conditions:

1. Premium rates shall be made in accordance with Chapter 19 of this title.

2. No policy of legal services insurance may be delivered or issued for delivery in this Commonwealth unless it contains a provision that the insurer shall issue to the person in whose name the policy is issued, for delivery to each insured, a certificate summarizing the essential features of the insurance coverage and to whom benefits under the policy are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

B. An insurer authorized to transact legal services insurance in this Commonwealth may, in connection with the implementation and operation of any legal services insurance program, contract with any person that offers and manages a group legal services insurance plan, including a state, city, county, or circuit bar association; or any person permitted to practice law in this Commonwealth.

C. The Commission shall not approve any legal services insurance contract if, after providing notice and opportunity to be heard, the Commission finds that the contract violates any law of this Commonwealth.

CHAPTER 24.

FIDELITY AND SURETY INSURANCE.

Article 1.

General Provisions.

§ 38.2-2400. Class of insurance to which chapter applies.— This chapter applies to fidelity and surety insurance as defined in §§ 38.2-120 and 38.2-121.

Drafting Note: 1. The first portion of the sentence was deleted because all of the provisions of this chapter apply to fidelity and surety insurance. There are no express exclusions.

2. Reference to proposed § 38.2-121 has been added to accord with the changes made in Article 2 of Chapter 1.

§ 38.2-2401. Fidelity and surety insurer defined.—The term "fidelity and surety insurer" means any company licensed to transact fidelity or surety insurance in this Commonwealth, and includes any company elsewhere designated or referred to in this Code as a guaranty, indemnity, fidelity, surety or security company.

§ 38.2-2402. Fidelity and surety insurer not to transact insurance without appropriate license.—No fidelity and surety insurer shall transact the business of fidelity insurance or surety insurance without first obtaining a license from the Commission to transact that class of insurance.

Drafting Note: Fidelity and surety companies are licensed separately for fidelity and surety insurance. This new section is intended to clarify the existing limitation on authority for those fidelity and surety companies that may be licensed for only one of these classes of insurance.

§ 38.2-2403. Limitation of liability on risks.—In applying the limitation specified in § 38.2-208 to fidelity and surety risks, the net amount of exposure on any single risk shall be considered to be within the prescribed limit if the fidelity and surety insurer is protected against losses in excess of the limit by:

1. Reinsurance with a fidelity and surety insurer that enables the obligee or beneficiary to maintain an action on the contract against the insurer jointly with the reinsurer;

2. The cosuretyship of any other fidelity and surety insurer;

3. A deposit of property with it in pledge, or conveyance of property to it in trust for its protection;

4. A conveyance or mortgage of property for its protection; or

5. A deposit or other disposition of a portion of any property held in trust so that no future sale, mortgage, pledge or other disposition can be made of that portion of the property except with the consent of the fidelity and surety insurer or by decree or order of a competent court whenever the obligation is entered into on behalf or on account of a person holding property in a fiduciary capacity.

Drafting Note: It is not necessary to specify "licensed" as fidelity and surety companies are defined to be licensed in this Commonwealth in proposed § 38.2-2401.

§ 38.2-2404. Limit when penalty of bond exceeds actual exposure to risk.—When the penalty of a suretyship obligation exceeds (i) the amount of a judgment described on the obligation as appealed from and secured by the obligation, (ii) the amount of the subject matter in controversy, or (iii) the amount of the estate held in trust by the person acting in a fiduciary capacity, the bond may be executed by any fidelity and surety insurer if the actual amount of the judgment or the subject matter in controversy or estate not subject to supervision or control of the surety is not in excess of the limitation specified in § 38.2-208. When the penalty of a suretyship obligation executed for the performance of a contract exceeds the contract price, the contract price shall be taken as the basis for estimating the limit of risk specified in § 38.2-208.

§ 38.2-2405. When insurer accepted as surety.—Any fidelity and surety insurer shall be accepted as surety upon any bond required by the laws of this Commonwealth or by any court, judge, public officer, board, or organization upon presentation of evidence satisfactory to the court, judge, or other officer authorized to approve the bond that the insurer is licensed to transact surety insurance.

Drafting Note: The qualification that a fidelity and surety company be licensed has been deleted because "licensed" is included in the definition of fidelity and surety companies.

§ 38.2-2406. Requirements deemed met by insurer.—Whenever a bond, undertaking, recognizance, guaranty, or similar obligation is required, permitted, authorized or allowed by any law of this Commonwealth, or whenever the performance of any act, duty or obligation, or the refraining from any act, is required, permitted, authorized or allowed to be secured or guaranteed by any law of this Commonwealth, the bond or similar obligation, or the security or guaranty, may be executed by any fidelity and surety insurer licensed to execute such instruments. The execution by any fidelity and surety insurer of a bond, undertaking, recognizance, guaranty or similar obligation by its officer, attorney in fact, or other authorized representative shall be accepted as fully complying with every law or other requirement, now or hereafter in force, requiring that the bond, undertaking, recognizance, guaranty or similar obligation be

given or accepted or that it be executed by one or more sureties, or that the surety or sureties be residents, householders or freeholders, or possess any other qualifications.

§ 38.2-2407. Sureties with respect to guaranteed arrest bond certificates of automobile clubs and associations.--A. Any domestic or foreign fidelity and surety insurer licensed to transact surety business in this Commonwealth may become surety in any year for any guaranteed arrest bond certificates issued in that year by an automobile club or association by filing with the Commission an undertaking to become surety.

B. The undertaking shall be in a form prescribed by the Commission and shall state the following:

1. The name and address of the automobile club or automobile association issuing the guaranteed arrest bond certificates for which the fidelity and surety insurer undertakes to be surety.

2. The unqualified obligation of the fidelity and surety insurer to pay the fine or forfeiture of any person who, after posting a guaranteed arrest bond certificate for which the fidelity and surety insurer has undertaken to be surety, fails to make the appearance guaranteed by the arrest bond certificate.

C. The term " guaranteed arrest bond certificate " as used in this chapter means any printed card or other certificate (i) issued by an automobile club or association to any of its members, (ii) signed by the member and (iii) containing a printed statement that the automobile club or association and a fidelity and surety insurer guarantee the appearance of the person whose signature appears on the card or certificate and that they will pay any fine or forfeiture imposed on that person in the event that the person fails to appear in court at the time of trial.

§ 38.2-2408. Guaranteed arrest bond certificate to be accepted in lieu of cash bail in event of violation of motor vehicle laws.--Any guaranteed arrest bond certificate for which a fidelity and surety insurer has become surety as provided in § 38.2-2407 shall be accepted as a bail bond in lieu of cash bail when posted by the person whose signature appears on it. The guaranteed arrest bond certificate shall be accepted as a guarantee of the person's appearance in any court, including general district courts, in this Commonwealth at the court appointed time. The bond may be posted for any person arrested for violation of any motor vehicle law of this Commonwealth or ordinance of any municipality in this Commonwealth committed prior to the date of expiration shown on the guaranteed arrest bond certificate. However, the bond may not be posted for the offense of driving while intoxicated or for any felony. Any guaranteed arrest bond certificate posted as a bail bond in any court in this Commonwealth shall be subject to the forfeiture and enforcement provisions for bail bonds posted in criminal cases as set forth in Chapter 9 (§ 19.2-119 et seq.) of Title 19.2. Any guaranteed arrest bond certificate posted as a bail bond in any general district court in this Commonwealth shall be subject to the forfeiture and enforcement provisions of this chapter or ordinance of the particular municipality pertaining to bail bonds posted.

Drafting Note: The $200 limitation has been deleted as the same limitation was deleted from § 38.1-644.1 by 1982 legislation.

"Municipal courts" have been replaced with "general district courts," as municipal courts no longer exist. General district courts now have the responsibilities that municipal courts had.

§ 38.2-2409. Agreement for joint control of money and assets.--Any person required to execute a bond, undertaking or other obligation may agree with his surety to deposit any or all assets for which he and his surety may be held responsible. The deposit shall be with a bank, savings bank, safe deposit company, or trust company authorized by law to do business as such, or with any other depository approved by the court or a judge of the court, if the deposit is otherwise proper. Assets shall be deposited for safekeeping and held in a manner that prevents the withdrawal of the whole or any part of the deposit without the written consent of the surety, or without an order of a court or a judge, made on any notice to the surety which the court or judge directs. The agreement shall not in any manner release or change the liability of the principal or sureties as established by the terms of the bond.

§ 38.2-2410. Expense of securing bond to be allowed in settlements; exceptions.--Any court, judge or other officer whose duty it is to approve the account of any person required to execute a bond with surety shall, whenever a fidelity and surety insurer has become surety on the bond, allow a sum for the expense of obtaining the surety in the settlement of the account. The sum allowed shall accord with the applicable rate filing in effect for the insurer under the provisions of this title. The allowance shall not be made to any state, county or municipal officer.

§ 38.2-2411. Furnishing court clerks with information as to licensed insurers.-- In April of each year the Commission shall furnish the clerk of the Supreme Court of Virginia and the clerk of every circuit court in this Commonwealth a list of the names of all fidelity and surety insurers in this Commonwealth, together with a statement of the assets and liabilities of each of the insurers. Each clerk shall file the list in his office.

§ 38.2-2412. Notice to clerks of revocation of an insurer's license.--Whenever the Commission revokes the license of any fidelity and surety insurer, it shall immediately give notice of the revocation to the clerk of the Supreme Court of Virginia and each circuit court in this Commonwealth.

§ 38.2-2413. Release of insurers from liability; rights and remedies.--Any fidelity and surety insurer shall be released from its liability on the same terms and conditions as are prescribed by law for the release of individuals. Any fidelity and surety insurer shall have all the rights, remedies and relief to which an individual guarantor, indemnitor, or surety is entitled.

§ 38.2-2414. Insurer estopped to deny power to assume liability.—Any fidelity and surety insurer that executes any bond as surety under the provisions of this chapter shall be estopped, in any proceedings to enforce the liability it has assumed, to deny its power to execute the bond or assume the liability.

§ 38.2-2415. Where civil proceedings may be instituted.—Any suit or other civil proceeding may be instituted against any fidelity and surety insurer (i) at the place where it became surety or assumed any duty or obligation that may be the subject of suit or other civil proceeding; or (ii) at the place where the principal obligor for whom it has become surety may be sued. When the Commonwealth is a party, plaintiff or defendant, the suit or proceeding shall be in the Circuit Court of the City of Richmond.

Drafting Note: The phrase "as principal or otherwise" is being deleted as this confuses the obligation of the principal with that of the surety.

Drafting Note: This section is deleted as there is a comprehensive penalty section.

Article 2.

Power of Attorney to Execute Bonds.

§ 38.2-2416. Power of attorney to be recorded.—Each power of attorney from a fidelity and surety insurer to an agent making the agent an attorney in fact to execute any bond or other obligation in the name and on behalf of the insurer as surety, shall, unless the power of attorney is special and limited to one transaction or to definitely stated transactions, be duly acknowledged for recordation and recorded in the deed book in the clerk's office of each county or corporation in which the powers delegated by it are to be exercised.

§ 38.2-2417. Continuance of power; revocation.—The power of an attorney in fact to bind the fidelity and surety insurer as surety within the authority conferred by a power of attorney shall, unless the power of attorney is otherwise limited, continue for the agency until the expiration of the power of attorney or until the power is revoked by the insurer's sealed written instrument duly acknowledged for recordation and admitted to record in the county or corporation in which the power of attorney is recorded.

§ 38.2-2418. Recordation of instrument of revocation.—Any instrument of revocation shall be recorded in the deed book in the office of the clerk in which the power of attorney was recorded, upon the acknowledgment prescribed by law for the acknowledgment of deeds for recordation. The admission to record the instrument of revocation shall constitute notice to all concerned of the revocation of the power previously conferred.

§ 38.2-2419. Marginal notation of revocation; indexing.—When the power of attorney has been revoked, the clerk in whose office the power of attorney is recorded shall note its revocation on the margin of the page of the deed book where the power of attorney is recorded, together with a reference to the book and page where the instrument of revocation is recorded. The clerk shall index the instrument of revocation both in the name of the fidelity and surety insurer and of its attorney in fact.

§ 38.2-2420. Bonds executed under power of attorney binding on insurer.—Any bond or obligation executed in the name and on behalf of the insurer as surety under the authority of the power of attorney shall have the same force, effect and validity, and shall be as binding upon the insurer in the name and on behalf of which it is executed as if it were properly executed by the insurer itself through its officers under its common seal. For the purpose of this section, the seal of the insurer or the seal of the attorney in fact shall not be required to be affixed to the bond or obligation.

Title 38.2

CHAPTER 25.

Mutual Assessment ~~Insurance Fire~~ Property and Casualty Insurers

The following major changes have been made in proposed Chapter 25 (existing Chapter 15):

1. The entire chapter has been reorganized and rewritten for clarity.

2. Chapter 25 insurers are required to have minimum surplus levels. (§ 38.2-2503)

3. A formal process is made available for Chapter 25 insurers to become subject to Chapter 10. (§ 38.2-2507.)

4. Section 38.2-2517 requires that policy forms be filed with the Commission.

5. Single risks limits are imposed on a comparable basis with other companies. (§ 38.2-2527.)

6. Chapter 25 insurers are required to establish unearned premium reserves for the first time. (§ 38.2-2529.)

7. Grandfather clauses which previously exempted more than one-half of the Chapter 25 insurers from formal regulation have been deleted.

8. The requirement that all coverages written by insurers subject to Chapter 25 be associated with fire coverage is outdated and has been deleted.

9. Certain additional lines available to property and casualty insurers licensed pursuant to Chapter 10 may now be underwritten by Chapter 25 insurers.

10. Agents must be licensed according to new § 38.2-2525, which requires agents to be fully licensed in accordance with Chapter 18, Insurance Agents. Section 38.2-2525 also provides that agents who sell the classes of insurance listed in subsections A and B of § 38.2-2503 do not have to take a written examination.

CHAPTER 25.

MUTUAL ASSESSMENT PROPERTY AND CASUALTY INSURERS.

Article 1.

General Provisions.

§ 38.2-2500. Scope of chapter. – This chapter applies to mutual assessment property and casualty insurers as defined in this chapter, and to insurance written by those insurers.

§ 38.2-2501. Definitions.–As used in this chapter:

"Mutual assessment insurance" means property and casualty insurance written by an insurer which has a right to assess its members for contributions and which is licensed pursuant to this chapter.

Drafting Note: Classes of insurance have been moved to § 38.2-2503.

"Mutual assessment property and casualty insurer " means a company without capital stock that writes only mutual assessment insurance insuring property located in or protecting against losses of members who are residents of this Commonwealth.

§ 38.2-2502. Mutual assessment insurance authorized.–Mutual assessment property and casualty insurers licensed pursuant to this chapter may write mutual assessment insurance.

Drafting Note: Surplus restrictions for writing all lines of insurance have been moved to § 38.2-2503.

Drafting Note: This provision has been moved to § 38.2-2504.

§ 38.2-2503. Classes of insurance that may be written by mutual assessment property and casualty insurers; minimum surplus to policyholders required.–A. Any mutual assessment property and casualty insurer with surplus to policyholders of at least $25,000 may write the following classes:

1. Fire insurance as defined in § 38.2-110;

2. Miscellaneous property damage insurance as defined in § 38.2-111; and

3. Animal insurance as defined in § 38.2-116.

B. Any mutual assessment property and casualty insurer with surplus to policyholders of at least $100,000 may write the following classes of insurance, in addition to those classes enumerated in subsection A of this section:

1. Water damage insurance as defined in § 38.2-112;

2. Burglary and theft insurance as defined in § 38.2-113;

3. Glass insurance as defined in § 38.2-114;

4. Boiler and machinery insurance as defined in § 38.2-115;

5. Personal injury liability insurance as defined in § 38.2-117;

6. Property damage liability insurance as defined in § 38.2-118;

7. Marine insurance as defined in § 38.2-126;

8. Home protection insurance as defined in § 38.2-129;

9. Homeowners insurance as defined in § 38.2-130;

10. Farmowners insurance as defined in § 38.2-131;

11. Commercial multi-peril insurance as defined in § 38.2-132; and

12. Contingent and consequential losses insurance as defined in § 38.2-133. The liability coverages specified in this subsection may be written only by insurers having a surplus to policyholders of at least $300,000 unless the coverages are fully reinsured.

C. Any mutual assessment property and casualty insurer with surplus to policyholders of at least $800,000 may write the following classes of insurance, in addition to those classes enumerated in subsections A and B of this section:

1. Workers' compensation and employers' liability insurance as defined in § 38.2-119;

2. Fidelity insurance as defined in § 38.2-120;

3. Surety insurance as defined in § 38.2-121;

4. Credit insurance as defined in § 38.2-122;

5. Motor vehicle insurance as defined in § 38.2-124;

6. Aircraft insurance as defined in § 38.2-125;

7. Legal services insurance as defined in § 38.2-127; and

8. Mortgage guaranty insurance as defined in § 38.2-128.

Drafting Note: This section is a revision of existing § 38.1-659. Surplus requirements are established on a class basis with the traditional classes being subject to the lowest surplus requirements. For the newer and more complex classes, surplus requirements are higher. The companies have traditionally been allowed to write all classes available to a property and casualty company and therefore the list of classes available has been expanded accordingly. The requirement for a basic fire policy to be issued prior to other coverages has been deleted.

§ 38.2-2504. Property beyond authorized territory. – A mutual assessment property and casualty insurer shall not insure real property outside the limits of the territory for which it is authorized to write insurance as specified in its charter or bylaws. However, members may be provided liability or other insurance on risks other than real property insurable under this chapter, wherever located. When members own real property near the border of the territory which extends in a contiguous manner beyond the territory, all of the property may be insured if otherwise insurable under this chapter, whether the property is within or without the territory.

Drafting Note: This is a revision of existing § 38.1-661. The change allows an insurer to provide insurance coverage on members who are residents of their territory. Previously, coverage was provided only to those that owned real property in the territory.

§ 38.2-2505. Risks limited to those specified in this chapter; personal liability for loss.–No mutual assessment property and casualty insurer shall insure against any losses except as specified in this chapter. Any officer or agent who knowingly or willfully violates or who causes the insurer to violate this provision shall be fined in accordance with § 38.2-218.

Drafting Note: Proposed § 38.2-218 is existing § 38.1-40. This is a revision of existing § 38.1-687.

§ 38.2-2506. What laws applicable.– Except as otherwise provided in this chapter, and except when the context otherwise requires, all the provisions of this title relating to insurers generally, and those relating to insurers writing the same class of insurance that mutual assessment property and casualty insurers are authorized to write under this chapter, are applicable to these insurers.

The provisions of §§ 38.2-1032 and 38.2-1035 shall not apply to mutual assessment property and casualty insurers.

Drafting Note: The final paragraph of this section, taken from existing § 38.1-91, is more appropriately located in this chapter.

Proposed §§ 38.2-1032 and 38.2-1035 are existing §§ 38.1-90 and 38.1-93, respectively.

§ 38.2-2507. Conversion of mutual assessment property and casualty insurers.–A. Any mutual assessment property and casualty insurer desiring to remove itself from the provisions of this chapter and desiring to become an insurer under the provisions of Chapter 10 of this title may do so by meeting the requirements of Chapter 10. The mutual assessment property and casualty insurer shall submit an application to the Commission showing that each requirement of Chapter 10 has been met. If the applicant does not meet the requirements of Chapter 10, the applicant may submit a plan that includes a schedule for meeting the requirements of Chapter 10. The schedule shall provide for compliance with those requirements within ten years of the approval of the application. For good cause shown, the Commission may grant, after informal hearing, an additional period in order to achieve compliance with the requirements of Chapter 10.

B. If the Commission approves the application, the insurer shall have all the rights, privileges and responsibilities of an insurer licensed under the provisions of Chapter 10 of this title.

C. Upon failure of the applicant to comply with the terms of the approved schedule, the Commission may require the applicant to adhere to the provisions of this chapter.

Drafting Note: This section is added to aid any Chapter 25 insurer desiring to transfer its license to the provisions of proposed Chapter 10. (Organization, Admission and Licensing of Insurers.)

Drafting Note: This section, along with other grandfather provisions, is being deleted to gain standardization of regulation.

Drafting Note: This section is redundant in light of proposed § 38.2-2511.

Drafting Note: There are no county mutuals to which this section applies.

Article 2.

Organization and Licensing of Insurers.

§ 38.2-2508. Incorporation of insurers.–Mutual assessment property and casualty insurers formed after July 1, 1986, shall be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, as modified by the provisions of this title. Except as otherwise provided in this title, mutual assessment property and casualty insurers shall be subject to all the general restrictions and have all the general powers imposed and conferred upon those corporations by law. Mutual assessment property and casualty insurers formed prior to July 1, 1986, may continue to operate as organized.

§ 38.2-2509. Directors; terms; annual meetings; voting; executive committee.–As provided in the certificate or articles of incorporation and the bylaws, the management of any mutual assessment property and casualty insurer shall be vested in a board of at least five directors, each of whom shall be a member of the insurer. Each director shall hold office for one year or for a longer term if specified in the bylaws, and thereafter until his successor is elected and has qualified. Vacancies in the board may be filled for the unexpired term by the remaining directors. The annual meeting of the members of the insurer shall be held as provided by the certificate or articles of incorporation or the bylaws. A quorum shall consist of (i) ten members or (ii) the number of members specified by either the certificate or articles of incorporation or the bylaws, whichever number is larger In all meetings of members, each member of the insurer shall be entitled to one vote, or a number of votes based upon insurance in force, the number of policies held or the amount of premiums paid as provided by the bylaws of the insurer. Votes by proxy may be received in accordance with the certificate or articles of incorporation or the bylaws. The date of the annual meeting shall be stated in the policy, or notice of the date and location of the annual meeting shall be provided annually. Notwithstanding the provisions of the charter of any insurer, upon a resolution adopted by the board of directors and approved by a majority of its members present in person or by proxy, the directors may be divided into classes and a portion only elected each year. Pursuant to the provisions of § 13.1-869, the directors may appoint an executive committee to exercise the powers and perform the duties set out in that section.

Drafting Note: 1. The first deleted statement that directors may be divided into classes with a portion being elected each year is not needed as it is redundant.

2. The introduction of the weighting of members' votes codifies existing practice.

3. A choice is provided for giving notice of annual meetings. Notification of the meeting must be provided either in the policy or by annual notice.

§ 38.2-2510. Officers.–Unless the certificate or articles of incorporation provides otherwise, the directors shall elect from their number a president. The directors shall also elect a secretary, treasurer, and any additional officers they consider necessary, who may or may not be members. The offices of secretary and treasurer may be held by one person. Unless otherwise provided in the certificate or articles of incorporation, the term of those officers shall be not less than one year nor more than three years or until their successors are elected or selected and qualified.

Drafting Note: 1. To parallel the corporations title, the requirement for vice president to be elected has been deleted.

2. The statement "until their successors are elected..." is changed to a conditional clause that will allow for the three-year period to be extended.

§ 38.2-2511. How license obtained.– The applicant insurer shall file with and have approved by the Commission its application for the license required by § 38.2-1024 prior to transacting the business of insurance in this Commonwealth. The Commission shall not grant a license to any insurer until it is satisfied that the insurer has complied with the requirements of § 38.2-1024 and has filed with the Commission a statement verified by its president and secretary or two of its directors, setting forth:

1. That the corporation holds bona fide applications for insurance of the classes proposed to be issued from 100 or more persons who own property insurable by the insurer under the provisions of this chapter and who desire to become members of the insurer;

2. The names of the proposed members and the amount of insurance subscribed for by each;

3. A statement that the insurer has received from each proposed member the initial fees and assessments required for the insurance requested;

4. The names and addresses of the officers and directors of the insurer;

5. The location of the insurer's principal office in this Commonwealth;

6. The classes of insurance proposed to be written; and

7. The territory within which the insurer proposes to transact insurance.

Drafting Note: Companies will be required to file forms as specified in proposed § 38.2-2517.

Article 3.

Members.

§ 38.2-2512. Who may become members.– Any person having a risk insurable under this chapter who resides in the territory in which the insurer operates or who owns property located in the territory may

become a member of a mutual assessment property and casualty insurer and shall be entitled to all the rights and privileges pertaining to membership. Any officer, trustee, board member or legal representative of a corporation, board, estate or association may be recognized as acting for or on its behalf for the purpose of the membership, but shall not be personally liable under the contract of insurance by reason of acting in such representative capacity.

Drafting Note: The requirement that a basic fire insurance policy be issued prior to the writing of other classes for a member has been deleted and therefore property ownership as a prerequisite to membership will no longer be required.

§ 38.2-2513. Withdrawal and exclusion of members.—A. Any member of a mutual assessment property and casualty insurer may withdraw as a member at any time by giving at least thirty days' written notice to the insurer and paying his share of all losses against the insurer that have occurred prior to the member's withdrawal and which have not been fully reserved or for which surplus is inadequate. Upon this withdrawal the member shall be paid by the insurer any unearned premium, unearned fee or unearned assessment paid in advance.

B. Any member who neglects or refuses to pay an assessment or premium when due may be excluded from membership for that or any other reason satisfactory to a majority of the directors or the executive committee, or as the bylaws prescribe. The member shall remain liable for the payment of any assessments made for losses that have occurred prior to his exclusion, and also for the amounts provided for in § 38.2-2522, if action is instituted within twelve months after the time the assessments become due.

Drafting Note: The exclusion from establishing unearned premium reserves has been deleted, as proposed § 38.2-2529 requires that unearned premium reserves be maintained. An insured need not return his policy as written notice was required for withdrawal. The relevant portions of existing §§ 38.1-670 and 38.1-669.1 have been shifted to this section.

Drafting Note: The relevant portions of this section have been shifted to proposed § 38.2-2513.

§ 38.2-2514. Procedure upon exclusion of member.—If any member is excluded from the insurer as provided in this article, the insurer shall note upon its records the exclusion of the member, the cancellation of his insurance policies, and the date of the exclusion. The insurer shall notify the member by mail of the exclusion and cancellation, and after at least five days have elapsed from the mailing of the notice, the policy shall no longer be effective and all further liability of the insurer under the policy shall cease. Proper notification shall be deemed to have been effected if the notice is deposited with the United States Postal Service and mailed to the member at his address as shown on the records of the insurer. If the bylaws or the policy provide that a member's policy shall be void without any notice if the member neglects or refuses to pay any assessment, that provision shall be valid and the notice required in this section need not be given. Upon the cancellation of the insurance or upon the policy becoming void, the member shall be entitled to receive from the insurer a repayment of an equitable portion of any premium, fee or assessment which was paid in advance.

§ 38.2-2515. Insurers to maintain membership of 100 or more; license suspended or revoked if membership not maintained; rehabilitation or liquidation.—Every mutual assessment property and casualty insurer shall maintain a membership of at least 100 persons at all times. Whenever the number of members falls below 100, the insurer shall notify the Commission immediately of that fact. Upon receipt of that notice, or upon information from any source that the membership of the insurer is less than 100, the Commission may revoke the insurer's license, or may issue an order requiring the insurer to increase its membership to at least 100 within a designated period not exceeding ninety days.

If at the expiration of the designated period the membership has not been increased to at least 100, the Commission shall revoke the insurer's license. Upon the revocation of its license as authorized in this section, delinquency proceedings against the insurer may be instituted and conducted as provided in Chapter 15 of this title.

Drafting Note: The grandfather provision is outdated and unnecessary.

Article 4.

Insurance Transactions.

§ 38.2-2516. Issuance of policies; bylaws as part of contract.—The directors of every mutual assessment property and casualty insurer shall issue insurance policies requiring the insurer to pay all losses or damages caused by the risk insured against during the time the policy is in force. Payment shall not exceed the amount insured. There shall be attached to or included in each of those policies the portion of the bylaws that constitute a part of the policy contract. Bylaws or their amendments that are not a part of the policy contract shall not affect the policy contract unless they are included as a suitable endorsement mailed or delivered to the policyholder.

Drafting Note: This section is replaced with proposed § 38.2-2527.

§ 38.2-2517. Policy forms to be filed.—Every mutual assessment property and casualty insurer shall file with the Commission a copy of all policy forms and standard endorsements which the insurer intends to use in the transaction of its business. Mutual assessment property and casualty insurers shall be exempt from the filing requirements of Chapter 3 of this title except for those classes of insurance enumerated in subsection C of § 38.2-2503, where full compliance with Chapter 3 shall be required.

Drafting Note: Previously companies were required to file forms with their application for license for classes of insurance they planned to offer. This new section requires forms to be filed and for

those more sophisticated classes listed in subsection C of § 38.2-2503 to meet the requirements of Chapter 3 (existing Chapter 8, Article 1).

Drafting Note: This section has been moved to proposed § 38.2-2528.

§ 38.2-2518. Assessment contract.– Each person insured by a mutual assessment property and casualty insurer shall be issued a contract prescribed by the insurer, that shall be uniform among members of the respective classes of insurance written by the insurer. Each member shall agree to pay his pro rata share of all losses or damages sustained, expenses of operation of the insurer, and the maintenance of an adequate surplus to policyholders as determined by the board of directors. Periodic assessments may be collected as advance premiums or post assessments or by both methods. The amount of assessments shall be established by the directors of the insurer.

§ 38.2-2519. Classification of risks; rates.–Any insurer writing mutual assessment property and casualty insurance may classify the property or risk insured in accordance with the risk or hazard to which the property is subject, and fix the rate of assessment or premium for that insurance in accordance with the classification.

Drafting Note: Reference to workers' compensation has been deleted since this class is covered by proposed Chapter 20.

§ 38.2-2520. Right to limit assessment liability.–Any mutual assessment property and casualty insurer having a surplus to policyholders equal to at least three times the average annual losses and expenses of the insurer during the last five-year period or a surplus to policyholders of at least $800,000 may limit the assessment liability of members. The liability of members for assessment may be limited during any one year to an amount not less than one additional current annual assessment.

Drafting Note: The surplus requirement of $300,000 for an insurer to limit assessments has been raised to $800,000. This requirement strengthens the financial integrity of these companies.

§ 38.2-2521. Notice of assessment; how given.–After an assessment is made, the insurer shall give every member subject to the assessment written notice stating the amount of the member's assessment and the date when payment is due. Except where the provisions of the bylaws or the policy provide otherwise, the time of payment shall be at least thirty days and no more than sixty days from the service of the notice. That notice may be served personally or by mail. If mailed, the notice shall be deposited with the United States Postal Service and addressed to the member at his residence or place of business as shown on the company records.

§ 38.2-2522. Action to recover assessments; penalty.–Within twelve months after an assessment becomes due, a mutual assessment property and casualty insurer may institute suit against any member to recover any assessment that the member fails to pay. The insurer shall be entitled to recover (i) the amount shown to be due, (ii) lawful interest, and (iii) fifty percent of the principal amount as liquidated damages for neglect or refusal to pay within the time required.

Drafting Note: This section is covered by proposed § 38.2-2518.

§ 38.2-2523. Notice of loss and adjustment. –Each policyholder after sustaining loss or damage from any cause specified in the policy shall notify the mutual assessment property and casualty insurer within the time prescribed in the policy. The insurer shall promptly proceed to ascertain and adjust the loss or damage in the manner provided by the policy, law and bylaws of the company.

Drafting Note: This section is covered by proposed § 38.2-2518.

§ 38.2-2524. Proceeding when loss or damage exceeds cash on hand.–If at any time any loss or damage to property insured by a mutual assessment property and casualty insurer exceeds the insurer's cash available to pay the loss or damage, the insurer may borrow money in an amount sufficient to pay the loss or damage. This shall be approved by the board of directors or the executive committee. The board of directors or the executive committee may levy an assessment sufficient to repay the loan or to pay the loss or damage, or any portion that is in excess of the cash on hand.

Drafting Note: The provisions of this section have been incorporated into proposed § 38.2-1034.

§ 38.2-2525. Agents licenses required.–Agents representing a mutual assessment property and casualty insurer shall be licensed by the Commission and appointed by the insurer in accordance with Chapter 18 of this title. However, agents whose licenses are limited to those classes of insurance referred to in subsections A and B of § 38.2-2503 shall not be required to take a written examination from the Commission in accordance with § 38.2-1814.

Drafting Note: Agents will be required to become fully licensed if they elect to sell the more sophisticated insurance products. However, no change in licensing is required if they remain in the traditional less complicated classes of insurance.

Drafting Note: Surplus requirements have been introduced in proposed § 38.2-2526. The mutual assessment property and casualty insurance companies will be subject to the investment laws as this chapter is not self-contained.

Article 5.

Financial Provisions.

§ 38.2-2526. Surplus to policyholders.–A. Surplus to policyholders in addition to the required surplus specified in subsections A and B of § 38.2-2503 may be accumulated in amounts as determined by the

board of directors. The surplus may be used for the payment of losses and operating expenses of the insurer.

B. Income earned on any surplus to policyholders may be used to pay losses, operating expenses, or added to surplus.

C. The provisions of this section shall become effective July 1, 1986.

D. Any mutual assessment property and casualty insurer already licensed on July 1, 1986, shall comply with the minimum surplus requirements of § 38.2-2503 by July 1, 1991. Any mutual assessment property and casualty insurer that does not meet the surplus requirements of this section as of July 1, 1986, and is not writing any of the classes authorized in subsections B and C of § 38.2-2503 on July 1, 1986, shall not write any of those classes until the specified surplus requirement is met.

Drafting Note: This new section sets forth surplus requirements. Insurers will be given until July 1, 1991, to meet these requirements. Any insurer not currently meeting the surplus requirements of a particular class cannot underwrite that class until the surplus requirement has been met.

Drafting Note: This provision is covered by proposed § 38.2-2518.

Drafting Note: This provision has been moved to proposed § 38.2-2520.

§ 38.2-2527. Limitation on single risk to be assumed. --A. No single risk shall be assumed by a mutual assessment property and casualty insurer in an amount exceeding ten percent of its surplus to policyholders. Any risk or portion of any risk which has been reinsured in accordance with § 38.2-2528 shall be deducted in determining the limitation of risk prescribed by this section. For the purposes of this section the amount of surplus to policyholders shall be determined on the basis of the last financial statement of the insurer, or the last report of examination filed with the Commission, whichever is more recent, at the time the risk is assumed. Mutual assessment property and casualty insurers licensed on or before July 1, 1986, shall conform to this limitation by July 1, 1991.

B. Until July 1, 1991, the following single risk limits after deducting for reinsurance will apply:

1. No insurer having less than two million dollars insurance in force shall insure any one risk for more than $10,000;

2. No insurer having more than two million dollars but less than five million dollars insurance in force shall insure any one risk for more than $12,000;

3. No insurer having more than five million dollars but less than ten million dollars insurance in force shall insure any one risk for more than $20,000;

4. No insurer having more than ten million dollars insurance in force shall insure any one risk for a sum in excess of fifteen cents for each $100 insurance it has in force; and

5. An insurer may insure any one risk in larger sums than prescribed in this section if (i) the excess over such prescribed maximum is reinsured as authorized in this chapter or (ii) the excess may be increased by the extent of twenty-five percent of the surplus of the insurer as of the time the insurance is written.

Drafting Note: The single risk limit is similar to that of a Chapter 10 company. The phase-in provision is the current single risk limit law.

Drafting Note: This provision has been moved to proposed § 38.2-2521.

§ 38.2-2528. Reinsurance.--Any mutual assessment property and casualty insurer may reinsure the whole or any part of its risks with any solvent insurer licensed in this Commonwealth or licensed or approved in any other state and meeting standards of solvency at least equal to those required in this Commonwealth if the reinsurance is ceded without contingent liability on the part of the reinsured insurer. Any mutual assessment property and casualty insurer having a surplus in excess of $800,000 may accept or assume reinsurance from any licensed property and casualty insurer. Any of those companies may accept or assume reinsurance on risks located within or without the territory in which it is authorized to transact insurance.

Nothing in this section shall be construed to prohibit the participation of a mutual assessment property and casualty insurer in a pool or other plan among similar companies approved by the Commission for the purpose of spreading losses or providing reinsurance or catastrophe coverage for participants. The acceptance of reinsurance by any insurer outside the territory in which it is authorized to transact the business of insurance shall not be construed to enlarge its territory so as to affect any tax exemption to which it may be entitled.

Drafting Note: This is a revision of existing § 38.1-675. The added language regarding standards of solvency is from subsection B of proposed § 38.2-1316. Reinsurance treaties will no longer be filed with the Commission. County mutuals may accept reinsurance if their surplus exceeds $800,000.

Drafting Note: This provision has been moved to proposed § 38.2-2522.

§ 38.2-2529. Unearned premium reserves required. -- A. Advance assessments received by mutual assessment property and casualty insurers shall be considered premiums and, except as provided in subsection B of this section, shall be subject to the requirement of an unearned premium reserve computed in accordance with § 38.2-1312. The reserves may be reduced for applicable reinsurance in accordance with the provisions of subsection B of § 38.2-1316.

B. The amount each insurer shall maintain in reserves for unearned premium reserves shall be as follows:

1. For calendar year 1987, at least ten percent of the unearned premium reserve as calculated in subsection A of this section; and

2. For each subsequent year, at least an additional ten percent as calculated in subsection A for that subsequent year in order that the full amount of unearned premium reserves shall be established by December 31, 1996.

Drafting Note: This is a new provision that will require a county mutual to carry unearned premium reserves. A ten-year phase-in period is provided.

Drafting Note: This section has been deleted as county mutuals will be subject to filing annual statements required by proposed § 38.2-1300.

Drafting Note: This section has been moved to proposed § 38.2-2505.

Drafting Note: The deletion of existing § 38.1-687.1 eliminates the problem the Commission currently has in determining the "types" of certain insurance companies.

CHAPTER 26.

Home Protection Companies.

1. The licensing fee is increased to $500 (proposed § 38.2-2603).

2. The requirement in existing § 38.1-934 (proposed § 38.2-2604) that home protection companies use a distinctive name has been deleted as there is no other general provision like this in the insurance title.

3. Existing § 38.1-948 has been deleted as it has been rendered unnecessary by a change in the Property and Casualty Guaranty Association chapter (proposed § 38.2-1603).

CHAPTER 26.

HOME PROTECTION COMPANIES.

Drafting Note: Short titles are being deleted throughout the entire title.

§ 38.2-2600. Definitions.—As used in this chapter:

"Fronting company" means a licensed insurer or licensed home protection company which generally transfers to one or more unlicensed insurers or unlicensed home protection companies by reinsurance or otherwise all or substantially all of the risk of loss under all of the home protection contracts written by it in this Commonwealth.

Drafting Note: The definition of "fronting company" is being transferred from § 38.1-944. No substantive changes have been made.

"Home protection company" means any person who performs, or arranges to perform, services pursuant to a home protection insurance contract.

Drafting Note: To improve clarity, the word "company" alone will not be used to refer to a home protection company.

"Home protection insurance contract" or "contract" means any insurance contract or agreement whereby a person undertakes for a specified period of time and for a predetermined fee to furnish, arrange for or indemnify for service, repair, or replacement of any and all of the structural components, parts, appliances, or systems of any covered residential dwelling necessitated by wear and tear, deterioration, inherent defect, or by the failure of an inspection to detect the likelihood of failure.

The contract shall provide for a system to effect repair or replacement if the contract undertakes to provide for repair or replacement services. The contract shall not include protection against consequential damage from the failure of any structural component, part, appliance or system.

Drafting Note: The intent of this change is to clarify that a home protection company may contract to provide indemnity services only.

"Structural component" means the roof, foundation, basement, walls, ceilings, or floors of a home.

§ 38.2-2601. Exemptions.—This chapter shall not apply to:

1. Performance guarantees given by either (i) the builder of a home or (ii) the manufacturer, seller, or lessor of the property that is the subject of the contract if no identifiable charge is made for the guarantee.

2. Any service contract, guarantee, or warranty intending to guarantee or warrant the repairs or service of a home appliance, component, part, or system that is issued by a person who has sold, serviced, repaired, or provided replacement of the appliance, component, part, or system at the time of or prior to issuance of the service contract, guarantee or warranty if such person does not engage in the business of a home protection company.

Drafting Note: This is the replacement for § 38.1-933 D.

§ 38.2-2602. Limited applicability to certain insurers.—A property and casualty insurer may be licensed to transact home protection insurance as defined in § 38.2-129. An insurer licensed in this Commonwealth to transact the class of insurance defined by § 38.2-111 on July 1, 1986, may also transact home protection insurance without additional authority. No other provision of this chapter, except § 38.2-2606 and §§ 38.2-2608 through 38.2-2614, shall be applicable to the insurers, their businesses, or their home protection contracts.

Drafting Note: This section replaces subsection B of § 38.1-933 and subsection C of § 38.1-945. Proposed § 38.2-129 is a new section in the proposed Chapter 1 definitions that defines home protection insurance. Proposed § 38.2-111 is existing § 38.1-7 dealing with miscellaneous property insurance.

§ 38.2-2603. License required; application; fee.— Except as provided in § 38.2-2602, no home protection company shall issue or offer to issue home protection contracts in this Commonwealth until a home protection company license has been granted by the Commission. Application for a license shall be made in writing, in the form prescribed by the Commission, and shall be accompanied by a nonrefundable application fee of $500.

Drafting Note: The change in the license fee places home protection companies on equal footing with other companies licensed by the Bureau of Insurance.

Drafting Note: This subsection is replaced with proposed § 38.2-2602.

Drafting Note: This subsection has been deleted as it is now obsolete.

Drafting Note: Subsection D is replaced with proposed § 38.2-2601.

Drafting Note: Subsection E is deleted as it seems unnecessary. It appears that we have adequate authority without this section.

§ 38.2-2604. Qualification for license; net worth; deposit of securities with State Treasurer.—A. No license shall be issued to any home protection company unless the applicant:

1. Is a Virginia corporation formed under the provisions of Article 3 (§ 13.1-618 et seq.) of Chapter 9 of Title 13.1, or Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1; or

2. Is a foreign corporation subject to regulation and licensing under the laws of its domiciliary jurisdiction which are substantially similar to those provided in this chapter, and has obtained a certificate of authority to transact business in this Commonwealth;

3. Furnishes the Commission with evidence satisfactory to it that the management of the home protection company is competent and trustworthy, and can be reasonably expected to successfully manage the company's affairs in compliance with law;

4. Establishes to the satisfaction of the Commission that it (i) maintains employees or has contractual arrangements sufficient to provide the services or indemnity undertaken by it, and (ii) agrees to accept requests for heating, electrical and plumbing services contracted for twenty-four hours per day, seven days per week;

Drafting Note: This paragraph was deleted since there is no other general provision like it throughout the rest of the title.

5. Makes the deposit of bonds or other securities required by this section;

6. Is otherwise in compliance with this chapter;

7. Has filed the required application and paid the required fee;

8. Has paid all fees, taxes, and charges required by law;

9. Has the minimum net worth prescribed by this section;

10. Has filed any financial statement and any reports, certificates, or other documents as the Commission deems necessary to secure a full and accurate knowledge of its affairs and financial condition; and

11. Keeps adequate, correct and complete books and records of accounts and maintains proper accounting controls.

B. The Commission shall not issue a license to or renew the license of a home protection company unless it is satisfied that the financial condition, the method of operation, and the manner of doing business enable the home protection company to meet its obligations to all contract holders and that the home protection company has otherwise complied with all the requirements of law.

C. A home protection company shall maintain a net worth in an amount not less than twenty percent of the premiums charged on its contracts currently in force; however, the minimum required net worth shall be not less than $100,000, and the maximum required net worth shall be that amount required of insurers under the provisions of Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title.

D. No license shall be granted to any home protection company until it presents to the Commission a certificate of the State Treasurer that bonds or other securities have been deposited with him to be held in accordance with the provisions of and upon the terms and conditions and in the amount as provided in Article 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

§ 38.2-2605. Expiration and renewal of license.–Every home protection company licensed under this chapter shall obtain a renewal of its license annually from the Commission. Every license issued under this chapter shall expire at midnight on June 30 immediately following the date of issuance. No renewal license shall be issued unless the home protection company has paid all taxes, fees, assessments and other charges imposed upon it, and has complied with all the other requirements of law. The Commission shall not fail or refuse to renew the license of any home protection company without giving the home protection company ten days' notice of the failure or refusal to renew and providing it an opportunity to be heard and to introduce evidence in its behalf. Any such hearing may be informal, and the required notice may be waived by the Commission and the home protection company.

§ 38.2-2606. Reserves required.–A home protection company licensed in this Commonwealth shall maintain reserves in an amount sufficient to provide for its liability to furnish appropriate indemnity, repairs, and replacement services under its issued and outstanding contracts. The reserve account shall be calculated according to sound actuarial principles, but shall equal at a minimum fifty percent of the premiums received from all contracts in force in this Commonwealth, net of applicable reinsurance and any amounts paid on account of liabilities incurred under the contracts. To receive credit for reinsurance on home protection contracts, the reinsurance contract or policy shall be issued by a solvent insurer licensed in this Commonwealth or any other state having standards of solvency at least equal to those required in this Commonwealth.

Drafting Note: District of Columbia is deleted because the definition of "state" will include District of Columbia.

§ 38.2-2607. Annual statements.– On or before March 1 of each year, each home protection company shall file with the Commission its annual statement pursuant to the provisions of § 38.2-1300, in the form prescribed by the Commission. The annual statement may be based on accounting principles common to the home protection business, provided that they enable the Commission to ascertain whether the reserves required by § 38.2-2606 have been established. However, the Commission may prescribe a uniform accounting system to be used by home protection companies. The Commission may also require the uniform reporting of statistical information under a plan prescribed or approved by the Commission.

Drafting Note: Annual statements are generally considered public documents. It is not necessary to state that they are public documents.

§ 38.2-2608. Home protection contracts; filing; form and contents; application or agreement to purchase; regulation of rates and charges.—A. No home protection contract shall be issued or used in this Commonwealth unless it has been filed with and approved by the Commission.

Drafting Note: No substantive change is intended here. This change is intended to clarify the current Bureau policy.

B. No home protection contract shall be issued in this Commonwealth unless it:

1. Is written in simple and readable words with common meanings and is understandable without special insurance knowledge or training;

2. Specifically sets forth:

a. The services to be performed by the home protection company and the terms and conditions of the performance;

b. Any service fee or deductible amount applicable per claim or per occurrence;

c. Each of the systems, appliances, and structural components covered by the contract;

d. All exclusions and limitations respecting the extent of coverage;

e. The period during which the contract will remain in effect and the cancellation provision;

f. All limitations regarding the performance of services, including any restrictions as to the time periods when services will be performed;

3. Provides for the initiation of covered services contracted for upon telephonic request without first requiring the filing of written claim forms or written applications; and

4. Provides for the initiation of covered services contracted for by or under the direction of the home protection company within seventy-two hours of the request for the service by the contract holder, and provides for the completion of the services as soon as reasonably possible. For malfunctions of furnace or heating systems during the winter months, the contract must provide for the initiation of services immediately.

C. Every application for or agreement to purchase a home protection contract shall include a statement that the purchase of the contract is not mandatory and may be waived, and shall include a statement of the premium.

D. 1. Chapter 20 of this title shall apply to the rates charged by home protection companies until such time as the Commission determines, after proper notice and hearing, that sufficient competition exists in the home protection industry to justify its regulation under Chapter 19 of this title. Upon this determination, Chapter 19 of this title shall apply to the rates charged by home protection companies.

2. No home protection company shall make or issue a contract except in accordance with the filings that are in effect for that company. No home protection company or any of its representatives shall charge or receive any fee, compensation or consideration for the contract that is not included in the rate in effect for that company.

3. The rates charged shall be based on sound actuarial principles and shall not be excessive, inadequate, or unfairly discriminatory as defined in § 38.2-1904.

§ 38.2-2609. Qualifications of agents.— No person shall recommend, solicit, negotiate, or sell home protection contracts in this Commonwealth unless (i) he has a valid license to transact property and casualty insurance in this Commonwealth, (ii) he has a valid license to sell real estate in this Commonwealth, issued pursuant to Chapter 18 (§ 54-730 et seq.) of Title 54, or (iii) he is the builder of the home or one of his authorized agents.

§ 38.2-2610. Cancellation of home protection contracts.—A. No home protection contract shall be cancellable by the home protection company during the initial term for which it is issued, except for:

1. Nonpayment of premium;

2. Fraud or misrepresentation of facts material to the issuance of the contract; or

3. Contracts providing coverage prior to the time the residential property is purchased, provided that purchase of the property does not occur.

B. Nothing in this section establishes the right of a contract holder to renew any contract.

§ 38.2-2611. Unfair discrimination.— No person shall make or permit any unfair discrimination between individuals in the rates or fees charged for any contract, in the performance of services or payments for

services, or in any other terms or conditions of the contract.

§ 38.2-2612. Unfair trade practices.– In addition to the provisions of Chapter 5 of this title, the Commission may order any home protection company or its representatives to cease and desist from engaging in the following unfair trade practices:

1. The making of any false or misleading statements, either oral or written, in connection with the sale, offer to sell, or advertisement of a home protection contract;

2. The omission of any material statement in connection with the sale, offer to sell, or advertisement of a contract that under the circumstances should have been made in order to make the statements that were made not misleading;

3. The making of any statement that the purchase of a home protection contract is mandatory;

4. The making of any false or misleading statements, either oral or written, about the benefits or services available under the contract;

5. The failure to perform the services promised under the contract in a timely, competent, or workmanlike manner; or

6. Any statement or practice which has the effect of creating or maintaining a fraud.

§ 38.2-2613. Application of insurance laws.–Except as otherwise specifically provided in this chapter or where the context requires otherwise, all of the provisions of this title that apply to property and casualty insurers shall apply in every respect to home protection companies licensed under this chapter. In addition, Article 1 (§ 58.1-2500 et seq.) and Article 2 (§ 58.1-2520 et seq.) of Chapter 25 of Title 58.1 shall apply to the operation of a home protection company.

Drafting Note: There are a number of provisions in the insurance title not specifically excluded in this chapter that should not be applied to home protection companies.

§ 38.2-2614. Fronting not permitted.– No licensed insurer or licensed home protection company shall act as a fronting company for any unlicensed insurer or unlicensed home protection company.

Drafting Note: The definition of fronting company has been moved to proposed § 38.2-2600.

§ 38.2-2615. Other insurance transactions prohibited .–A. A home protection company that engages in any business other than the business of a home protection company is not eligible for the issuance or renewal of a license in this Commonwealth.

B. Nothing in this chapter shall be deemed to authorize any home protection company to transact any business other than that of a home protection company or to transact any other business of insurance, unless the company is authorized by a license issued by the Commission.

Drafting Note: This subsection is replaced with the new § 38.2-2602.

Drafting Note: This section is being deleted in favor of a uniform injunction section in Chapter 1.

Drafting Note: This section is being deleted in light of the decision to use a single penalty section for the entire title.

Drafting Note: A proposed change in the definition of member insurer in the Property and Casualty Guaranty Association chapter has rendered this section unnecessary.

Title 38.2

CHAPTER 27.

Basic Property Insurance Inspection and Placement Plan and Joint Underwriting Association.

Existing §§38.1-748 and 38.1-748.1 are replaced by proposed §§38.2-2702 through 38.2-2706. The replacement sections do not specify the form of organization as the current sections do. However, the plan of operation is subject to the Commission's approval under the proposed replacement sections.

CHAPTER 27.

BASIC PROPERTY INSURANCE RESIDUAL MARKET FACILITY

AND JOINT UNDERWRITING ASSOCIATION.

§ 38.2-2700. Purposes of chapter.—The purposes of this chapter are:

1. To assure stability in the property insurance market of this Commonwealth;

2. To assure the availability of basic property insurance for qualified property ;

3. To encourage maximum use of the voluntary insurance market provided by licensed insurers in obtaining basic property insurance; and

4. To provide for the equitable distribution among licensed insurers of the responsibility for insuring qualified property for which basic property insurance cannot be obtained through the voluntary insurance market.

Drafting Note: The word "voluntary" has been substituted in this section as we believe it to be the generally accepted term for the available or normal insurance market.

The word "licensed" is used in place of "authorized" to avoid possible confusion with surplus lines carriers.

§ 38.2-2701. Definitions.—As used in this chapter:

"Basic property insurance" means insurance against direct loss to any property caused by perils defined and limited in the standard fire policy prescribed in §§ 38.2-2101 through 38.2-2112, and in the extended coverage endorsement approved by the Commission pursuant to § 38.2-2117;

"Inspection service " means any organization designated or approved by the Commission to determine the insurability and conditions of the properties for which basic property insurance is sought;

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of basic property insurance and the basic property insurance component of multi-peril policies less (i) all return premiums on those policies, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits.

"Qualified property" means all real property and all tangible personal property at a fixed location in this Commonwealth, whether or not the property is subject to exposure from an external hazard located on property that is neither owned nor controlled by the prospective insured, and whether or not the property is subject to exposure from riot hazard, where the property:

1. Is not used for manufacturing purposes;

2. Complies with applicable state laws and regulations and local building codes and ordinances;

3. Is not commonly owned or controlled, or combinable for rating purposes, with property insured for similar coverages elsewhere; and

4. Has characteristics of ownership, condition or occupancy that do not violate any public policy.

"Residual market facility" means any organization approved by the Commission to equitably distribute the responsibility to provide basic property insurance on qualified property among insurers licensed to write basic insurance or other insurance containing a basic property insurance component.

Drafting Note: The new definition of "net direct premiums written" is intended to correspond with similar changes already made regarding the medical malpractice joint underwriting association.

The definition of "residual market facility" is necessary due to the deletion of §§ 38.1-748 and 38.1-748.1 and the addition of §§ 38.2-2702, 38.2-2703 and 38.2-2704. Please see the drafting note to § 38.1-748.1 for a more complete explanation.

Drafting Note: §§ 38.1-748 and 38.1-748.1 have been consolidated into a single section. Existing § 38.1-748 establishes an industry placement facility for the fire insurance residual market. Existing § 38.1-748.1 allows the authorized insurers to establish a direct insurance association. Under the proposed consolidated § 38.2-2702, a residual market entity will be mandated, but its plan of operation and form of organization will be left open. The plan of operation will be subject to Commission approval. The rules, rates, policy forms and endorsements used by the residual market facility shall be subject to the Commission's approval under proposed § 38.2-2703. Proposed §§ 38.2-2704, 38.2-2705 and 38.2-2706 address some of the other topics previously addressed in §§ 38.1-748 and 38.1-748.1. In addition, new language has been added to the proposed § 38.2-2702 which specifies the powers of the residual market facility.

§ 38.2-2702. Establishment of residual market facility.—A. A residual market facility shall be established and maintained by all insurers licensed to write basic property insurance or other insurance containing a basic property insurance component. The plan of operation of the residual market facility shall be subject to approval by the Commission.

B. The residual market facility shall be governed by a board of fifteen directors. Four directors shall be appointed by the Commissioner, two of whom shall be property and casualty insurance agents and two of whom shall be from the general public.

C. The residual market facility shall have the power to:

1. Employ or retain persons necessary to perform the duties of the residual market facility;

2. Acquire, hold, and dispose of real and personal property, or any interest in real and personal property;

3. Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

4. Negotiate and become a party to those contracts necessary to carry out the purposes of this chapter;

5. Indemnify any director or member of its governing body, officer, employee, or agent in the manner permitted by and subject to the limitations contained in Article 9 (§ 13.1-875 et seq.) of Chapter 10 of Title 13.1; and provide any other or further indemnity to any such person that may be authorized by the plan of operation except an indemnity against his gross negligence or willful misconduct, and purchase and maintain insurance in the manner permitted by § 13.1-882; and

6. Perform any other acts necessary or proper to carry out the purposes of this chapter.

D. The residual market facility shall not be deemed to be an insurer within the provisions of § 38.2-100.

§ 38.2-2703. Rules, rates, policy forms and endorsements subject to the approval of Commission.—The rules, rates, policy forms, and endorsements of the residual market facility shall be subject to the Commission's approval prior to use.

§ 38.2-2704. Inspection of property.—Any person having an insurable interest in real property and tangible personal property at a fixed location in this Commonwealth is entitled, upon request, to an inspection of the property by representatives of the residual market facility to determine whether the property is within the definition of qualified property. A copy of the inspection report shall be made available upon request to the applicant, his agent, or the insurer.

§ 38.2-2705. Operation of inspection service.—A. The residual market facility may employ other organizations to perform inspection services to determine whether property is within the definition of qualified property.

B. The plan of operation regarding the inspection service, the experience and qualifications of the organization proposed to conduct the inspection service, the manner and scope of the inspection, and the form of the inspection report shall be set forth by the residual market facility in a written report made to the Commission and shall be subject to approval by the Commission.

§ 38.2-2706. Service of process.—Service of any notice, proof of loss, legal process or other communication relating to the policy or any notice or order of the Commission shall be made upon the residual market facility by service upon the residual market facility's manager, or any duly appointed assistant manager.

§ 38.2-2707. When Commission may order implementation of §§ 38.2-2708 and 38.2-2709.— If the Commission finds, after a reasonable period of time, that the residual market facility established by § 38.2-2702 is not creating a market that meets the purposes of this chapter, the Commission may order the implementation of §§ 38.2-2708 and 38.2-2709.

§ 38.2-2708. Creation and plan of operation of joint underwriting association.—A. After providing notice and opportunity to be heard and upon promulgation of an order by the Commission pursuant to § 38.2-2707, a joint underwriting association shall be created consisting of all insurers licensed to write basic property insurance or other insurance that contains a basic property insurance component in this Commonwealth, but excluding insurers exempted from rate regulation by subsection C of § 38.2-1902. Each insurer that is required to be a member of the joint underwriting association shall remain a member as a condition of its license to write basic property insurance and other insurance that contains a basic property insurance component in this Commonwealth.

B. The joint underwriting association shall, pursuant to this chapter and the plan of operation, have the power to (i) cause its members to issue policies of basic property insurance on qualified property to applicants; (ii) assume reinsurance on qualified property from members; and (iii) cede reinsurance.

C.1. Within ninety days following the effective date of the order of the Commission, the joint underwiting association shall submit to the Commission for its review a proposed plan of operation consistent with this chapter. The plan of operation shall provide for economical, fair and nondiscriminatory administration and for the prompt and efficient provision of basic property insurance to promote orderly community development. The plan of operation shall include, but not be limited to, (i) preliminary assessment of all members for initial expenses necessary to commence operations, (ii) establishment of necessary facilities, (iii) management of the joint underwriting association, (iv) assessment of members to defray losses and expenses, (v) commission arrangements, (vi) reasonable underwriting standards and limits

of liability, (vii) acceptance and cession of reinsurance, and (viii) procedures for determining amounts of insurance to be provided.

2. The plan of operation shall be subject to approval by the Commission after consultation with affected individuals and organizations, and shall take effect ten days after its approval. If the Commission disapproves all or any part of the proposed plan of operation, the joint underwriting association shall within thirty days submit for review an appropriately revised plan of operation. If the joint underwriting association fails to submit a revised plan, or if the revised plan is unacceptable, the Commission shall promulgate whatever plan of operation it deems necessary to carry out the purposes of this chapter.

3. The joint underwriting association may, on its own initiative or at the request of the Commission, amend the plan of operation. Any amendment to the plan of operation shall be subject to the Commission's approval.

§ 38.2-2709. Ceding basic property insurance to association; participation of members; governing body.— A. Any member of the joint underwriting association may cede to the association basic property insurance written on qualified property, to the extent and on the terms and conditions set forth in the plan of operation.

B. All members of the joint underwriting association shall participate in its writings, expenses, profits and losses, or in any categories thereof that may be separately established by the joint underwriting association, in the proportion that the net direct premiums written by each member during the preceding calendar year bear to the aggregate net direct premiums written in this Commonwealth by all members of the joint underwriting association during the preceding calendar year, but excluding (i) premiums on property used for manufacturing purposes, and (ii) that portion of premiums attributable to the operation of the joint underwriting association.

C. The joint underwriting association shall be governed by a board of fifteen directors. Four directors shall be appointed by the Commissioner, two of whom shall be property and casualty insurance agents and two of whom shall be from the general public. The remaining eleven directors shall be elected annually by a cumulative vote of the joint underwriting association's members, whose votes shall be weighted in accordance with each member's premiums written during the preceding calendar year. The first board shall be elected at a meeting of the members or their authorized representatives, which shall be held within thirty days after approval of the plan of operation as provided in § 38.2-2708.

Drafting Note: The specification regarding the appointment of directors is taken from the bylaws of the VPIA.

§ 38.2-2710. Supervision and regulation by Commission.— The residual market facility, any inspection service, and any joint underwriting association shall at all times be subject to the supervision and regulation of the Commission. The Commission, or any person designated by it, shall have the power :

1. To visit and examine the operations of the residual market facility, any inspection service, and any joint underwriting association;

2. To examine directors, officers, agents, employees, or any other person having knowledge of those operations; and

3. To summon and qualify witnesses under oath. Pursuant to these powers, the Commission shall have free access to all books, records, files, papers and documents that relate to those operations.

§ 38.2-2711. Immunity from liability; reports, etc., not public documents.—A. There shall be no liability on the part of, and no cause of action shall arise against any insurer, any inspection service, the residual market facility, the joint underwriting association, or their directors, governing committee members, officers, agents or employees, or the Commission or its authorized representatives, for any action taken by them in good faith in the performance of their powers and duties under this chapter, nor for any inspections undertaken or statements made by them (i) in any reports and communications concerning the property insured or to be insured, (ii) at the time of the hearings conducted in connection with the property insured or to be insured, or (iii) in the findings required by this chapter.

B. The reports and communications of an inspection bureau service, the residual market facility, and the joint underwriting association shall not be public documents.

§ 38.2-2712. Appeal from decision of inspection service, residual market facility or joint underwriting association.— Any person aggrieved by any action or decision of an inspection service, the residual market facility, or the joint underwriting association may appeal to the Commission within thirty days from the action or the decision. The Commission shall provide the aggrieved person and the inspection service, the residual market facility, or the joint underwriting association an opportunity to be heard on not less than ten days' written notice. The Commission shall then issue an order (i) approving the action or decision, (ii) disapproving the action or decision, or (iii) directing the inspection service, the residual market facility or the joint underwriting association to reinspect the property, or place the application or cause it to be placed pursuant to its plan of operation, whichever is appropriate.

§ 38.2-2713. Obligations not to be impaired in event of repeal of chapter.—If the General Assembly repeals this chapter, (i) the obligations incurred by the residual market facility and the joint underwriting association and policies issued by either organization or by their members shall not be impaired by the repeal, and (ii) the residual market facility and joint underwriting association shall be continued until they

have fully performed their respective outstanding obligations.

Drafting Note: It would appear reasonable to apply this section to both entities, not just a JUA formed under § 38.2-2708.

Title 38.2

CHAPTER 28.

Medical Malpractice Joint Underwriting Association.

The following changes have been proposed for this Chapter:

1. The definition of "premiums written" has been changed to "net direct premiums written".

2. Section 38.1-776 (proposed § 38.2-2801) has been changed to include the provision, now §38.1-776.2, allowing the Commission to activate the Joint Underwriting Association (JUA) if market conditions indicate the need for one. The requirement that the Commission report annually to the General Assembly on whether or not this chapter should be repealed or amended has been deleted.

3. A new paragraph has been added to §38.1-776.1 (proposed § 38.2-2802) to clarify that any monetary contribution or assessment paid by a member to the association would be refunded before dissolution of the association.

4. Subsection F of § 38.1-781 (proposed § 38.2-2807) has been amended to clarify that preliminary organizational assessments shall be refunded to members upon dissolution of the association.

CHAPTER 28.

MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION.

§ 38.2-2800. Definitions.—As used in this chapter:

"Association" means the joint underwriting association established pursuant to the provisions of this chapter.

"Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of health care that: (i) cannot be obtained in the voluntary market because medical malpractice insurance is being provided pursuant to this chapter; and (ii) cannot be obtained through other involuntary market mechanisms.

"Liability insurance" includes the classes of insurance defined in §§ 38.2-117 through 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125, and 38.2-130 through 38.2-132.

"Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or failing to render professional service by any provider of health care.

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less, (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

"Provider of health care" means any of the following deemed by the Commission to be necessary for the delivery of health care: (i) a physician and any other individual licensed or certified pursuant to Chapter 12 (§ 54-273 et seq.) of Title 54 ; (ii) a nurse, dentist, or pharmacist licensed pursuant to Title 54; (iii) any health facility licensed or eligible for licensure pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 ; and (iv) any other group, type, or category of individual or health- related facility that the Commission finds to be necessary for the continued delivery of health care after providing notice and opportunity to be heard.

Drafting Note: Subsection (c) of § 38.1-279.31 (proposed § 38.2-1902) does not exempt insurance from regulation; it exempts certain insurers from regulation. The insurers exempted by subsection C of proposed § 38.2-1902 are exempted from participation in the association by an amendment to subsection A of proposed § 38.2-2801.

The other changes to this definition are necessitated by changes in Chapter 1, Article 2.

§ 38.2-2801. Association activation; members; purpose; determinations by Commission; powers of association.—A. After investigation, notice, and hearing, the Commission shall be empowered to activate a joint underwriting association if it finds that medical malpractice insurance cannot be made reasonably available in the voluntary market for a significant number of any class, type, or group of providers of health care. The association shall consist of all insurers licensed to write and engaged in writing liability insurance within this Commonwealth on a direct basis except those exempted from rate regulation by subsection C of § 38.2-1902. Each such insurer shall be a member of the association as a condition of its license to write liability insurance in this Commonwealth.

Drafting Note: The Joint Underwriting Association under the provisions of its enabling legislation was to cease to operate and to dissolve after July 1, 1980. The provision in existing § 38.1-776.2 allowing the Commission to reactivate the association should the Commission find it necessary has been moved to this section.

B. The purpose of the association shall be to provide a market for medical malpractice insurance on a self-supporting basis without subsidy from its members.

Drafting Note: The requirement that the Commission report annually to the General Assembly on whether or not this chapter should be repealed or amended has been deleted.

C. 1. The association shall not commence underwriting operations for any class, type or group of providers of health care until it is activated by the Commission. At the direction of the Commission, the association shall commence operations in accordance with the provisions of this chapter.

Drafting Note: The countersignature requirement of agents has been repealed by prior legislation. The deletion of the requirement here is intended to accord with this legislation.

2. If the Commission determines at any time that medical malpractice insurance can be made reasonably available in the voluntary market for any class, type or group of providers of health care, the association shall, at the direction of the Commission, cease its underwriting operations for that class, type or group of providers of health care.

D. The Commission shall also determine after investigation and a hearing whether the association shall be the exclusive source of medical malpractice insurance for any class, type or group of providers of health care and the type of policy or policies that shall be issued to any class, type or group of providers of health care. If the Commission determines that a claims-made policy will be issued to any class, type or group of providers of health care, the Commission shall also provide for the guaranteed availability of insurance that covers claims that (i) result from incidents occurring during periods when the basic claims-made policies are in force, and (ii) are reported after the expiration of the basic claims-made policies. The Commission may from time to time after an investigation and hearing reexamine and

reconsider any determination made pursuant to this subsection.

E. Pursuant to this chapter and the plan of operation required by § 38.2-2804, the association shall have the power on behalf of its members to : (i) issue, or cause to be issued, policies of medical malpractice insurance to applicants, including incidental coverages, subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under any one policy and three million dollars for all claimants under one policy in any one year; (ii) underwrite the insurance and adjust and pay losses on the insurance; (iii) appoint a service company or companies to perform the functions enumerated in this subsection; (iv) assume reinsurance from its members; and (v) reinsure its risks in whole or in part.

§ 38.2-2802. Dissolution.—A. When the association has ceased all of its underwriting operations by order of the Commission under subsection C of § 38.2-2801, it shall be subject during its continued existence to the following:

1. The association shall remain in existence for the sole purpose of completing its orderly dissolution;

2. The association shall refund to all of its members all assessments, contributions and other funds paid to the association that have not been reimbursed prior to dissolution; and

3. The board of the association shall satisfy and discharge its obligations and, subject to the approval of the Commission, shall have authority to do all other acts required to conclude its business affairs, including but not limited to, transfer of policies in force to approved carriers.

B. When the Commission finds the association has met its obligations incident to termination of its business affairs, the Commission shall by order issue a certificate of dissolution and the existence of the association shall cease.

Drafting Note: Under the proposed changes to this chapter, this section is no longer necessary. Proposed § 38.2-2801 as it is revised provides the Commission with the authority to activate a JUA when the need arises. Therefore, a "reactivation" section is not necessary.

§ 38.2-2803. Directors.—A. The association shall be governed by a board of fourteen directors. Two directors shall be appointed by each of the following three insurance industry trade associations: (i) the American Insurance Association; (ii) the Alliance of American Insurers; and (iii) the National Association of Independent Insurers. The Commission shall appoint two directors to represent insurers not affiliated with the insurance industry trade associations listed above. One director shall be appointed by each of the following two agent trade associations: (a) the Independent Insurance Agents of Virginia; and (b) the Professional Insurance Agents Association of Virginia and the District of Columbia. Two directors shall be appointed by the Medical Society of Virginia and two directors shall be appointed by the Virginia Hospital Association.

B. If any of the foregoing associations fail to appoint a director or directors within a reasonable period of time, the Commission shall have the power to make the appointments.

Drafting Note: The above changes reflect the fact that some of the trade associations have changed their names.

§ 38.2-2804. Plan of operation.—A. Within forty-five days of the date the Commission makes a determination to activate a joint underwriting association pursuant to subsection A of § 38.2-2801, the directors of the association shall submit to the Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for economic, fair and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance. The plan shall contain other provisions including (i) preliminary assessment of all members for initial expenses necessary to commence operations, (ii) establishment of necessary facilities, (iii) management of the association, (iv) temporary contribution of members to defray losses and expenses, (v) reasonable and objective minimum underwriting standards developed in consultation with the medical and hospital advisory committees provided for in § 38.2-2805, (vi) acceptance and cession of reinsurance, (vii) appointment of servicing carriers or other servicing arrangements, (viii) the establishment of premium payment plans, (ix) procedures for determining amounts of insurance to be provided by the association, (x) procedures for the recoupment of assessments and temporary contributions by members, and (xi) any other matters necessary for the efficient and equitable operation and termination of the association.

C. The plan of operation shall be subject to approval by the Commission after consultation with the members of the association and representatives of interested individuals and organizations. If the Commission disapproves all or any part of the proposed plan of operation, the directors shall within fifteen days submit for review an appropriate revised plan of operation. If the directors fail to do so, the Commission shall promulgate a plan of operation. The plan of operation approved or promulgated by the Commission shall become effective and operational upon order of the Commission.

D. Amendments to the plan of operation may be made by the directors of the association, subject to the approval of the Commission.

§ 38.2-2805. Medical and hospital advisory committees.—The Commission shall appoint a medical advisory committee to the association composed of five physicians licensed to practice medicine in this Commonwealth and a hospital advisory committee composed of five representatives of hospitals licensed in

this Commonwealth.

§ 38.2-2806. Policy forms; applicants to be issued policies; cancellation of policies; rates; examination of business of association.—A. All policies issued by the association shall be subject to the group retrospective rating plan and to the stabilization reserve fund required by § 38.2-2807. No policy form shall be used by the association unless it has been filed with the Commission and either (i) the Commission has approved it or (ii) thirty days have elapsed and the Commission has not disapproved it as misleading or in violation of public policy.

B. Policies shall be issued by the association, after receipt of the premium or portion of the premium prescribed by the plan of operation, to applicants that (i) meet the minimum underwriting standards, and (ii) have no unpaid or uncontested premium due as evidenced by the applicant having failed to make written objection to premium charges within thirty days after billing.

C. Any policy issued by the association may be cancelled for any one of the following reasons: (i) nonpayment of premium or portion of the premium; (ii) suspension or revocation of the insured's license ; (iii) failure of the insured to meet the minimum underwriting standards; (iv) failure of the insured to meet other minimum standards prescribed by the plan of operation; and (v) nonpayment of any stabilization reserve fund charge.

D. The rates, rating plans, rating rules, rating classifications, premium payment plans and territories applicable to the insurance written by the association, and related statistics shall be subject to the provisions of Chapter 20 of this title. Due consideration shall be given to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this Commonwealth, trends in the frequency and severity of losses, the investment income of the association, and other information the Commission requires. All rates shall be on an actuarially sound basis, giving due consideration to the group retrospective rating plan and the stabilization reserve fund, and shall be calculated to be self-supporting. The Commission shall take all appropriate steps to make available to the association the loss and expense experience of insurers writing or having written medical malpractice insurance in this Commonwealth.

E. All policies issued by the association shall be subject to a nonprofit group retrospective rating plan to be approved by the Commission under which the final premium for all policyholders of the association, as a group, will be equal to the administrative expenses, loss and loss adjustment expenses, and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net expenses and a reasonable management fee on policyholder supplied funds. Any additional premium resulting from a retrospective adjustment will first be collected from the stabilization fund set forth in § 38.2-2807. If those funds are insufficient to pay the entire amount due, the balance shall be collected through surcharges upon policyholders in accordance with a plan approved by the Commission.

F. In the event that sufficient funds are not available for the sound financial operation of the association, subject to recoupment as provided in this chapter and the plan of operation, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided in this chapter.

G. The Commission shall examine the business of the association as often as it deems appropriate to make certain that the group retrospective rating plan is being operated in a manner consistent with this section. If the Commission finds that it is not being operated in a manner consistent with this section, it shall issue an order to the association, specifying (i) how its operation is not consistent and (ii) stating what corrective action shall be taken.

§ 38.2-2807. Stabilization reserve fund.—A. When an association is activated under § 38.2-2801, a stabilization reserve fund shall be created. The fund shall be administered by five directors appointed by the Commission, one of whom shall be a representative of the Commission, two of whom shall be representatives of the association, and two of whom shall be representatives of the association's policyholders.

B. The directors shall act by majority vote with three directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the fund. The directors shall not be subject to any personal liability with respect to the administration of the fund.

C. Each policyholder shall pay to the association a stabilization reserve fund charge equal to one-half of the annual premium due for medical malpractice insurance through the association until the fund reaches a level deemed appropriate by the Commission. The means of payment shall be set forth in the plan of operation and such shall be separately stated in the policy. The association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge. Upon the termination of any policy during the term of the policy, payments made to the stabilization reserve fund shall be returned to the policyholder on a pro rata basis identical to that applied in computing that portion of the premium which is returned to the policyholder.

D. All moneys received by the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the moneys held in trust, subject to the approval of the directors. All investment income shall be credited to the fund. All expenses of administration of the fund shall be charged against the fund. The moneys held in trust shall be used solely for the purpose of

discharging when due any retrospective premium charges payable by policyholders of the association under the group retrospective rating plan provided for in this chapter. Payment of retrospective premium charges shall be made by the directors upon certification to them by the association of the amount due.

E. The association shall promptly pay the trustee of the fund all stabilization reserve fund charges that it collects from its policyholders and any retrospective premium refunds payable under the group retrospective rating plan provided for in this chapter.

F. Upon dissolution of the association, all assets remaining in the fund shall be distributed equitably to the policyholders who have contributed to the fund under procedures authorized by the directors. Distribution of assets remaining in the fund shall be made after final disposition of all claims, expenses, and liabilities against the fund, including reimbursement of temporary assessments made pursuant to subsection F of § 38.2-2806 and preliminary organizational assessments made pursuant to subsection B of § 38.2-2804.

Drafting Note: Subsection F has been amended to clarify that preliminary organizational assessments shall be refunded to members upon dissolution of the association.

§ 38.2-2808. Participation in association by insurers.– Each insurer that is a member of the association shall participate in the temporary contributions to finance the operation of the association in the proportion that the net direct premiums written by each member during the preceding calendar year bears to the aggregate net direct premiums written in this Commonwealth by all members of the association. However, the net direct premiums written by each member shall exclude that portion of premiums attributable to the operation of the association. Each insurer's participation in the association shall be determined annually on the basis of such premiums written during the preceding calendar year in the manner set forth in the plan of operation.

§ 38.2-2809. Review of actions or decisions of association.–Any insurer, applicant or other person aggrieved by any action or decision of the association or of any insurer as a result of its participation in the association, may appeal to the board of directors of the association. The decision of the board of directors may be appealed to the Commission within thirty days from the date the aggrieved person received notice of the board's action.

§ 38.2-2810. Annual statements.–The association shall file an annual statement with the Commission within three months of the close of each fiscal year. The annual statement shall contain information on its transactions, condition, operations and affairs during the preceding fiscal year. The form and content of the annual statement shall be subject to the Commission's approval. The Commission may at any time require the association to furnish additional information on its transactions, condition or any matter connected with the association considered to be material and of assistance in evaluating the scope, operation and experience of the association.

Drafting Note: The changes to this section are intended to provide a more flexible approach to reporting requirements.

§ 38.2-2811. Annual examination into affairs of association.–The Commission shall examine the affairs of the association at least annually. The examination shall be conducted and the report of the examination filed in the manner prescribed in §§ 38.2-1317 through 38.2-1321. The expenses of each examination shall be borne and paid by the association.

§ 38.2-2812. Public officers or employees.–No member of the board of directors of the stabilization reserve fund who is a public officer or employee shall forfeit his office or employment, or incur any loss or diminution in the rights and privileges associated with his office or employment, because of membership on the board.

§ 38.2-2813. Commissions for placing and servicing risk with association.–For any medical malpractice insurance or incidental coverage policy issued by the association, the commission payable to the person that places the risk with the joint underwriting association or services the risk shall be limited to five percent of the annual premium for the policy or $1,000, whichever is less.

§ 38.2-2814. Liability.–There shall be no liability imposed on the part of and no civil cause of action of any nature shall arise against the association, its board of directors, its agents, its employees, any service carrier, any participating insurer or its employees, any licensed producer, the Commission or its authorized representatives, the medical and hospital advisory committees, or their members or employees for any statements or actions made by them in good faith in carrying out the provisions of this chapter.

Drafting Note: Section 38.1-789 is a severability clause. It is being deleted here in favor of a title-wide severability clause.

CHAPTER 29.

[Reserved.]

CHAPTER 30.

UNINSURED MOTORISTS FUND.

§ 38.2-3000. Supervision and control of Fund by Commission; payments from Fund.—The Uninsured Motorists Fund, referred to in this chapter as the Fund, shall be under the supervision and control of the Commission. Payments from the Fund shall be made on warrants of the Comptroller issued on vouchers signed by a person designated by the Commission. The purpose of the Fund is to reduce the cost of the insurance required by subsection A of § 38.2-2206.

Drafting Note: The stated purpose of the Fund should not be to reduce the cost of motor vehicle liability insurance generally, but rather should agree with the current practice of using it to reduce the cost of uninsured motorist coverage specifically.

§ 38.2-3001. Distribution to insurers; records of loss experience as prerequisite to payment.—The Commission shall distribute moneys annually from the Fund among the several insurers writing motor vehicle bodily injury and property damage liability insurance on motor vehicles registered in this Commonwealth. Moneys shall be distributed in the proportion that each insurer's premium income for the basic uninsured motorists limits coverage bears to the total motorists limits premium income for basic uninsured coverage written in this Commonwealth during the preceding year. Premium income shall be gross premiums less cancellation and return premiums for coverage required by subsection A of § 38.2-2206. Only insurers that maintain records satisfactory to the Commission shall receive any payment from the Fund. Records shall be considered satisfactory if they adequately disclose the loss experience for the coverage required by subsection A of § 38.2-2206.

Drafting Note: This section is deleted as there is a comprehensive section enabling the Commission to issue rules and regulations.

Title 38.2

CHAPTER 31.

Life Insurance.

ARTICLE 1.

General Provisions.

The following substantive changes are proposed for Article 1:

1. In § 38.1-433 (proposed § 38.2-3102), the requirement that the Commission mail insurers a notice of reciprocal states has been deleted.

2. In § 38.1-434 (proposed § 38.2-3103), Fraudulent procurement of a policy; penalty, the section has been broadened to include "attempt to secure" in addition to "secure" or "cause to be secured".

3. In § 38.1-439 (proposed § 38.2-3109), a new sentence has been added to clarify that the reinstatement of a policy will not affect the running of the contestable period except as provided in this section, and an outdated sentence pertaining to reinstatements prior to 1950 has been deleted.

4. Existing §§ 38.1-408.1 and 38.1-422.1 have been combined into a new section, proposed § 38.2-3112, Designation of testamentary trustee, because of the overlap between the two sections.

5. In § 38.1-443 (proposed § 38.2-3113), a provision on rules and regulations was deleted because we are proposing one title-wide general rules and regulations section.

6. Proposed § 38.2-3116 has been added to provide a readability requirement for life insurance and annuities similar to the accident and sickness readability requirement, existing §38.1-354.1 (proposed § 38.2-3404).

7. Proposed § 38.2-3117 has been added to give the Commission authority to establish standards for variable life insurance, universal life insurance or similar types of life insurance policies and annuities.

ARTICLE 2.

Proceeds of Certain Policies.

The following substantive change is proposed for Article 2:

In § 38.1-449 (proposed § 38.2-3123), "householders or heads of families" has been changed to "householders", using the same definition for "householder" as in §34-1.

ARTICLE 3.

Reserves.

Changes in this article are purely editorial. Existing § 38.1-456 has been subdivided into thirteen new sections (proposed §§ 38.2-3130 through 38.2-3142) to improve the organization of the article. There are no substantive changes intended in this article.

CHAPTER 31.

LIFE INSURANCE.

Article 1.

General Provisions.

§ 38.2-3100. Scope of chapter.—Except as otherwise provided, this chapter applies to insurers transacting life insurance and the granting of annuities, and to life insurance and annuities as defined in §§ 38.2-102 through 38.2-107.

Drafting Note: The cross-references have been expanded to include the new definitions of credit life, industrial life, variable life and variable annuity. This is not intended to be a substantive change.

§ 38.2-3101. Legal reserve insurers.—Any life insurer, association or society whose policies or certificates are required to contain any provision that a person insured shall, upon surrender of the policy during his lifetime, receive a surrender value, either in cash, paid-up insurance, or extended insurance, shall be regarded as a "legal reserve insurer," and shall maintain a reserve calculated in accordance with the provisions of Article 3 (§ 38.2-3126 et seq.) of this chapter. Nothing in this section shall be construed to apply to any insurer in the transaction of industrial sick benefit insurance as defined in § 38.2-3544, nor to fraternal benefit societies.

§ 38.2-3102. Domestic insurers prohibited from insuring lives and persons of residents of "reciprocal states."—A. As used in this section, "reciprocal state" means a state whose laws prohibit its domestic insurers from insuring the lives or persons of residents of this Commonwealth unless the insurer is licensed in this Commonwealth. The prohibition may be subject to exceptions similar to those set forth in subsection C of this section.

B. Subject to the exceptions set forth in subsection C of this section, a domestic insurer shall not enter into an insurance contract upon the life or person of a resident of a reciprocal state unless the insurer is licensed in that state.

Drafting Note: The requirement that the Commission mail insurers a notice specifying reciprocal states has been deleted.

C. The following are exceptions to the provisions of subsection B of this section:

1. Contracts entered into when the person insured, or proposed to be insured, is, at the time he signs the application, personally present in a state where the insurer is licensed;

2. Certificates issued under any lawfully issued group life or group accident and sickness policy, when the group policy is entered into in a state where the insurer is licensed ;

3. Contracts made pursuant to a pension or retirement plan of an employer, when the contracts are applied for in a state where the employer is personally present or doing business and where the insurer is also licensed; or

4. Contracts renewed, reinstated, converted, or continued in force, with or without modification, that are otherwise lawful and that were not originally executed in violation of this section.

§ 38.2-3103. Fraudulent procurement of policy; penalty.—A. No person shall knowingly secure, attempt to secure or cause to be secured a life insurance policy on any person who is not in an insurable condition by means of misrepresentations or false or fraudulent statements.

B. An insurance agent who violates this section shall be subject to penalties under § 38.2-1831 in addition to the penalties of § 38.2-218.

Drafting Notes: 1. The section has been broadened to include "attempt to secure".

2. The reference to "agents and physicians" was deleted because they would be included in "person" as it is defined in proposed § 38.2-100.

3. A reference to agents being subject to license revocation under proposed § 38.2-1831 has been added.

§ 38.2-3104. No policy to be issued purporting to take effect more than six months before application made; conversion permitted.- A. No life insurance policy delivered or issued for delivery in this Commonwealth shall be backdated more than six months from the date the written application for the insurance was made if the premium on the policy is less than the premium that would be payable on the policy, as determined by the nearest birthday of the insured when the application was made.

B. Neither the provisions of subsection A of this section nor any other provision of general law shall prohibit the conversion or exchange to some form of life insurance dated back to become effective at an age not less than the insured's age at his nearest birthday on the date of issue of the existing contract for:

1. A policy insuring one person for a policy insuring another person dated not earlier than the original policy exchanged;

2. The conversion of any existing life insurance policy; or

3. Any deferred annuity contract purchased by a consideration payable in annual or more frequent installments, and under which no annuity payments have yet been made.

The exchanged or converted form of life insurance shall not exceed the greater of (i) the amount of insurance under the existing policy or (ii) the amount of insurance that the premium or consideration paid for the existing policy or contract would have purchased at the insured's age on his nearest birthday at the date of issue of the existing policy or contract.

§ 38.2-3105. What contracts with respect to life insurance may be made by minors.—A. A minor who is at least fifteen years of age:

1. Shall be competent to contract for life insurance upon his own life for his own benefit or for the benefit of his ascending or descending kindred, spouse, brothers or sisters;

2. May exercise every right, privilege and benefit provided by any life insurance policy on his own life, subject to the foregoing limitations as to designation of beneficiary; and

3. Shall not be permitted to recover any premiums paid on the policy solely because he is a minor.

B. If the minor resides with at least one of his parents, the application for the policy shall be approved in writing by the parent with whom he resides. No promissory note or other evidence of debt given by a minor in payment of any first year premium on a policy shall be validated by this section.

C. Any such minor shall be competent to give a valid discharge for any benefit accruing or money payable under the policy, and to create liens on the policy in favor of the insurer issuing the policy for money borrowed or for unpaid premiums and interest on the policy. However, any beneficiary or beneficiaries named in the policy who are then at least fifteen years of age shall unite in the discharge or in the instrument creating the lien.

§ 38.2-3106. Suicide and execution not grounds of defense; exception.—A. Except as provided in subsection B of this section, the fact that an insured committed suicide, or was executed under law, shall not be a defense in any action, motion or other proceeding on a life insurance policy that (i) was issued to any person residing in this Commonwealth at the time of issuance, or (ii) is otherwise subject to the laws of this Commonwealth, to recover for the death of that person.

B. An express provision in the body of the policy limiting the liability of the insurer to an insured who, whether sane or insane, dies by his own act within two years from the date of the policy shall be valid but the insurer shall be obligated to return or pay at the least the amount of the premium paid for the policy.

§ 38.2-3107. Incontestability of certain policies.—A. No life insurance policy shall be contestable after it has been in force during the lifetime of the insured for two years from its date, except for nonpayment of premiums.

B. Provisions relating to benefits in event of disability, and provisions granting additional insurance specifically against death by accident or accidental means may be exempted in an incontestability provision.

§ 38.2-3108. Misstatement of age.— Each life insurance policy shall contain a provision that, if at any time before final settlement under the policy the age of the insured, or the age of any other person if considered in determining the premium, is found to have been misstated, the amount payable under the policy shall be the amount that the premium would have purchased at the correct age at the time the policy was issued.

§ 38.2-3109. Contestability of reinstated policy.—Reinstatement of a life insurance policy shall not affect the running of the contestable period except as provided in this section. A life insurance policy reinstated after the effective date of this section, regardless of whether the original policy was issued before or after the effective date, shall be contestable on account of fraud or misrepresentation of any material fact pertaining to the reinstatement contained in a written application for reinstatement, or in any written statement supplemental to the application for reinstatement, only for the same period after reinstatement as the policy provides for contestability after original issue.

§ 38.2-3110. Incontestability not applicable to excluded or restricted coverage.— Any life insurance policy provision stating that the policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy that exclude or restrict coverages, whether or not those restrictions or exclusions are excepted in the incontestability provision.

§ 38.2-3111. Assignment of life insurance policies.— No life insurance policy shall be taken out by the insured or by a person having an insurable interest in the insured's life for the mere purpose of assignment. A policy may be assigned whether or not the assignee has an insurable interest in the life insured unless the policy provides otherwise.

Drafting Note: Existing §§ 38.1-408.1 and 38.1-442.1 have been combined into a new section, proposed § 38.2-3112, because of the overlap between the two sections.

§ 38.2-3112. Designation of testamentary trustee as beneficiary. —A. A life insurance policy may designate as beneficiary a trustee or trustees named or to be named by will if the designation is made in accordance with the provisions of the policy and the requirements of the insurer issuing the policy.

B. A trustee may qualify immediately after probate of the will. Upon appointment and qualification of a trustee, the proceeds of the insurance shall be paid to the trustee to be held and disposed of under the terms of the will. If there is no valid will appointing a trustee or if the trust provided by the will is invalid for any other cause, the designation of a trustee as beneficiary of the policy shall be void. If no qualified trustee makes claim to the proceeds from the insurer within one year after the death of the insured, or if satisfactory evidence is furnished to the insurer within the one-year period showing that no trustee can qualify to receive the proceeds, payment shall be made by the insurer to the executors, administrators or assigns of the insured, unless otherwise provided for by the owner of the policy, if the owner is other than the insured, or by the insured by agreement with the insurer.

C. The proceeds of the insurance as collected by a trustee shall not be subject to debts of the insured nor to estate taxes to any greater extent than if the proceeds were payable to any other named beneficiary other than the estate of the insured.

D. For purposes of trust administration, the proceeds shall be subject to the court's jurisdiction over the trust as in any other testamentary trust, but the proceeds shall not be considered as payable to the estate of the insured.

E. This section does not authorize payment of policy proceeds to any testamentary trustee who is not otherwise qualified to act as a testamentary trustee. A qualified substitute trustee may be appointed to perform the trust provided by the will.

F. Enactment of this section shall not be construed as casting any doubt upon the validity of any previous life insurance policy beneficiary designations naming trustees of a trust established or to be established by will.

G. As used in this section, "life insurance policy" shall include other types of contracts under which proceeds become payable on the death of the testator to the end that interests other than those described as "life insurance" may be made payable or transferred to a trustee named or to be named in a will in the same manner and to the same extent they could be made payable to or transferable to any other person.

§ 38.2-3113. Variable life insurance and variable annuities; separate accounts to be established; authority to issue; reports; special voting rights and procedures for owners.—A. Each domestic insurer that issues life insurance or annuities providing for payments that vary directly according to investment experience shall establish one or more separate accounts in connection with these types of life insurance or annuities. All amounts received by the insurer that are required by contract to be applied to provide for variable payments shall be added to the appropriate separate account. The assets of any such separate account shall not be chargeable with liabilities arising out of any other business the insurer may conduct. Any surplus or deficit that may arise in any separate account by virtue of mortality experience shall be adjusted by withdrawals from or additions to the account so that the assets of the account shall always at least equal the assets required to satisfy the insurer's obligations for the variable payments.

B. A foreign or alien insurer licensed to do business in this Commonwealth may be licensed to deliver or issue for delivery life insurance or annuity contracts in this Commonwealth providing for payments which vary directly according to investment experience only if authorized to issue such life insurance or annuity contracts under the laws of its domicile.

C. No domestic, foreign, or alien insurer shall be licensed to deliver or issue for delivery variable life insurance or variable annuity contracts in this Commonwealth, until the insurer has satisfied the Commission that its condition and methods of operation in connection with the issuance of variable life insurance or variable annuity contracts will not render its operation hazardous to the public or to its policyholders in this Commonwealth. In determining the qualification of an insurer to deliver or issue for delivery such variable life insurance or variable annuity contracts in this Commonwealth, the Commission shall consider, but shall not be limited to considering, the following: (i) the history and financial condition of the insurer; (ii) the character, responsibility, and general fitness of the officers and directors of the insurer; and, (iii) in the case of a foreign or alien insurer, whether the regulation provided by the laws of its domicile provides a degree of protection to policyholders and the public substantially equal to that provided by this section and any rules and regulations issued by the Commission.

D. Each insurer that delivers or issues for delivery variable life insurance or variable annuity contracts in this Commonwealth shall file with the Commission, in addition to the annual statement required by § 38.2-1300, any other periodic or special reports the Commission prescribes.

E. The provisions of this section shall not apply to any contracts or policies which do not provide for payments which vary directly according to investment experience.

F. Any domestic life insurer that establishes one or more separate accounts pursuant to this section may amend its charter to provide for special voting rights and procedures for the owners of variable life insurance or variable annuity contracts relating to investment policy, investment advisory services and selection of certified public accountants, in relation to the administration of the assets in any such separate account. This subsection shall not in any way affect existing laws pertaining to the voting rights of the

insurer's policyholders.

Drafting Note: Subsection (f) has been eliminated because of the title-wide rules and regulations section in proposed Chapter 2.

§ 38.2-3114. Statements required in variable life insurance and variable annuity contracts and certificates issued pursuant to group variable life insurance and group variable annuity contracts.—Any variable life insurance or variable annuity contract delivered or issued for delivery in this Commonwealth, and any certificate evidencing variable benefits issued pursuant to any life insurance or annuity contract issued on a group basis shall:

1. State the essential features of the procedure to be followed by the insurer in determining the value of benefits or other contractual payments under the contract;

2. State clearly that the benefits may decrease or increase according to the procedure; and

3. State clearly on its first page that the benefits or other contractual payments are on a variable basis.

Drafting Note: Except for editorial changes, this new section is the same as existing § 38.1-408. No change was intended.

§ 38.2-3115. Interest on life insurance proceeds.—A. If an action to recover the proceeds due under a life insurance policy or annuity contract results in a judgment against the insurer, interest on the judgment at the legal rate of interest shall be paid from (i) the date of presentation to the insurer of proof of death on a life insurance policy or annuity contract or (ii) the date of maturity of an endowment policy to the date judgment is entered.

B. If no action is brought, interest upon the principal sum paid to the beneficiary or policyowner shall be computed daily at an annual rate of two and one-half percent or at the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater, commencing from the date of death on a life insurance policy or annuity contract claim and from the date of maturity of an endowment contract to the date of payment. The interest shall be added to and become a part of the total sum payable.

C. No insurer shall be required to pay interest computed under this section if the total interest is less than five dollars.

D. This section shall not apply to policies or contracts issued prior to July 1, 1977, but shall apply to any renewals or reissues of group life insurance policies or contracts occurring after that date.

§ 38.2-3116. Commission to establish standards for simplified and readable life insurance and annuity policies.—A Pursuant to the authority granted under § 38.2-223, the Commission may issue rules and regulations establishing standards for simplified and readable life insurance policies and annuity contracts. The standards shall apply to all policy forms for annuities as defined in §§ 38.2-106 and 38.2-107 and life insurance as defined in §§ 38.2-102 through 38.2-105.

B. As used in this section, "policy form" means:

1. Any individual life insurance policy, plan or agreement, and any annuity contract delivered or issued for delivery in this Commonwealth;

2. Any policy, certificate or contract, including any riders, endorsements or amendments providing death benefits, delivered or issued for delivery in this Commonwealth by a fraternal benefit society;

3. Any group life insurance policy, contract, plan or agreement, including any riders, endorsements or amendments, delivered or issued for delivery in this Commonwealth, to a group with ten or fewer members; or

4. Any certificate, including any riders, endorsements or amendments, issued under a group life insurance policy delivered or issued for delivery in this Commonwealth.

C. No insurer shall issue a life insurance policy that has been filed with the Commission unless the Commission has determined that the policy form satisfies the readability standards established by the rules and regulations and complies with other statutory requirements.

Drafting Note: This new readability requirement is similar to the accident and sickness readability requirement, § 38.1-354.1 (proposed § 38.2-3404).

§ 38.2-3117. Standards for certain policies; prohibited policies.—A. Pursuant to the authority granted under § 38.2-223, the Commission may issue rules and regulations that may include but shall not be limited to policy provisions, definitions, standards for full and fair disclosure and standards for minimum benefits, for variable life insurance policies, universal life insurance policies or other nontraditional types of life insurance policies, annuities and variable annuities.

B. The Commission may prescribe the method of identification of policies and contracts based upon coverage provided.

C. The Commission may issue rules and regulations that specify prohibited policies or policy provisions

not otherwise specifically authorized by statute which in the opinion of the Commission are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary, owner, or any other person insured under the policy.

Drafting Note: This new section would provide the Commission with more authority to set standards for forms for the many new life insurance products.

Article 2.

Proceeds of Certain Policies.

§ 38.2-3118. Spendthrift trusts created under life insurance policies.—If, under the terms of any life insurance policy or of any written agreement supplemental to a life insurance policy, the proceeds are retained by the insurer at maturity or otherwise, no person entitled to any part of the proceeds, or to any installment of interest due or becoming due, may commute, anticipate, encumber, alienate or assign the proceeds or any part of the proceeds or interest if permission is expressly withheld by the terms of the policy or supplemental agreement. If the life insurance policy or supplemental agreement provides, no payments of interest or principal shall be in any way subject to the person's debts, contracts or engagements, nor to any judicial process to levy upon or attach the interest or principal for payment of those debts, contracts, or engagements.

§ 38.2-3119. Limitation on § 38.2-3118. —A. The provisions of § 38.2-3118 shall not apply to any proportionate part of the proceeds of any such policy or supplemental contract mentioned in § 38.2-3118 arising or resulting from premiums paid by the beneficiary. The proportionate part of the proceeds shall be determined by comparing the total premiums paid for the policy, without interest, with the premiums for the policy, without interest, paid by the beneficiary.

B. Notwithstanding the other provisions of this section, an insurer who (i) has no written notice of any claim that premiums have been paid by the beneficiary and (ii) has no written notice of an adverse claim of any other character under this section, shall be protected in making or withholding payments pursuant to the terms of a policy or supplemental agreement.

C. Notwithstanding the other provisions of this section, upon an insurer's acceptance of proof that premiums have been paid by the beneficiary and the insurer's payment of the corresponding proportionate part of the proceeds of the policy or supplemental agreement, the insurer's payment shall constitute full release of the insurer from all liability with respect to the proportionate part of the proceeds of the policy or supplemental agreement.

§ 38.2-3120. Application of exemptions; protection of insurer; applicability of § 55-19.— The exemption from the debts of the beneficiary provided under §§ 38.2-3118 and 38.2-3119 and any similar exemption available to any beneficiary under the provisions of § 55-19 shall not exceed in the aggregate the amount prescribed in § 55-19. The beneficiary shall make an election as to the manner in which the exemptions shall be applied as between the proceeds of life insurance policies and estates in trust, and the election of the beneficiary shall be binding on all creditors. In the absence of notice of an adverse claim under this section, an insurer shall be protected in making or withholding payments pursuant to the terms of a policy or supplemental agreement referred to in §§ 38.2-3118 and 38.2-3119.

§ 38.2-3121. Segregation of proceeds not required.—No insurer holding the proceeds of any policy mentioned in § 38.2-3118 shall be required to segregate the proceeds but may hold them as a part of its general corporate funds.

§ 38.2-3122. Proceeds of policies payable to others free of claims against insured.— The assignee or lawful beneficiary of an insurance policy shall be entitled to its proceeds against any claims of the creditors or representatives of the insured or the person effecting the policy, except in cases of transfer with intent to defraud creditors, subject to the following conditions:

1. The policy shall have been effected by a person on his own life or on another life, in favor of a person other than himself;

2. The assignee of the policy, or the payee, if the policy is otherwise made payable to another, shall not be the insured, nor the person effecting the policy, nor the executors or administrators;

3. The right to change the beneficiary may or may not have been reserved or permitted;

4. The policy may be payable to the person whose life is insured if the beneficiary or assignee predeceases the insured; and

5. Subject to the statute of limitations, the amount of any premiums for such policy paid with the intent to defraud creditors, or paid under such circumstances as to be void under § 55-81, with the interest thereon, shall be to the benefit of the creditors from the proceeds of the policy.

§ 38.2-3123. Amount of proceeds limited in certain cases.—A. In the case of policies under whose terms the right to change the beneficiary is reserved and as to which the cash surrender or loan value of the policy is claimed by the creditors, the insurance shall not be entitled to the protection afforded by § 38.2-3122. However, householders or their beneficiaries or their assignees shall be entitled to the protection

afforded by § 38.2-3122 for such insurance not exceeding $10,000. When the amount of insurance represented by two or more policies exceeds that limit, the protection afforded by § 38.2-3122 shall be allowed as to each of the policies pro rata in accordance with the respective annual premiums involved.

B. For the purpose of this section, "householder" includes any person, married or unmarried, who maintains a separate residence or living quarters, whether or not others are living with him.

Drafting Note: In § 34-1, homestead and other exemptions, the definition of householder has been changed so "householder" and "householder or head of family" no longer have the same meaning. § 38.2-3123 now uses the same definition as § 34-1.

§ 38.2-3124. Protection of insurers from creditor's claims.—Notwithstanding §§ 38.2-3122 and 38.2-3123 any insurer issuing any insurance policy shall be discharged of all liability on that policy by payment of its proceeds in accordance with its terms, unless before payment the insurer receives written notice by or on behalf of a creditor of a claim, stating the amount claimed and the nature of the claim.

§ 38.2-3125. Other rights of beneficiaries and assignees protected. —Since the purpose of §§ 38.2-3122 and 38.2-3123 is to confer additional rights, privileges and benefits upon beneficiaries and assignees of policies, no beneficiary or assignee shall by reason of these sections be divested or deprived of or prohibited from exercising or enjoying any right, privilege or benefit that he would have or could exercise or enjoy had §§ 38.2-3122 and 38.2-3123 not been enacted.

Article 3.

Reserves.

§ 38.2-3126. Annual valuation of reserves.—The Commission shall annually value or have valued the reserve liabilities, referred to in this article as "reserves," for all outstanding life insurance policies and annuity and pure endowment contracts of each life insurer doing business in this Commonwealth. For an alien insurer the valuation shall be limited to its United States business. The Commission may certify the amount of the reserves, specifying the mortality table, interest rates and net level premium or other methods to be used in calculating the reserves. In calculating the reserves, the Commission may use group methods and approximate averages for suitable periods. The Commission may accept a certificate of valuation from the insurer for the reserve liability for the disability provision incorporated in life insurance policies if the Commission is satisfied, by using general averages and percentages, that the reserve has been computed in accordance with this article.

§ 38.2-3127. Acceptance of valuation of another state.—A. Instead of the valuation of the reserves required of any foreign or alien insurer under § 38.2-3126, the Commission may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction if (i) the valuation complies with the minimum standards of this article and (ii) the official of the jurisdiction accepts, as sufficient and valid for all legal purposes, the certificate of valuation of the Commission when that certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

B. Each foreign or alien insurer shall annually furnish to the Commission a certificate from the insurance supervisory official of its state of domicile or entry into the United States that he has made a valuation of the insurer's policies in force on December 31, and that he finds the value of the policies to be as reported in the insurer's annual statement. The certificate shall be due at the time the annual statement is due. Any insurer failing to furnish this certificate shall have its policies valued by the Commission as provided in § 38.2-3126.

§ 38.2-3128. Decrease of standards higher than minimum.—Each insurer that has adopted a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this article may, with the approval of the Commission, adopt any lower standard of valuation that equals or exceeds the minimum provided in this article.

§ 38.2-3129. Minimum valuation standard for policies issued prior to certain dates.—This section shall apply only to those policies and contracts issued prior to the operative date stated in § 38.2-3214.

1. The legal minimum standard for the valuation of life insurance contracts issued prior to January 1, 1937, shall be on the basis of the American Experience Table of Mortality, with interest at four percent per year, and strictly in accordance with the terms and conditions of such contracts, and for life insurance contracts issued on and after that date shall be the one-year preliminary term method of valuation, as hereinafter modified, on the basis of the American Experience Table of Mortality or at the option of the insurer, the American Men Ultimate Table of Mortality with interest at three and one-half percent per year.

2. If the net renewal premium under a limited payment life preliminary term policy providing for the payment of less than twenty annual premiums under the policy, or under an endowment preliminary term policy, exceeds that under a twenty payment life preliminary term policy, the reserve for that policy at the end of any year, including the first, shall be at least the reserve on a twenty payment life preliminary term policy issued in the same year and at the same age, together with an amount equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment maturing one year after

the date on which the last annual premium is due, or at the end of twenty years if the policy provides for the payment of premiums for more than twenty years, equal to the difference between the value on the maturity date of a twenty payment life preliminary term policy and the full net level premium reserve at such time of such a limited payment life or endowment policy. Policies valued by the above method shall contain a clause specifying either that the reserve of the policies shall be computed in accordance with the twenty payment life modification of the preliminary term method of valuation, or that the first year's insurance is term insurance.

3. Except as otherwise provided in § 38.2-3131 for group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities issued on and after January 1, 1937, shall be the Combined Annuity Table, with interest at four percent per year, but annuities deferred ten or more years and written in connection with life insurance shall be valued on the same basis as that used in computing the consideration or premium for the life insurance, or upon any higher standard, at the insurer's option.

4. The legal minimum standard for the calculation of the reserve liability for insurance against disability incorporated in life insurance policies issued on and after January 1, 1937, shall be on the basis of any table adopted by the insurer and approved by the Commission, with interest at three and one-half percent per year. However, in no case shall such liability be less than one-half of the net annual premium for the disability benefit computed by the table.

5. The legal standard for the valuation of group insurance written as yearly renewable term insurance issued on and after January 1, 1937, shall be on the basis of the American Men Ultimate Table of Mortality with interest at three and one-half percent per year.

6. The legal minimum standard for the valuation of industrial policies issued on and after January 1, 1937, shall be the American Experience Table of Mortality, with interest at three and one-half percent per year; however, any insurer may voluntarily value its industrial policies on the basis of the standard industrial mortality table or the substandard industrial mortality table, and by the level net premium method or in accordance with their terms by the modified preliminary term method as described in paragraph 2 of this section, or the full preliminary term method.

All industrial policies issued on and after January 1, 1937, shall be valued under the rules set forth in this section, whether or not the policies provide for surrender values, either in cash, paid-up insurance, or extended insurance.

7. The Commission may vary the standards of interest and mortality in the case of alien insurers as to contracts issued by those insurers in countries other than the United States, and in particular cases of invalid lives and other extra hazards.

8. If the actual annual premium charged for insurance is less than the net annual premium for the insurance, computed as specified in this section, the insurer shall set up an additional reserve equal to the value of an annuity of the difference between the actual premium charged and the net premium required by this section, and the term of which at the date of the valuation shall equal the period during which future premium payments are to become due on the insurance. The annuity shall be valued according to the table of mortality with the rate of interest at which the net annual premium is calculated.

9. Reserves for all of these policies and contracts, or all of any class of these policies and contracts, may be calculated, at the insurer's option, according to any standards which produce greater aggregate reserves for all the policies and contracts, or all of the class of the policies and contracts so valued, than the minimum reserves required by this section; and in each case the insurer shall report to the Commission in its annual statement the standards it used in making the valuation.

Drafting Note: Proposed § 38.2-3129 applies only to policies and contracts previously issued. The repeal or alteration of this section has no effect on those policies already issued as they were subject to the law existing at the time of their issuance. Therefore, the section is being kept for reference only.

Drafting Note: Former § 38.1-456 (proposed §§ 38.2-3130 through 38.2-3142) below has been reorganized into 13 sections to improve the internal cross-references and make the section less cumbersome.

§ 38.2-3130. Minimum valuation standard of policies subsequently issued.—This section shall apply only to those policies and contracts issued on or after the operative date stated in § 38.2-3214, except as provided in this article and except as otherwise provided in §§ 38.2-3131 through 38.2-3136 for group annuity and pure endowment contracts issued before the operative date.

Except as otherwise provided in §§ 38.2-3131 through 38.2-3136, the minimum standard for the valuation of all such policies and contracts shall be the Commissioners reserve valuation methods defined in §§ 38.2-3137, 38.2-3138 and 38.2-3141, three and one-half percent interest, or for policies and contracts other than annuity and pure endowment contracts issued on or after July 1, 1975, four percent interest for such policies issued before July 1, 1979, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other policies issued on or after July 1, 1979, and the following tables:

1. For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in those policies, the Commissioners 1941 Standard Ordinary Mortality Table for those policies issued before the operative date of § 38.2-3215, and the Commissioners 1958 Standard Ordinary Mortality Table for those policies issued on or after the operative date of § 38.2-3215 and before

the operative date of § 38.2-3209. For any category of those policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured. For policies issued on or after the operative date of § 38.2-3209 (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those policies.

2. For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in those policies, the 1941 Standard Industrial Mortality Table for those policies issued before the operative date of § 38.2-3216, and for those policies issued on or after that operative date the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those policies.

3. For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in those contracts–the 1937 Standard Annuity Mortality Table or, at the insurer's option, the Annuity Mortality Table for 1949 Ultimate, or any modification of those tables approved by the Commission.

4. For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in those contracts–the Group Annuity Mortality Table for 1951, any modification of that table approved by the Commission, or, at the insurer's option, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

5. For total and permanent disability benefits in or supplementary to ordinary policies or contracts–for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either those tables or, at the insurer's option, the Class (3) Disability Table (1926); and for policies issued before January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

6. For accidental death benefits in or supplementary to policies–for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those policies; for policies issued on or after January 1, 1961, and before January 1, 1966, either that table or, at the insurer's option, the Inter-Company Double Indemnity Mortality Table; and for policies issued before January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

7. For group life insurance, life insurance issued on the substandard basis and other special benefits, any table approved by the Commission.

§ 38.2-3131. Minimum valuation standard for annuities subsequently issued. –A. Except as provided in §§ 38.2-3132 through 38.2-3136, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section as defined herein, and for all annuities and pure endowments purchased on or after that date under group annuity and pure endowment contracts, shall be the Commissioners reserve valuation methods defined in §§ 38.2-3137 and 38.2-3138 and the following tables and interest rates:

1. For individual annuity and pure endowment contracts issued before July 1, 1979, excluding any disability and accidental death benefits in those contracts–the 1971 Individual Annuity Mortality Table, or any modification of that table approved by the Commission, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts.

2. For individual single premium immediate annuity contracts issued on or after July 1, 1979, excluding any disability and accidental death benefits in those contracts–the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those contracts, or any modification of those tables approved by the Commission, and seven and one-half percent interest.

3. For individual annuity and pure endowment contracts issued on or after July 1, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in those individual annuity and pure endowment contracts–the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those contracts, or any modification of those tables approved by the Commission, and five and one-half percent interest for single premium deferred annuity and pure

endowment contracts and four and one-half percent interest for all other individual annuity and pure endowment contracts.

4. For all annuities and pure endowments purchased before July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts—the 1971 Group Annuity Mortality Table, or any modification of that table approved by the Commission, and six percent interest.

5. For all annuities and pure endowments purchased on or after July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts—the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commission for use in determining the minimum standard of valuation for those annuities and pure endowments, or any modification of those tables approved by the Commission, and seven and one-half percent interest.

B. After July 1, 1975, any insurer may file with the Commission a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for that insurer; however, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this section for that insurer shall be January 1, 1979.

§ 38.2-3132. Computation of minimum valuation standard of policies subsequently issued. —The interest rates used in determining the minimum standard for the valuation of the following items shall be the calendar year statutory valuation interest rates as defined in §§ 38.2-3130 through 38.2-3136:

1. All life insurance policies issued in a particular calendar year, on or after the operative date of § 38.2-3209;

2. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1983, except that an insurer may elect for this to apply to all individual annuity and pure endowment contracts issued after July 1, 1982;

3. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1983, under group annuity and pure endowment contracts; and

4. Any net increase in a particular calendar year after January 1, 1983, in amounts held under guaranteed interest contracts.

§ 38.2-3133. Calendar year statutory valuation interest rates.—A. The calendar year statutory valuation interest rates, referred to in this section as " I, " shall be determined as follows and the results rounded to the nearest one-quarter of one percent:

1. For life insurance,

$I = .03 + W (R1 - .03) + (W/2) (R2 - .09)$

where R1 is the lesser of R and.09,

R2 is the greater of R and.09,

R is the reference interest rate defined in § 38.2-3135, and

W is the weighting factor defined in § 38.2-3134;

2. For single premium immediate annuities, and for annuity benefits involving life contingencies arising from other annuities with cash settlement options, and from guaranteed interest contracts with cash settlement options,

$I = .03 + W (R - .03)$

where

R is the reference interest rate defined in § 38.2-3135, and

W is the weighting factor defined in § 38.2-3134;

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in paragraph 2 of this subsection, the formula for life insurance stated in paragraph 1 of this subsection shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years. The formula for single premium immediate annuities stated in paragraph 2 of this subsection shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

4. For other annuities with no cash settlement options and for guaranteed interest contracts with no

cash settlement options, the formula for single premium immediate annuities stated in paragraph 2 of this subsection shall apply;

5. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in paragraph 2 of this subsection shall apply.

B. However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for life insurance policies shall equal the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined for 1979, and shall be determined for each later calendar year regardless of when § 38.2-3209 becomes operative.

§ 38.2-3134. Weighting factors. –The weighting factors referred to in the formulas in § 38.2-3133 are given in the following tables:

1. Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both that are guaranteed in the original policy.

2. Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contract with cash settlement options:

.80

3. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in paragraph 2 of this section, shall be as specified in tables a, b, and c below, according to the rules and definitions in paragraphs 4, 5 and 6 of this section:

a. For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

b.	Plan Type A	B	C
For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in table a increased by:	.15	.25	.05

c.	Plan Type A	B	C
For annuities and guaranteed interest contracts valued on an issue year basis , other than those with no cash settlement options , that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors			

shown in table a or derived
in table b increased by:
.05 . 05 .05

4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rates for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to begin.

5. Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholders may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, (ii) without that adjustment but in installments over five years or more, (iii) as an immediate life annuity, or (iv) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, (ii) without that adjustment but in installments over five years or more, or (iii) no withdrawal permitted. At the end of the interest rate guarantee, funds may be withdrawn without the adjustment in a single sum or in installments over less than five years.

Plan Type C: The policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or in installments over less than five years either (i) without adjustment to reflect changes in interest rate or asset values since receipt of the funds by the insurer, or (ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

6. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change-in-fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis. As used in §§ 38.2-3132 through 38.2-3136, an issue-year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract. As used in §§ 38.2-3132 through 38.2-3136, the change-in-fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

§ 38.2-3135. Reference interest rate. –The reference interest rate referred to in § 38.2-3133 means:

1. For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average–Monthly Average Corporates, as published by Moody's Investors Service, Inc.

2. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of Moody's Corporate Bond Yield Average–Monthly Average Corporates, as published by Moody's Investors Service, Inc.

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in paragraph 2 of this section, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average–Monthly Average Corporates, as published by Moody's Investors Service, Inc.

4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in paragraph 2 of this section, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average–Monthly Average Corporates, as published by Moody's Investors Service, Inc.

5. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average–Monthly Average Corporates, as published by Moody's Investors Service, Inc.

6. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, except as stated in paragraph 2 of this section, the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average–Monthly Average Corporates, as published by Moody's

Investors Service, Inc.

§ 38.2-3136. Alternative method for determining reference interest rates. –If Moody's Corporate Bond Yield Average–Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or if the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average–Monthly Average Corporates as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate as defined in § 38.2-3135, then an alternative method for determination of the reference interest rate may be substituted if it is adopted by the National Association of Insurance Commissioners and approved by the Commission.

§ 38.2-3137. Reserve valuation method–life insurance and endowment benefits. –A. Except as otherwise provided in §§ 38.2-3138 and 38.2-3141, reserves according to the Commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be any excess of the present value at the date of valuation of any future guaranteed benefits provided for by those policies, over the then present value of any future modified net premiums for those policies. The modified net premiums for any such policy shall be a uniform percentage of the respective contract premiums for those benefits, excluding any extra premiums charged because of impairments or special hazards, so that the present value at the date of issue of the policy of all the modified net premiums shall be equal to the sum of the then present value of those benefits provided for by the policy and the excess of 1 over 2, as follows:

1. A net level annual premium equal to the present value at the date of issue of those benefits provided for after the first policy year, divided by the present value at the date of issue of an annuity of one dollar per year payable on the first and each following anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of the policy.

2. A net one-year term premium for the benefits provided for in the first policy year.

B. For any life insurance policy issued on or after January 1, 1986, (i) for which the contract premium in the first policy year exceeds that of the second year, (ii) for which no comparable additional benefit is provided in the first year for that excess first year premium and (iii) that provides an endowment benefit or a cash surrender value or a combination of both in an amount greater than the excess first year premium, the reserve according to the Commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined to be the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, shall, except as otherwise provided in § 38.2-3141, be the greater of the reserve as of the policy anniversary calculated as described in subsection A of this section and the reserve as of the policy anniversary calculated as described in that subsection, but with (a) the value defined in paragraph 1 of that subsection being reduced by fifteen precent of the amount of the excess first year premium, (b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (c) the policy being assumed to mature on the annual ending date as an endowment, and (d) the cash surrender value provided on the annual ending date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in §§ 38.2-3130 through 38.2-3136 shall be used.

C. Reserves according to the Commissioners reserve valuation method for (i) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums, (ii) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code, as amended, (iii) disability and accidental death benefits in all policies and contracts, and (iv) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this section.

§ 38.2-3138. Reserve valuation method–annuity and pure endowment benefits.–A. This section shall apply to annuity and pure endowment contracts, other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code, as amended.

B. Reserves according to the Commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in those contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by those contracts at the end of each respective contract year, over the present value at the date of valuation of any future valuation considerations derived from future gross considerations required by the terms of the contract that become payable before the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in those contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of those contracts to determine nonforfeiture values.

§ 38.2-3139. Mimimum reserves. –In no event shall an insurer's aggregate reserves for all life insurance

policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in §§ 38.2-3137, 38.2-3138, 38.2-3141 and 38.2-3142 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for those policies.

§ 38.2-3140. Optional reserve calculation.– Reserves for any category of policies, contracts or benefits as established by the Commission may be calculated, at the insurer's option, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this article, but the rate or rates of interest used for policies and contracts other than annuity and pure endowment contracts shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in those policies and contracts.

§ 38.2-3141. Reserve calculation–valuation net premium exceeding the gross premium charge. –A. If in any contract year the gross premium charged by a life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in §§ 38.2-3130 through 38.2-3136.

B. For any life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for that excess and which provides an endowment benefit or a cash surrender value or a combination of both in an amount greater than the excess premium, the provisions of this section shall be applied as if the method actually used in calculating the reserve for the policy were the method described in § 38.2-3137, ignoring subsection B of § 38.2-3137. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with § 38.2-3137, and the minimum reserve calculated in accordance with this section.

§ 38.2-3142. Reserve calculation–indeterminant premium plans.–For any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on estimates of future experience, or for any plan of life insurance or annuity whose minimum reserves cannot be determined by the methods described in §§ 38.2-3137, 38.2-3138 and 38.2-3141, the reserves held under any such plan shall:

1. Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

2. Be computed by a method consistent with the principles of this article, as determined by regulations promulgated by the Commission.

§ 38.2-3143. Assessment against insurers whose policies are valued.–The Commission is hereby authorized to assess against every insurer whose policies are valued a sum not exceeding one cent for each $1,000 of insurance in force, but no more than the cost of valuation, which shall be paid into the state treasury and placed by the Comptroller to the credit of the maintenance fund of the Bureau of Insurance.

§ 38.2-3144. Article not applicable in certain cases.–Nothing in this article shall be construed to apply to any insurer in the transaction of industrial sick benefit insurance as defined in § 38.2-3544, nor to fraternal benefit societies.

Title 38.2

CHAPTER 32.

Standard Nonforfeiture Provisions for Life Insurance.

Section 38.1-470.1 in existing Chapter 9, Article 4 has been subdivided into multiple sections, proposed §§ 38.2-3219 through 38.2-3229, to improve the readability.

CHAPTER 32.

STANDARD NONFORFEITURE

PROVISIONS FOR LIFE INSURANCE

§ 38.2-3200. Nonforfeiture benefits and cash surrender values in life policies issued prior to operative date stated in § 38.2-3214.—A. This section shall apply only to life insurance policies issued prior to the operative date stated in § 38.2-3214.

B. The nonforfeiture benefit referred to in § 38.2-3309 shall be available to the insured in the event of default in premium payments, after premiums have been paid for three full years. The premium paid for the insured under any policy provision shall not be considered in default. The nonforfeiture benefit shall be a stipulated form of insurance, effective from the due date of the defaulted premium, the net value of which shall at least equal the reserve at the date of default on the policy and on any dividend additions to the policy, exclusive of the reserve on account of return premium insurance and on total and permanent disability and additional accidental death benefits, less a sum not more than two and one-half percent of the amount insured by the policy and of any dividend additions to the policy and less any existing indebtedness to the insurer on or secured by the policy. The policy shall specify the mortality table and rate of interest used in computing these reserves. Instead of allowing a deduction from the reserve of a sum not more than two and one-half percent of the amount insured by the policy, and of any dividend additions to the policy, the insurer may insert in the policy a provision that one-fifth of the reserve may be deducted, or may provide in the policy that a deduction may be made of two and one-half percent of the amount insured by the policy or one-fifth of the reserve, at the insurer's option. The cash surrender value referred to in § 38.2-3309 shall be available upon surrender of the policy to the insurer within one month of the due date of the defaulted premium and shall at least equal the sum which would otherwise be available for the purchase of insurance. The insurer may defer payment for not more than three months after the application for the cash surrender value is made.

C. If more than one option is provided, the policy shall stipulate which of the options shall be effective if the insured does not elect any option on or before the expiration of the grace period allowed for the payment of the premium.

D. A provision may also be inserted in the policy that in the event of default in a premium payment before the options become available, the reserve on any dividend additions then in force may, at the insurer's option, be paid in cash or applied as a net premium to the purchase of paid-up term insurance for any amount not exceeding the face amount of the original policy.

E. This section shall apply to term insurance policies only if the term is for more than twenty years.

Drafting Note: This section applies only to policies that have already been issued. If it were repealed, the policies to which it applies would still have to comply because they were issued subject to this section. Likewise, any rewording would have no legal effect, as the language applicable at the time the policy was issued would be the standard with which the policy would have to comply. This section is being kept for reference only, and therefore only editorial changes are being proposed.

§ 38.2-3201. Same; for industrial life policies.—A. This section shall apply only to industrial life insurance policies issued prior to the operative date stated in § 38.2-3214.

B. The nonforfeiture benefits referred to in § 38.2-3347 shall be available in the event of default in premium payments after premiums have been paid for five full years, without action on the part of the insured. The nonforfeiture benefit shall be a stipulated form of insurance, effective from the due date of the defaulted premium, the net value of which at least equals the reserve on the policy, excluding any reserves for provisions (i) relating to benefits for specific types of disability, (ii) granting additional insurance specifically against accidental death, and (iii) granting other benefits in addition to life insurance, at the end of the last completed policy year for which premiums have been paid, and on any dividend additions to the policy, less a specified maximum percentage, not more than two and one-half, of the maximum face amount insured by the policy and of any dividend additions to the policy and less any existing indebtedness to the insurer on or secured by the policy. The policy shall specify the mortality table, rate of interest and method of valuation used for computing these reserves. The policy shall also specify the percentage or other rule of calculation so as to permit determination of the values for each year for which required values are not included in the policy. Instead of allowing for the deduction from the reserve of a sum not more than two and one-half percent of the maximum face amount insured by the policy and of any dividend additions to the policy, the insurer may insert in the policy a provision that one — fifth of the reserve may be deducted, or may provide in the policy that a deduction may be made of two and one-half percent of the maximum face amount insured by the policy or one—fifth of the reserve at the insurer's option.

C. If more than one option is provided, the policy shall stipulate which of the options shall apply if the insured fails to notify the insurer of his selection of an option.

D. The cash surrender value referred to in § 38.2-3347 shall be available after premiums have been paid for ten full years upon surrender of the policy to the insurer within three months of the due date of the defaulted premium and shall be at least equal to the sum which would otherwise be available for the purchase of insurance. The insurer may defer payment for not more than three months after the

application for the cash surrender value is made. This section shall not apply to term insurance policies of twenty years or less, but such term policy shall specify the mortality table, rate of interest and method of valuation adopted for computing reserves.

Drafting Note: The drafting note to proposed § 38.2-3200 applies.

§ 38.2-3202. Standard nonforfeiture law; required policy provisions.—A. On and after the operative date stated in § 38.2-3214, no life insurance policy, except as stated in § 38.2-3213, shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the following provisions and statements, or corresponding provisions and statements that in the opinion of the Commission (i) are at least as favorable to the defaulting or surrendering policyholder and (ii) essentially comply with § 38.2-3212:

1. That in the event of default in any premium payment, the insurer will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, in the amount specified in this article. Instead of the stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

2. That upon surrender of the policy within sixty days after the due date of any premium payment in default, after premiums have been paid for at least three full years for ordinary insurance or five full years for industrial insurance, the insurer will pay, instead of any paid-up nonforfeiture benefit, a cash surrender value in the amount specified in this chapter.

3. That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make an election selects another available option not later than sixty days after the due date of the premium in default

4. That for a policy paid up by completion of all premium payments or continued under any paid-up nonforfeiture benefit that became effective on or after the third policy anniversary for ordinary insurance or the fifth policy anniversary for industrial insurance, the insurer will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value in the amount specified in this article.

5. For policies that provide on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or both, or that provide an option for changes in benefits or premiums, or both, other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. All other policies shall include a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing any cash surrender value and any paid-up nonforfeiture benefit available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter. The values and benefits referred to in this paragraph shall be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

6. A brief and general statement of the method to be used in calculating the cash surrender value and the paid-up nonforfeiture benefits available under the policy on any policy anniversary beyond the last anniversary for which the values and benefits are consecutively shown in the policy, with an explanation of how the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy affects the cash surrender values and the paid-up nonforfeiture benefits.

B. To the extent that any of the foregoing provisions are not applicable to the plan of insurance, they may be omitted from the policy with the approval of the Commission.

C. The insurer shall reserve the right to defer the payment of any cash surrender value for no more than six months after demand for the cash surrender value and surrender of the policy.

§ 38.2-3203. Same; cash surrender value in case of default.—A. Any cash surrender value available under any life insurance policy issued on or after the operative date stated in § 38.2-3214 in the event of default in a premium payment due on any policy anniversary, whether or not required by § 38.2-3202, shall at least equal any excess of the present value, on that anniversary, of the future guaranteed benefits that would have been provided for by the policy, including any existing paid-up additions had there been no default, over the sum of (i) the then present value of the adjusted premiums as defined in § 38.2-3205 through § 38.2-3209, corresponding to premiums that would have fallen due on and after that anniversary, and (ii) the amount of any indebtedness to the insurer on the policy.

B. For any policy issued on or after the operative date of § 38.2-3209 and providing at the option of the insured supplemental life insurance or annuity benefits for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection A of this section shall at least equal the sum of (i) the cash surrender value defined in subsection A for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and (ii) the cash surrender value defined in subsection A for a policy providing only the benefits provided by the rider or supplemental policy provision.

C. For any family policy issued on or after the operative date of § 38.2-3209, defining a primary

insured and providing term insurance on the life of the spouse of the primary insured expiring before the spouse achieves the age of seventy-one, the cash surrender value referred to in subsection A of this section shall at least equal the sum of (i) the cash surrender value defined in subsection A for an otherwise similar policy issued at the same age without the term insurance on the life of the spouse and (ii) the cash surrender value defined in subsection A for a policy providing only the benefits provided by the term insurance on the life of the spouse.

D. Any cash surrender value available within thirty days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by § 38.2-3202, shall at least equal the present value, on that anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

§ 38.2-3204. Same; present value of paid-up nonforfeiture benefits on default.—Any paid-up nonforfeiture benefit available under a life insurance policy issued on or after the operative date stated in § 38.2-3214 in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of that anniversary shall at least equal the cash surrender value then provided for by the policy or, if none is provided for, shall equal the cash surrender value that would have been required by § 38.2-3203 in the absence of the condition that premiums have been paid for a specified period.

§ 38.2-3205. Same; calculation of adjusted premiums.—A. The provisions of this section shall not apply to policies issued on or after the operative date as defined in § 38.2-3209. Except as provided in subsection C of this section, the adjusted premium for any life insurance policy issued on or after the operative date stated in § 38.2-3214 shall be calculated on an annual basis and shall be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, so that the present value at the date of issue of the policy of all adjusted premiums is equal to the sum of: (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two percent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount as defined in subsection B of this section if the amount of insurance varies with the duration of the policy; (iii) forty percent of the adjusted premium for the first policy year; and (iv) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. However, in applying the percentages specified in (iii) and (iv) of this subsection, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or level amount equivalent to the amount of insurance. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

B. The equivalent uniform amount of a policy providing an amount of insurance varying with the duration of the policy is the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy. However, for a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by the policy at age ten.

C. The adjusted premiums for any policy providing term insurance benefits by a rider or a supplemental policy provision shall equal (i) the adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term insurance benefits are payable by (ii) the adjusted premiums for the term insurance. Items (i) and (ii) of this subsection shall be calculated separately and as specified in subsections A and B of this section. For the purposes of items (ii), (iii), and (iv) of subsection A of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in item (ii) of this subsection shall equal the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in item (i) of this subsection.

§ 38.2-3206. Same; tables used for calculations.—Except as otherwise provided in §§ 38.2-3207 and 38.2-3208, all adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3205 shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table. However, for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured and the calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per year, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, in calculating the present value of any paid-up term insurance with any accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130 percent of the rates of mortality according to the applicable table. For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on any other table of mortality specified by the insurer and approved by the Commission.

§ 38.2-3207. Same; use of new mortality table; ordinary policies.—The provisions of this section shall not apply to ordinary policies issued on or after the operative date as defined in § 38.2-3209. In the case of ordinary policies issued on or after the operative date of § 38.2-3215, all adjusted premiums and present

values referred to in §§ 38.2-3202 through 38.2-3205 shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, the rate of interest shall not exceed (i) three and one-half percent per year for policies issued before July 1, 1975, (ii) four percent per year for policies issued on or after July 1, 1975, and prior to July 1, 1979, and (iii) five and one-half percent per year for policies issued on or after July 1, 1979. Notwithstanding the foregoing provisions of this section, the rate of interest for any single premium whole life or endowment insurance policy issued on or after July 1, 1979, may be a rate not exceeding six and one-half percent per year. For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. For insurance issued on a substandard basis the calculation of any adjusted premiums and present values may be based on any other table of mortality specified by the insurer and approved by the Commission.

§ 38.2-3208. Same; industrial policies.—The provisions of this section shall not apply to industrial policies issued on or after the operative date as defined in § 38.2-3209. For industrial policies issued on or after the operative date of § 38.2-3216, all adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3205 shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, the rate of interest shall not exceed (i) three and one-half percent per year for policies issued before July 1, 1975, (ii) four percent per year for policies issued on or after July 1, 1975, and prior to July 1, 1979, and (iii) five and one-half percent per year for policies issued on or after July 1, 1979. Notwithstanding the foregoing provisions of this section, the rate of interest for any single premium whole life or endowment insurance policy issued on or after July 1, 1979, may be a rate not exceeding six and one-half percent per year. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. For insurance issued on a substandard basis, the calculations of any adjusted premiums and present values may be based on any other table of mortality specified by the insurer and approved by the Commission.

Drafting Note: The deletion of "However" in the next to the last sentence is consistent with the lack of "However" in the next to the last sentence of § 38.2-3207.

§ 38.2-3209. Same; adjusted premiums for policies.—A. This section shall apply to all policies issued on or after the operative date as defined in this section. Except as provided in subsection G of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, so that the present value at the date of issue of the policy of all adjusted premiums shall equal the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (iii) 125 percent of the nonforfeiture net level premium as defined in subsection B of this section. However, in applying the percentage specified in (iii) of this subsection no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

B. The nonforfeiture net level premium shall equal the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annual annuity of one dollar payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

C. For a policy that provides, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or both, or that provides an option for changes in benefits or premiums, or both, other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

D. Except as otherwise provided in subsection G of this section, the recalculated future adjusted premiums for any policy referred to in subsection C of this section shall be a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, so that the present value at the time of change to the newly defined benefits or premiums of all future adjusted premiums shall equal the excess of (1) over (2), where (1) is (i) the then present value of the then future guaranteed benefits provided for by the policy plus (ii) any additional expense allowance and (2) is the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

E. The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years after the change over the average amount of insurance before the change at the beginning of each of the first ten policy years after the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy and (ii) 125 percent of the increase, if positive, in the nonforfeiture net level premium.

F. The recalculated nonforfeiture net level premium shall equal (1) divided by (2), where (1) is the sum of (i) the nonforfeiture net level premium applicable before the change times the present value of an annual annuity of one dollar payable on each anniversary of the policy on or after the date of the change on which a premium would have fallen due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided by the policy, and (2) is the present value of an annual annuity of one dollar payable on each anniversary of the policy on or after the date of change on which a premium falls due.

G. Notwithstanding any other provisions of this section, for a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide the higher uniform amounts of insurance on the standard basis.

H. All adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3213 shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors. The premiums and values shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table. The premiums and values shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year, provided that:

1. At the insurer's option, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year;

2. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by § 38.2-3202, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit and any paid-up dividend additions;

3. An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions, under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

4. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance;

5. For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the tables referred to in this section;

6. Any ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commission for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table; and

7. Any industrial mortality tables adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commission for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

I. The nonforfeiture annual interest rate for any policy issued in a particular calendar year shall equal 125 percent of the calendar year statutory valuation interest rate for the policy as defined in §§ 38.2-3130 through 38.2-3142, rounded to the nearest one-quarter percent.

J. Any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

K. After July 1, 1982, any insurer may file with the Commission a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which shall be the operative date of this section for that insurer. If an insurer makes no election, the operative date of this section for that insurer shall be January 1, 1989.

§ 38.2-3210. Same; life insurance providing future premium determination.– For any plan of life

insurance providing for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or for any plan of life insurance for which minimum values cannot be determined by the methods described in §§ 38.2-3202 through 38.2-3209, then:

1. The Commission shall be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by §§ 38.2-3202 through 38.2-3209;

2. The Commission shall be satisfied that the benefits and the pattern of premiums of the plan are not misleading to prospective policyholders or insureds; and

3. The cash surrender values and paid-up nonforfeiture benefits provided by the plan shall not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of §§ 38.2-3202 through 38.2-3213, as determined by the Commission.

Drafting Note: The addition of "Same" to the title of the section is to make it consistent with the other section titles.

§ 38.2-3211. Same; other factors in calculations.—A. Any cash surrender value and any paid-up nonforfeiture benefit available under any life insurance policy issued on or after the operative date stated in § 38.2-3214 in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in §§ 38.2-3203 through 38.2-3209 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall at least equal the amounts used to provide these additions.

B. 1. Notwithstanding the provisions of § 38.2-3203, additional benefits payable in the following cases and premiums for them shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by §§ 38.2-3202 through 38.2-3216:

a. Death or dismemberment by accident or accidental means;

b. Total and permanent disability;

c. Reversionary annuity or deferred reversionary annuity benefits;

d. Term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply ;

e. Term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child; and

f. Other policy benefits additional to life insurance and endowment benefits.

2. No additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

§ 38.2-3212. Same; policies issued on or after January 1, 1986.—A. This section, in addition to all other applicable sections of law, shall apply to all policies issued on or after January 1, 1986. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall not differ by more than two-tenths percent of either (i) the amount of insurance, if the insurance is uniform in amount, or (ii) the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (i) the greater of zero and the basic cash value specified in this section and (ii) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

B. The basic cash value shall equal the present value on that anniversary of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as defined in this section, corresponding to premiums that would have fallen due on and after that anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in § 38.2-3203 or § 38.2-3205, whichever applies, shall be the same as the effects specified in § 38.2-3203 or § 38.2-3205, whichever applies, on the cash surrender values defined in those sections.

C. 1. The nonforfeiture factor for each policy year shall equal a percentage of the adjusted premium for the policy year, as defined in § 38.2-3205 or § 38.2-3209, whichever applies. Except as required by paragraph 2 of this subsection, such percentage:

a. Shall be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

b. Shall be such that no percentage after the later of the two policy anniversaries specified in paragraph 1a of this subsection may apply to fewer than five consecutive policy years.

2. No basic cash value shall be less than the value that would be obtained if the adjusted premiums for the policy, as defined in § 38.2-3205 or § 38.2-3209, whichever applies, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

D. All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases used in demonstrating the policy's compliance with the other sections of this article. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

E. Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment, shall be determined by a method consistent with the methods specified for determining the analogous minimum amounts in §§ 38.2-3202 through 38.2-3204, 38.2-3209 and 38.2-3211. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits, such as those listed as 1a through 1f in § 38.2-3211, shall conform with the principles of this section.

§ 38.2-3213. Same; exemptions from application of certain sections.—A. Sections 38.2-3202 through 38.2-3212 shall not apply to any:

1. Certificates of fraternal benefit societies;

2. Reinsurance;

3. Group insurance;

4. Pure endowments;

5. Annuities or reversionary annuity contracts;

6. Term policies of uniform amount (i) that provide no guaranteed nonforfeiture or endowment benefits, or renewal thereof; (ii) that are of twenty years or less expiring before age seventy-one; and (iii) for which uniform premiums are payable during the entire term of the policy;

7. Term policies of decreasing amount (i) that provide no guaranteed nonforfeiture or endowment benefits; (ii) on which each adjusted premium calculated as specified in §§ 38.2-3205 through 38.2-3209 is less than the adjusted premium calculated on term policies of uniform amount, or renewal thereof; (iii) that provide no guaranteed nonforfeiture or endowment benefits; (iv) that are issued at the same age and for the same initial amounts of insurance and for terms of twenty years or less expiring before age seventy-one; and (v) for which uniform premiums are payable during the entire term of the policy;

8. Policies (i) that provide no guaranteed nonforfeiture or endowment benefits and (ii) for which any cash surrender value or present value of any paid-up nonforfeiture benefit at the beginning of any policy year, calculated as specified in §§ 38.2-3203 through 38.2-3209, does not exceed two and one-half percent of the amount of insurance at the beginning of the same policy year; or

9. Policies delivered outside this Commonwealth through an agent or other representative of the insurer issuing the policy.

B. For purposes of determining the applicability of §§ 38.2-3202 through 38.2-3216, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

§ 38.2-3214. Same; operative date.— After March 17, 1948, any insurer may file with the Commission a written notice of its election to comply with the provisions of §§ 38.2-3202 through 38.2-3213 after a specified date before April 1, 1948. After the filing of the notice upon the specified date, which shall be the operative date for that insurer, the sections shall become operative with respect to the policies thereafter issued by that insurer. If an insurer makes no election, the operative date for the insurer shall be April 1, 1948. The Commission, for good cause shown by any insurer, may extend the operative date for that insurer to not later than January 1, 1949.

Drafting Note: See drafting note to § 38.2-3200.

§ 38.2-3215. Same; operative date for § 38.2-3207.—After July 1, 1959, any insurer may file with the Commission a written notice of its election to comply with the provisions of § 38.2-3207 after a specified date before January 1, 1966. After the filing of the notice, then upon the specified date, which shall be the operative date of this section for the insurer, § 38.2-3207 shall become operative with respect to the ordinary policies thereafter issued by that insurer. If an insurer makes no such election, the operative date of § 38.2-3207 for the insurer shall be January 1, 1966.

Drafting Note: See drafting note to § 38.2-3200.

§ 38.2-3216. Same; operative date for § 38.2-3208.—After July 1, 1962, any insurer may file with the Commission a written notice of its election to comply with the provisions of § 38.2-3208 after a specified date before January 1, 1968. After the filing of the notice, then upon the specified date, which shall be the operative date of this section for the insurer, § 38.2-3208 shall become operative with respect to the

industrial policies thereafter issued by that insurer. If an insurer makes no election, the operative date of § 38.2-3208 for the insurer shall be January 1, 1968.

Drafting Note: See drafting note to § 38.2-3200.

§ 38.2-3217. Loan provisions in policies issued prior to operative date stated in § 38.2-3214.– For those policies issued prior to the operative date stated in § 38.2-3214, the loan value referred to in former § 38.1-397 shall be the reserve at the end of the current policy year on the policy and on any dividend additions to the policy, exclusive of the reserve on account of return premium insurance and of total and permanent disability and additional accidental death benefits, less a sum not more than two and one-half percent of the amount insured by the policy and of any dividend additions to the policy. The policy shall specify the mortality table and rates of interest adopted for computing the reserve. The policy may further provide that the loan may be deferred for up to three months after the application for the loan is made. Instead of permitting the deduction from a loan on the policy of a sum not more than two and one-half percent of the amount insured by the policy and of any dividend additions to the policy, an insurer may insert in the policy a provision that one-fifth of the reserve may be deducted in case of a loan under the policy, or may provide in the policy that the deduction may be two and one-half percent of the amount insured by the policy or one-fifth of the reserve, at the insurer's option.

Drafting Note: The drafting note to proposed § 38.2-3200 applies. The cross-reference to § 38.1-397 remains even though that section has been repealed and replaced by § 38.2-3308, because the provisions of repealed § 38.1-397 are the ones that apply to the "policies issued prior to the operative date stated in § 38.2-3214."

§ 38.2-3218. Same; in policies subsequently issued.–For policies issued on or after the operative date stated in § 38.2-3214, the loan value referred to in former § 38.1-397 or § 38.2-3308, whichever applies, shall be the cash surrender value at the end of the current policy year required by § 38.2-3202. The insurer shall have the right to defer for up to six months after application for the loan is made a loan on the policy, except when made to pay premiums to the insurer.

Drafting Note: This section has been divided into a number of sections for better organization. The proposed organization is in conformity with the NAIC model.

Drafting Note: Short titles are being deleted throughout the Code.

§ 38.2-3219. Applicability.– Sections 38.2-3219 through 38.2-3229 shall not apply to any (i) reinsurance; (ii) group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code, as amended; (iii) premium deposit fund; (iv) variable annuity; (v) investment annuity; (vi) immediate annuity; (vii) deferred annuity contract after annuity payments have commenced; (viii) reversionary annuity ; or (ix) contract delivered outside this Commonwealth through an agent or other representative of the insurer issuing the contract.

§ 38.2-3220. Nonforfeiture requirements.–A. For contracts issued on or after the operative date as defined in § 38.2-3229, no contract of annuity, except as stated in § 38.2-3219, shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the following provisions and statements, or corresponding provisions and statements that in the opinion of the Commission are at least as favorable to the contract holder, upon cessation of payment of consideration under the contract:

1. That upon cessation of payment of considerations under a contract, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of the value specified in §§ 38.2-3222 through 38.2-3225 and § 38.2-3227.

2. If a contract provides for a lump sum settlement at maturity or at any other time, a provision that upon surrender of the contract at or before the beginning of any annuity payments, the insurer will pay instead of any paid-up annuity benefits a cash surrender benefit of the amount specified in §§ 38.2-3222, 38.2-3223, 38.2-3225 and 38.2-3227. The insurer shall reserve the right to defer the payment of the cash surrender benefit for up to six months after demand for payment with surrender of the contract.

3. A statement of the mortality table and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of those benefits.

4. That any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of how the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract or any prior withdrawals from or partial surrenders of the contract affects the benefits.

B. Notwithstanding the requirements of this paragraph, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to that period would be less than twenty dollars monthly, the insurer may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit. This payment shall relieve the insurer of any further obligation under the contract.

§ 38.2-3221. Minimum values.–The minimum values specified in §§ 38.2-3222 through 38.2-3225 and

38.2-3227 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon the minimum nonforfeiture amounts defined in this section.

A. 1. For contracts providing for flexible considerations, the minimum nonforfeiture amount at or any time before the beginning of any annuity payments shall equal an accumulation up to that time at an annual rate of interest of three percent of percentages of the net considerations as defined in this section, paid prior to that time, increased by an existing additional amount credited by the insurer to the contract and decreased by the sum of:

Drafting Note: The language deleted in 1.b below has been moved into 1 above.

a. Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per year and

b. The amount of any indebtedness to the insurer on the contract, including interest due and accrued.

2. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be not less than zero and shall equal the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars and less a collection charge of one dollar and twenty-five cents per consideration credited to the contract during that contract year. The percentages of net considerations shall be sixty-five percent of the net consideration for the first contract year and eighty-seven and one-half percent of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent of the portion of the total net consideration for any renewal contract year that exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent.

B. For contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be the same as for contracts with flexible considerations that are paid annually with two exceptions:

1. The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent of the net consideration for the first contract year plus twenty-two and one-half percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

2. The annual contract charge shall be the lesser of (i) thirty dollars or (ii) ten percent of the gross annual consideration.

C. For contracts providing for a single consideration, minimum nonforfeiture amounts shall be the same as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall equal ninety percent, and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars.

§ 38.2-3222. Computation of present value.– Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence at least equals the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

§ 38.2-3223. Calculation of cash surrender values. –For contracts that provide cash surrender benefits, the cash surrender benefits available before maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender, reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract. The present value shall be calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall at least equal the cash surrender benefit.

§ 38.2-3224. Calculation of paid-up annuity benefits.–For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity. The present value shall be calculated for the period before the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the insurer to the contract. For contracts that do not provide any death benefits before the beginning of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

§ 38.2-3225. Maturity date.–For the purpose of determining the benefits calculated under §§ 38.2-3223 and 38.2-3224 for annuity contracts under which an election may be made to have annuity payments

commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election is permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

§ 38.2-3226. Disclosure of limited death benefits. --Any contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the beginning of any annuity payments shall include a statement in a prominent place in the contract that those benefits are not provided.

§ 38.2-3227. Inclusion of lapse of time considerations.--Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for a lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

§ 38.2-3228. Proration of values; additional benefits. --For any contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall equal the sum of the minimum nonforfeiture benefits for the annuity portion and any minimum nonforfeiture benefits for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of §§ 38.2-3222 through 38.2-3225 and § 38.2-3227, additional benefits payable (i) in the event of total and permanent disability, (ii) as reversionary annuity or deferred reversionary annuity benefits, or (iii) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all the additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this article. The inclusion of these additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

§ 38.2-3229. Effective date.--After July 1, 1979, any insurer may file with the Commission a written notice of its election to comply with the provisions of §§ 38.2-3219 through 38.2-3229 after a specified date before July 1, 1981. The date specified in the notice shall be the operative date for that insurer in complying with the requirements of §§ 38.2-3219 through 38.2-3229 which shall apply to annuity contracts thereafter issued by that insurer. The operative date for insurers making no election shall be July 1, 1981.

Title 38.2

CHAPTER 33.

Life Insurance Policies.

ARTICLE 1.

Life Insurance Policies; Annuities.

The following substantive changes are proposed for this chapter:

1. In § 38.1-392 (proposed § 38.2-3303), the grace period was changed from one month to thirty-one days for consistency with the grace periods for other types of policies. Also, the provision for deducting overdue premiums from settlements has been limited to earned overdue premiums through the month of death.

2. In § 38.1-403 (proposed § 38.2-3314), a title will not be required on the back of policies.

3. In proposed § 38.2-3315, Variations for certain forms of policies; providing more favorable terms, reference to flexible premium policies was added.

Since most of this article contains standard policy provisions for individual life insurance policies, the following editorial changes have been made:

1. Moving existing §38.1-408 (proposed § 38.2-3114), Statements required in variable life insurance and annuity contracts and certificates issued pursuant thereto, and existing §38.1-408.1 (proposed § 38.2-3112), Designation of testamentary trustee as beneficiary, to Chapter 31.

2. Making existing §38.1-406 (proposed § 38.2-3316), Provisions prohibited, and existing §38.1-407 (proposed § 38.2-3317), Provisions required by other states or countries, not apply to group life insurance. Similar provisions have been added to Article 2, Group Life Insurance Policies.

ARTICLE 2.

Group Life Insurance Policies.

1. Existing Chapter 8, Article 7 and Chapter 9, Article 5 have been merged to create this new article.

2. The many sections detailing the requirements of types of eligible groups (from existing Chapter 9, Article 5) have been deleted. Instead, we would allow a group policy to be issued to any type of group.

   The draft proposes:

   A. Eliminating inconsistent and unnecessary requirements such as participation, minimum size and premium payment limitations;

   B. Allowing group coverage for spouses and children under all types of groups, except debtor groups, and increasing the amount limitations to be the same amount as the insured group member;

   C. Eliminating the amount limitation for credit union groups in existing § 38.1-476.1; and

   D. In existing § 38.1-482, which has been renumbered § 38.2-3339, Exemption of group life insurance policies from legal process, changing "employee" to "person insured" or "insured person" to clarify the meaning of the section. (This could possibly expand the scope of the exemption.)

3. In § 38.1-427.1 (proposed § 38.2-3330), Payment of benefits, a facility of payment provision, the $500 limit has been raised to $2,000;

4. In § 38.1-428.2 (proposed § 38.2-3333), Right to an individual policy upon termination of group policy or elimination of class of insured person, the $2,000 limit has been raised to $10,000.

5. A new section (proposed § 38.2-3338), which lists prohibited policy provisions has been added.

ARTICLE 3.

Industrial Life Insurance Policies.

In the definition of industrial life insurance the reference to "weekly premium policy" has been deleted because companies now sell weekly premium ordinary policies.

CHAPTER 33.

LIFE INSURANCE POLICIES.

Article 1.

Life Insurance Policies; Annuities.

§ 38.2-3300. Requirements; exceptions.—A. No individual life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains in substance all of the requirements prescribed in §§ 38.2-3301 through 38.2-3315 of this article.

B. As used in this article, "individual life insurance" means any life insurance other than group life insurance, industrial life insurance, annuities, credit life insurance, and pure endowments, with or without return of premiums or of premiums and interest. However, for the purposes of § 38.2-3308, "policy" includes annuity contracts that provide for policy loans and certificates issued by a fraternal benefit society.

C. The requirements of §§ 38.2-3300 through 38.2-3315 shall not apply to policies of reinsurance or to policies issued or granted in exchange for lapsed or surrendered policies.

Drafting Notes: 1. Individual life insurance was defined so that it would not have to always be referred to as "life insurance other than...."

2. A sentence has been added to clarify that the policy provision does apply to annuities with loan provisions and certificates issued by a fraternal benefit society.

3. The provisions contained in existing § 38.1-405, standard policy provisions not required in certain cases, have been moved up to become subsection C of this section.

§ 38.2-3301. Ten-day right to examine policy.—No individual life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it has printed on it a notice stating in substance that if, during a ten -day period from the date the policy is delivered to the policyowner, the policy is surrendered to the insurer or its agent with a written request for cancellation, the policy shall be void from the beginning and the insurer shall refund any premium paid for the policy. Nothing in this section shall prohibit an insurer from extending the right to examine period to more than ten days if the period is specified in the policy.

§ 38.2-3302. How premiums payable.— Each individual life insurance policy shall have a provision that all premiums after the first premium shall be payable in advance.

§ 38.2-3303. Grace period.—A. Each individual life insurance policy shall contain a provision that the insured is entitled to a grace period of not less than thirty-one days within which the payment of any premium after the first premium may be made, subject at the insurer's option to an interest charge that is not to exceed six percent per year for the number of days of grace elapsing before the payment of the premium.

B. The provision shall also state that during the grace period the policy shall continue in full force, but if a claim arises under the policy during the grace period before the overdue premium or any overdue premium installment is paid, the amount of any earned overdue premium or installment through the policy month of death with interest may be deducted from any amount payable under the policy in settlement. The grace period shall start on the premium payment due date.

Drafting Note: 1. The grace period was changed to 31 days for consistency with the grace periods for other types of policies.

2. The provision for deducting overdue premiums from settlements has been limited to earned overdue premiums through the month of death.

§ 38.2-3304. Policy constitutes entire contract; statements deemed representations.—A. Each individual life insurance policy shall contain a provision that the policy, or the policy and the application for the policy if a copy of the application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. All statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties; and

2. No statement shall be used in defense of a claim under the policy unless it is contained in a written application that is endorsed upon or attached to the policy when issued.

C. As used in this section, "policy" shall include any riders, endorsements or amendments.
Drafting Note. A definition of "policy" has been added for clarification.

§ 38.2-3305. Incontestability.—A. Each individual life insurance policy shall contain a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for two years from its date of issue except for nonpayment of premiums.

B. Provisions relating to benefits in event of disability, and provisions granting additional insurance specifically against death by accident or accidental means, may be excepted in the incontestability provision.

§ 38.2-3306. Misstatement of age.– Each individual life insurance policy shall contain a provision that if, at any time before final settlement under the policy, the age of the insured, or the age of any other person if considered in determining the premium, is found to have been misstated, the amount payable under the policy shall equal the amount that the premium would have purchased at the insured's or other person's correct age at the time the policy was issued.

§ 38.2-3307. Participation in surplus.–A. Each participating individual life insurance policy shall contain a provision that the policy shall participate in the surplus of the insurer. Any policy containing a provision for participation at the end of the first policy year, and annually thereafter, may also provide that each dividend shall be paid subject to the payment of the premiums for the next ensuing year. The policyowner under any annual dividend policy shall have the right each year to have the dividend arising from the participation paid in cash. If the policy provides other dividend options, it shall also state which of the options shall be effective if the insured does not elect any option on or before the expiration of the grace period allowed for the payment of the premium.

B. This section shall not apply to any form of paid-up insurance, temporary insurance, or pure endowment insurance, issued or granted in exchange for lapsed or surrendered policies.

Drafting Note: To clarify the applicability of this section at its beginning, the word "participating" was added to the first sentence, and the reference to nonparticipating policies was deleted from the last sentence. "Insured" was changed to "policyowner" since the insured might not be the owner of the policy.

§ 38.2-3308. Policy loans.–A. Each individual life insurance policy shall contain a provision that after the policy has been in force three policy years the insurer shall at any time, while the policy is in force other than as extended term insurance, advance, on proper assignment or pledge of the policy and on the sole security of the policy, a sum equal to or, at the option of the policyowner, less than the amount required by § 38.2-3218, under the conditions specified by that section.

B. Each individual life insurance policy issued after July 1, 1975, and prior to July 1, 1981, shall contain only one of the following policy loan interest rate provisions:

1. A provision that a policy loan shall bear interest at a specified rate not exceeding eight percent per year; or

2. A provision that all loans under the policy, including outstanding loans, shall bear interest at a variable rate not exceeding eight percent per year, specified from time to time by the insurer. The effective date of any increase in the variable rate shall be not less than one year after the effective date of the establishment of the previous rate. If the interest rate is increased, the amount of the increase shall not exceed one percent per year. The variable rate may be decreased without restriction as to amount or frequency. With respect to policies providing for a variable rate, the insurer shall give notice of:

a. The variable rate currently effective when a loan is made and when notification of interest due is furnished;

b. Any increase in the variable rate at least thirty days before the effective date for any loans outstanding forty days before that date; and

c. The increase at the time a loan is made for any loans made during the forty days before the effective date of the increase. The notice shall be given as directed by the policyowner and any assignee as shown on the records of the insurer at its home office.

C. 1. Each individual life insurance policy issued after July 1, 1981, shall contain a policy loan interest rate provision permitting either:

a. A maximum fixed interest rate of not more than eight percent per year; or

b. An adjustable maximum interest rate established from time to time by the insurer as permitted by law.

2. The interest rate charged on a policy loan made under paragraph 1 b of this subsection shall not exceed the greater of:

a. The Published Monthly Average for the calendar month ending two months before the date on which the rate is determined; or

b. The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per year.

3. For the purposes of this subsection, the "Published Monthly Average" means:

a. Moody's Corporate Bond Yield Average–Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto; or

b. If the Moody's Corporate Bond Yield Average–Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the Commission.

4. If the maximum interest rate is determined pursuant to paragraph 1 b of this subsection, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

5. The maximum interest rate for each policy shall be determined at regular intervals at least once every twelve months, but not more frequently than once every three months. At the intervals specified in the policy:

a. The rate being charged may be increased whenever the increase as determined under paragraph 2 of this subsection would increase that rate by one-half percent or more per year;

b. The rate being charged shall be reduced whenever the reduction as determined under paragraph 2 of this subsection would decrease that rate by one-half percent or more per year.

6. The insurer shall:

a. Notify the policyowner at the time a cash loan is made of the initial interest rate;

b. Notify the policyowner of the initial interest rates on a policy loan as soon as it is reasonably practical to do so after making the loan. Notice need not be given to the policyowner when a further premium loan is added, except as provided in paragraph 6 c below;

c. Send reasonable advance notice of any increase in the rates to policyowners with loans; and

d. Include the substance of the pertinent provisions of paragraphs 1 and 4 of this subsection in the notices required above.

7. No policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

8. The substance of the pertinent provisions of paragraphs 1 and 4 of this subsection shall be set forth in the policies to which they apply.

9. For the purposes of this section:

a. The interest rate on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

b. The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the insurer as they fell due.

c. The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts that provide for policy loans.

10. No other provision of law, including Chapter 7.2 (§ 6.1-330.6 et seq.) of Title 6.1, shall apply to policy loan interest rates unless made specifically applicable to the rates.

D. The insurer may deduct from the loan value any indebtedness not already deducted in determining the value of any unpaid balance of the premium for the current policy year and any interest that may be allowable on the loan to the end of the current policy year. The policy may further provide that if the interest on the loan is not paid when due, it shall be added to the existing loan and shall bear interest at the same rate.

E. A policy loan provision shall not be required in term insurance policies.

Drafting Note: 1. In subsection C, paragraph 9, the existing reference to policyholder was deleted. The current Code uses the terms "insured," "policyholder," and "policyowner" interchangeably. The correct term for this section is "policyowner."

2. In subsection D, the sentence "This provision shall not be required in term insurance" has been moved to a new subsection and reworded to clarify that the policy loan provision does not apply to term insurance policies.

§ 38.2-3309. Nonforfeiture benefits and cash surrender values.–A. Each individual life insurance policy shall contain a provision for nonforfeiture benefits. The provision shall specify the options to which the policyowner is entitled, in accordance with the requirements of § 38.2-3202.

B. Each individual life insurance policy shall have a provision for cash surrender values in accordance with the requirements of § 38.2-3203.

§ 38.2-3310. Table of values and options.–Each individual life insurance policy shall contain a table showing the loan values in figures, line by line. The table shall also show any options available under the policy each year upon default in premium payments, during at least the first twenty years of the policy or during the premium-paying period if it is less than twenty years.

§ 38.2-3311. Reinstatement.– Each individual life insurance policy shall have a provision that in the event of default in premium payments, if (i) the value of the policy has been applied automatically to the purchase of other insurance as provided for in this article, (ii) the insurance is in force, and (iii) the original policy has not been surrendered to the insurer and cancelled, the policy may be reinstated within three years from default, upon:

1. Evidence of insurability satisfactory to the insurer;

2. Payment of premiums in arrears with interest at a rate not exceeding six percent per year payable annually; and

3. The payment or reinstatement of any other indebtedness to the insurer upon the policy, with interest at the rate set forth in the policy for the indebtedness.

Drafting Note: The changes in 2 and 3 were made to eliminate an inconsistency between this section and paragraph 9a of subsection C of proposed § 38.2-3308, which requires a different interest rate on policy loans.

§ 38.2-3312. Settlement.– Each individual life insurance policy shall contain a provision that when a death claim arises under the policy, settlement shall be made upon receipt of due proof of death.

§ 38.2-3313 Table of installments.– If an individual life insurance policy provides that the proceeds may be payable in installments that are determinable prior to the maturity of the policy, the policy shall have a table showing the guaranteed installments.

§ 38.2-3314. Title.–Each individual life insurance policy shall have a title on its face that shall briefly and accurately describe the nature and form of the policy.

Drafting Note: A title will no longer be required on the back of policies.

§ 38.2-3315. Variations for certain forms of policies; providing more favorable terms.–A. Any of the requirements of §§ 38.2-3300 through 38.2-3314 not applicable to single premium, nonparticipating, term, variable, or flexible premium life insurance policies shall to that extent, as approved by the Commission, be appropriately modified or not be incorporated in these policies.

B. Any individual life insurance policy that, in the opinion of the Commission, contains provisions more favorable to the policyholder than those required by §§ 38.2-3300 through 38.2-3314, may be delivered or issued for delivery in this Commonwealth after approval by the Commission.

Drafting Note: A reference to flexible premium policies has been added.

Drafting Note: This section is now subsection C of proposed § 38.2-3300.

§ 38.2-3316. Provisions prohibited.–No individual life insurance policy shall be delivered or issued for delivery in this Commonwealth if it contains any provision:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues;

2. For any mode of settlement at maturity, of less value than the amount insured on the face of the policy plus any dividend additions, less any indebtedness to the insurer on or secured by the policy, and less any premium or portion of any premium, that may by the terms of the policy be deducted. This paragraph shall not apply to any nonforfeiture provision that employs the cash value less any indebtedness to purchase paid-up or extended insurance, and shall not prohibit the issuance of policies providing for a limitation in the amount payable under certain specified conditions;

3. For forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on any policy loan, while the total indebtedness on the policy, including interest, is less than the loan value of the policy; or

4. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person insured under the policy.

Drafting Note: Existing item (2) has been deleted because the subject is covered in more detail in § 38.2-3104.

§ 38.2-3317. Provisions required by other jurisdictions.– Individual life insurance policies issued by any foreign or alien insurer for delivery in this Commonwealth may contain any provision that is prescribed by the laws of its domiciliary jurisdiction and that is not in conflict with the laws of this Commonwealth. Policies issued by any domestic insurer for delivery in any other jurisdiction may contain any provision required by the laws of that jurisdiction.

Drafting Note: As part of the plan to have this article contain only standard policy provisions for individual life insurance policies, this section, which applies to both individual and group life insurance policies, has been moved to Chapter 31 (proposed § 38.2-3114).

Drafting Note: Under the plan of having this article contain standard policy provisions for individual life insurance, this section has been moved to Chapter 31, Article 1. It should be noted that § 38.1-442.1 of existing Chapter 9, Article 1 has the same title. These provisions are being combined into one section (proposed § 38.2-3112).

Article 2.

Group Life Insurance Policies.

§ 38.2-3318. Definitions.—As used in this article:

"Burial association group life insurance" means group life insurance issued to an incorporated association, as described in § 38.2-4000, whose principal purpose is to assist its members in (i) financial planning for their funerals and burials and (ii) obtaining insurance for the payment, in whole or in part, of funeral, burial and other expenses. The association shall be deemed to be the policyholder, to insure the members of the association for the benefit of persons other than the association.

"Group credit life insurance" means group life insurance issued to a creditor or its parent holding company or to a trustee or agent designated by two or more creditors, who shall be deemed the policyholder, to insure the debtors of the creditor or creditors in connection with a loan or other credit transaction of more than ten years' duration.

Drafting Note: 1. Existing law limits group life insurance to certain types of groups. Since many of the requirements are inconsistent and seem unnecessary, we have proposed to (i) eliminate the restriction that group life insurance can only be issued to certain types of groups in favor of a general requirement that group life insurance may be issued to any type of group, and (ii) have the same requirements for all groups with additional requirements for burial and creditor groups.

2. The burial association group life insurance definition is from existing § 38.1-471.1.

3. The group credit life insurance definition is based on existing § 38.1-480.

§ 38.2-3319. Insurance shall meet requirements of this article.—No group life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it conforms to the requirements of this article.

Drafting Note: This section has been moved from existing § 38.1-471 and modified.

§ 38.2-3320. Group requirements.—A. A group life insurance policy shall comply with the following requirements:

1. The members eligible for insurance under the policy shall be all the members of the group, or all of any class or classes of the group. However, an insurer may exclude or limit coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

2. A group life insurance policy shall cover at least two persons, other than spouses or minor children, at the issue date and at each policy anniversary date.

3. The amounts of insurance under a group life insurance policy shall be based upon some plan precluding individual selection by the policyholder, employer, union, association, or other organization.

4. A group life insurance policy shall be for the benefit of persons other than the employer or labor union.

B. In addition to the requirements of subsection A of this section, group credit life insurance as defined in § 38.2-3318 shall be subject to the following requirements:

1. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classses of debtors. The policy may provide that the term "debtors" include (i) borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction; (ii) the debtors of one or more subsidiary corporations; and (iii) the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control.

2. The premium for the policy shall be paid by the policyholder, either from the creditor's fund, or from charges collected from the insured debtors, or from both. Except as provided in paragraph 3 of this section, a policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The amount of insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor.

5. The insurance shall be payable to the creditor, or any successor of the right, title or interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

6. Insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

Drafting Notes: 1. The sections limiting group life insurance to certain types of groups have been

eliminated. Therefore, the Code would no longer:

a. Describe the types of groups such as employee groups;

b. State specifically to whom the policy may be issued, i.e. "issued to the employer or the trustees of a fund established by an employer, which employer shall be deemed to be the policyholder";

c. Define "employee" for employee groups to include retired employees, employees of subsidiaries, individual proprietors and certain directors;

d. Specify to whom a public employee group policy may be issued, such as a department head or association of public employees;

e. Define "public employees"; or

f. Define "employee" for employers' association groups, trustee groups or professional groups.

2. So that the requirements for all groups would be the same, with additional requirements for creditor groups and burial groups, the following requirements were deleted:

a. Participation requirements (e.g. 100% of employees in a noncontributory plan);

b. Minimum size requirements (e.g. employee group: ten employees; labor union: twenty-five members);

c. Restrictions on premium payments (such as requiring labor unions to pay part of the premiums); and

d. Amount limitations for credit union groups.

3. The following requirements were retained:

a. The amounts of insurance under the policy must be based on a plan precluding individual selection but no longer for the insured;

b. The members eligible for insurance must be all the members of the group, or all or any class or classes of the group. However, an insurer may exclude or limit coverage on any person as to whom individual insurability is not satisfactory to the insurer; and

c. The creditor group provisions are from existing § 38.1-480. The reference to credit transactions of ten years or less in item (7) of § 38.1-480 has been omitted from this section because a similar provision is being added in Chapter 37 as subsection B of § 38.2-3702.

4. The various restrictions that a policy shall be issued for the benefit of persons other than the employer (or labor union, credit union, etc.) have been replaced by a restriction that a group life insurance policy shall be for the benefit of persons other than the employer or labor union.

§ 38.2-3321. Burial association group life insurance. --Burial association group life insurance may not be issued to an association in which membership is conditioned upon the member's designating at any time a specific funeral director or cemetery as the beneficiary under the insurance, so as to deprive the representatives or family of the deceased member from, or in any way control them in, obtaining funeral supplies and services in an open competitive market.

Drafting Note: This provision is from existing § 38.1-471.1, paragraph 4.

§ 38.2-3322. Trustee groups.--One or more groups may be insured under one group life insurance policy issued to a trustee.

Drafting Note: The present law allows only for certain types of groups to have policies issued to a trustee, but this new section would allow any one or more groups to be insured under one policy issued to a trustee.

Drafting Note: Portions of this section now appear in proposed §§ 38.2-3318 and 38.2-3321. The rest of this section has been deleted to be consistent with the reorganization of this article.

§ 38.2-3323. Group life insurance coverages of spouses and minor dependent children; dependent handicapped children.--A. Coverage under a group life insurance policy, except a group credit life insurance policy, may be extended to insure the spouse and any child who is under the age of nineteen years or who is a dependent and a full-time student under twenty-five years of age, or any class of spouses and dependent children, of each insured group member who so elects. The amount of insurance on the life of a spouse or child shall not exceed the amount of insurance on the life of the insured group member.

B. A spouse insured under this section shall have the same conversion right to the insurance on his or her life as the insured group member.

C. Notwithstanding the provisions of § 38.2-3331, one certificate may be issued for each family unit if a statement concerning any spouse's or dependent child's coverage is included in the certificate.

D. In addition to the coverages afforded by the provisions of this section, any such plan for group life insurance which includes coverage for children shall afford coverage to any child who is both (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (ii) chiefly dependent upon the employee for support and maintenance. The insurer shall be allowed to charge a premium at the insurer's then customary rate applicable to such group policy for such extended coverage.

E. 1. Upon termination of such group coverage of a child, the child shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual life insurance policy without disability or other supplementary benefits, if:

a. An application for the individual policy is made, and the first premium paid to the insurer, within thirty-one days after such termination; and

b. The individual policy, at the option of such person, is on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

c. The individual policy is in an amount not in excess of the amount of life insurance which ceases

because of such termination, less the amount of any life insurance for which such person becomes eligible under the same or any other group policy within thirty-one days after such termination, provided that any amount of insurance which has matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

d. The premium on the individual policy is at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the individual age attained on the effective date of the individual policy.

2. Subject to the same conditions set forth above, the conversion privilege shall be available (i) to a surviving dependent, if any, at the death of the group member, with respect to the coverage under the group policy which terminates by reason of such death, and (ii) to the dependent of the group member upon termination of coverage of the dependent, while the group member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

Drafting Note: 1. The current law provides that only policies for employee groups, employers' association groups, trustee groups, and professional groups may extend coverage to spouses and minor children. We have proposed that any group except a creditor group may extend coverage to spouses and minor children. "Employee" was changed to "group member" because of this change.

2. The specific amount and the fifty percent limitations have been replaced by a limitation that the amount of insurance on the life of a spouse or lives of minor children shall not exceed the amount on the life of a group member.

3. The premium payment provision has been deleted.

Drafting Note: This section has been modified and moved to become subsection B of § 38.2-3320. A similar provision for credit transaction under ten years is provided for in proposed § 38.2-3702.

§ 38.2-3324. Standard provisions required; exceptions.—A. No group life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the standard provisions prescribed in this article. The standard provisions required for individual life insurance policies shall not apply to group life insurance policies.

B. If a group life insurance policy is not term insurance, it shall contain a nonforfeiture provision that in the opinion of the Commission is equitable to the insured persons and to the policyholder. This subsection shall not be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

C. The provisions of § 38.2-3330, subsection A of § 38.2-3331, and §§ 38.2-3332 through 38.2-3334 shall not apply to group credit life insurance policies.

Drafting Note: 1. The exception for debtor group life insurance (now referred to as group credit life insurance) was put into a separate subsection.

2. The provision concerning assignments is being moved to a separate section (proposed § 38.2-3337) since it is not a standard policy provision.

§ 38.2-3325. Grace period.— Each group life insurance policy shall contain a provision that the policyowner is entitled to a grace period of not less than thirty-one days for the payment of any premium due except the first. The provision shall also state that during the grace period the death benefit coverage shall continue in force, unless the policyowner has given the insurer written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance . The policy may provide that the policyowner shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

§ 38.2-3326. Incontestability.—A. Each group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue.

B. The provision shall also state that no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and

2. Unless the statement is contained in a written instrument signed by him.

§ 38.2-3327. Entire contract; statements deemed representations.—A. Each group life insurance policy shall contain a provision that the policy and any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. A copy of any application of the policyowner shall be attached to the policy when issued;

2. All statements made by the policyowner or by the persons insured shall be deemed representations and not warranties; and

3. No written statement made by any person insured shall be used in any contest unless a copy of the statement has been furnished to the person, his beneficiary or his personal representative.

§ 38.2-3328. Evidence of individual insurability.–Each group life insurance policy shall contain a provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

§ 38.2-3329. Misstatement of age.– Each group life insurance policy shall contain a provision that an equitable adjustment of premiums, benefits, or both shall be made if the age of a person insured has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.

§ 38.2-3330. Payment of benefits.– Each group life insurance policy shall contain a provision that any sum payable because of the death of the person insured shall be payable to the beneficiary or beneficiaries designated by the person insured, subject to:

1. The provisions of the policy as to all or any part of such sum if there is no designated beneficiary living at the time of death of the person insured; and

2. Any right reserved by the insurer in the policy and set forth in the certificate to pay a part of the sum, not exceeding $2,000, to any person appearing to the insurer to be equitably entitled thereto because of having incurred funeral or other expenses incident to the death or last illness of the person insured.

Drafting Note: The $500 limit was raised to $2,000 because of inflation. The NAIC Group Life Insurance Model Act also has a $2,000 limit.

§ 38.2-3331. Individual certificates.–A. Each group life insurance policy shall contain a provision that the insurer will issue to the policyholder, for delivery to each person insured, an individual certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions and exclusions applicable to the coverage provided;

2. To whom the insurance benefits are payable; and

3. The rights and conditions set forth in §§ 38.2-3332, 38.2-3333 and 38.2-3334.

B. Each group credit life insurance policy, where any part of the premium is paid by the debtors or by the creditor from identifiable charges collected from the insured debtors not required of an uninsured debtor, shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form that will contain a statement that the life of the debtor is insured under the policy and that any death benefit paid under the policy by reason of his death shall be applied to reduce or extinguish the indebtedness.

Drafting Note: Subsection B was moved from existing § 38.1-428.4, and minor editorial changes have been made.

§ 38.2-3332. Right to individual policy upon termination of employment or membership.– Each group life insurance policy shall contain a provision that if the insurance, or any portion of it, on a person covered under the policy, other than a minor child insured pursuant to § 38.2-3323, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the person shall be entitled to have the insurer issue him without evidence of insurability an individual policy of life insurance, without disability or other supplementary benefits, subject to the following:

1. Application for the individual policy shall be made, and the first monthly or other mutually agreeable model premium paid to the insurer, within thirty-one days after the termination;

2. The individual policy shall at the option of the person be on any one of the forms, except term insurance, then customarily issued by the insurer, subject to the insurer's customary age and amount requirements for the forms;

3. The amount of the individual policy shall not exceed the amount of terminated group life insurance less the amount of any group life insurance that the person is or becomes eligible for within thirty-one days after the termination. Any amount of insurance maturing on or before the date of the termination as an endowment payable to the person insured, whether in one sum, installments or in the form of an annuity, shall not be included in the amount of terminated group life insurance; and

4. The premium on the individual policy shall be at the insurer's then current rate applicable to the form and amount of the individual policy, to the class of risk to which the person then belongs, and to the person's age on the effective date of the individual policy.

§ 38.2-3333. Right to individual policy upon termination of group policy or elimination of class of insured persons.–Each group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person, other than a minor child insured pursuant to § 38.2-3323, whose insurance terminates and who has been insured for at least five years prior to the termination date shall be entitled to have the insurer issue him an individual life insurance policy. The individual life policy shall be subject to the conditions and limitations set forth in § 38.2-3332. However, the group policy may contain a provision that the amount of

the individual policy shall not exceed the smaller of (i) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days after the termination, or (ii) $10,000.

Drafting Note: The $2,000 limit has been raised to $10,000.

§ 38.2-3334. Death after termination of group insurance and before issuance of individual policy.—Each group life insurance policy shall contain a provision that if a person insured under the group policy dies during the period within which he is entitled to have an individual policy issued to him in accordance with § 38.2-3332 or § 38.2-3333 and before the individual policy has become effective, the amount of life insurance that he would have been entitled to have issued to him under an individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium was made.

Drafting Note: This section has been moved to become subsection B of proposed § 38.2-3331.

§ 38.2-3335. Additional persons becoming eligible.—Each group life insurance policy shall contain a provision that any person who subsequently becomes a member of a group or class that is covered under the policy shall be eligible for group life insurance in accordance with the same requirements as any other member of the group or class.

Drafting Note: The references to types of groups were deleted because of the proposal to eliminate the requirement of allowing only certain types of groups.

§ 38.2-3336. Provisions required by other jurisdictions.— Group life insurance policies issued by any foreign or alien insurer for delivery in this Commonwealth may contain any provision that is prescribed by the laws of its domiciliary jurisdiction and that is not in conflict with the laws of this Commonwealth. Policies issued by any domestic insurer for delivery in any other jurisdiction may contain any provision required by the laws of that jurisdiction.

§ 38.2-3337. Assignment.—With mutual agreement among the insured, the policyholder, and the insurer, any person insured under a group life insurance policy may make an irrevocable assignment of the rights and benefits conferred on him by any provision of the policy or by this article. The assignment may be made to any person other than the insured's employer.

Drafting Note: This provision concerning assignment was moved from existing § 38.1-424.

§ 38.2-3338. Provisions prohibited.—No group life insurance policy shall be delivered or issued for delivery in this Commonwealth if it contains any provision:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues; or

2. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person insured under the policy.

Drafting Note: This section contains the applicable requirements of existing § 38.1-406 that would apply to group insurance. § 38.1-406 is in Article 5, which pertains primarily to individual policies, but § 38.1-406 applies to group policies. These provisions as applicable to group insurance were moved here so that the group provisions and individual provisions would be in separate articles.

§ 38.2-3339. Exemption of group life insurance policies from legal process.—No group life insurance policy, nor its proceeds, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law, to pay any debt or liability of any person insured under the policy, or his beneficiary, or any other person who has a right under the policy, either before or after payment. If the proceeds of a group life insurance policy are not made payable to a named beneficiary, the proceeds shall not constitute a part of the insured person's estate for the payment of his debts.

Article 3.

Industrial Life Insurance Policies.

§ 38.2-3340. Definition of industrial life insurance.—" Industrial life insurance " means life insurance provided by an individual insurance contract (i) under which premiums are payable monthly or more frequently, and (ii) with the words "industrial policy" printed upon the policy as a part of the descriptive matter.

Drafting Note: The reference to "weekly premium policy" has been deleted because companies now sell weekly premium ordinary policies.

§ 38.2-3341. Standard provisions required.—No industrial life insurance policy shall be delivered or issued for delivery in this Commonwealth, unless it contains in substance the provisions prescribed in this article or provisions that are, in the Commission's opinion, more favorable to policyowners.

§ 38.2-3342. Ten-day right to examine policy.—No industrial life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it has printed on it a notice stating in substance that if during a ten -day period from the date the policy is delivered to the policyowner, the policy is surrendered

to the insurer or its agent with a written request for cancellation, the policy shall be void from the beginning and the insurer shall refund any premium paid for the policy. Nothing in this section shall prohibit an insurer from extending the right to examine period to more than ten days if the period is specified in the policy.

§ 38.2-3343. Grace period.—A. Each industrial life insurance policy shall contain a provision that the insured is entitled to a grace period of twenty-eight days within which the payment of any premium after the first may be made. This grace period shall terminate at noon on the twenty-eighth day after the due date of the defaulted premium. However, for monthly payment policies the insured shall be entitled to a grace period of not less than thirty-one days.

B. Each policy shall also contain a provision that during the grace period the policy shall continue in full force, but if a claim arises under the policy during the grace period and before the overdue premiums are paid, the amount of overdue premiums may be deducted in any settlement under the policy.

§ 38.2-3344. Policy and application to constitute entire contract; statements deemed representation.—A. Each industrial life insurance policy shall contain a provision that the policy, or the policy and the application for the policy, if a copy of the application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. All statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties; and

2. No such statement shall be used in defense of a claim under the policy unless it is contained in a written application that is endorsed upon or attached to the policy when issued.

Drafting Note: This section has been changed to be consistent with proposed § 38.2-3304, which applies to individual life insurance policies.

§ 38.2-3345. Incontestability.— Each industrial life insurance policy shall contain a provision that the policy shall be incontestable after it has been in force for two years from the date of issue during the lifetime of the insured, except for nonpayment of premiums, and except as to provisions and conditions (i) relating to benefits in the event of certain specific types of disability and (ii) granting additional insurance specifically against death by accident or accidental means.

§ 38.2-3346. Misstatement of age.— Each industrial life insurance policy shall contain a provision that if, before final settlement of the policy, the age of the insured or the age of any other person if considered in determining the premium is found to have been misstated, the amount payable under the policy shall equal the amount that the premium would have purchased at the insured's or other person's correct age, at the time the policy was issued.

§ 38.2-3347. Nonforfeiture benefits and cash surrender values.—Each industrial life insurance policy shall contain a provision for nonforfeiture benefits in accordance with the requirements of §§ 38.2-3202 and 38.2-3208, and a provision for cash surrender values in accordance with the requirements of §§ 38.2-3203 and 38.2-3209.

Drafting Note: Changes have been made to update this section and make it consistent with the standard nonforfeiture provisions that were amended in 1982.

§ 38.2-3348. Reinstatement.— Each industrial life insurance policy shall contain a provision that the policy, if not surrendered for its cash value or if the period of extended term insurance has not expired, may be reinstated within one year from the date of default in payment of premiums upon:

1. Payment of all overdue premiums and, at the insurer's option, interest on the overdue premiums at an annual rate not exceeding six percent; and

2. Presentation of evidence satisfactory to the insurer of the insurability of the insured.

§ 38.2-3349. Table of nonforfeiture options.—Each industrial life insurance policy shall contain a table showing the nonforfeiture options available under the policy each year upon default in the payment of premiums during at least the first twenty years of the policy, or during the premium-paying period if less than twenty years. There shall also be a provision that the insurer will furnish, upon request, an extension of the table beyond the years shown in the policy.

§ 38.2-3350. Settlement.— Each industrial life insurance policy shall contain a provision that when a death claim arises under the policy, settlement shall be made within two months after receipt of due proof of death.

§ 38.2-3351. Title.— Each industrial life insurance policy shall have a title on its face that briefly and accurately describes the nature and form of the policy.

§ 38.2-3352. Provisions not required in certain policies.—The provisions of this article do not apply to policies issued or granted in exercise of the nonforfeiture provisions of § 38.2-3347.

§ 38.2-3353. Provisions required by other jurisdictions.— Industrial life insurance policies issued by any foreign or alien insurer for delivery in this Commonwealth may contain any provision that is prescribed by

the laws of its domiciliary jurisdiction and is not in conflict with the laws of this Commonwealth. Policies issued by any domestic insurer for delivery in any other jurisdiction may contain any provision required by the laws of that jurisdiction.

§ 38.2-3354. Prohibited provisions.— No industrial life insurance policy shall be delivered or issued for delivery in this Commonwealth if it contains any of the following provisions:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues;

2. For any mode of settlement at maturity of less value than the amount insured by the policy plus any dividend additions to the policy, less (i) any indebtedness to the insurer on or secured by the policy and (ii) any premium that may by the terms of the policy be deducted. This paragraph shall not apply to any nonforfeiture provision that employs the cash value less any indebtedness, to purchase paid up or extended insurance, and shall not prohibit the issuance of policies providing for a limitation in the amount payable under certain specified conditions; or

3. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person insured under the policy.

Title 38.2

CHAPTER 34.

Provisions Relating to Accident and Sickness Insurance Policies.

1. Existing articles 2, 2.2 and 2.3 of Chapter 8 have been reorganized. The plan is to have two separate chapters (proposed chapters 34 and 35) for accident and sickness insurance with the following articles:

Chapter 34:

Provisions Relating to Accident and Sickness Insurance

Article 1 - General Provisions

Article 2 - Mandated Benefits

Article 3 - Jurisdiction Over Providers of Health Care Services

Chapter 35:

Accident and Sickness Insurance Policies

Article 1 - Individual Accident and Sickness Insurance

Article 2 - Individual Accident and Sickness Insurance Minimum Standards Act (now Article 2.3)

Article 3 - Group Accident and Sickness Insurance Policies

Article 4 - Industrial Sick Benefit Insurance

2. The following major substantive changes have been proposed for this chapter:

a) Proposed § 38.2-3402:

(i) The section has been expanded to require a certification regarding the effect of false statements in applications for group policy certificates where individual underwriting is done.

(ii) The section has been changed to require that the certificate be part of the application.

(iii) A sentence has been added to provide flexibility for direct response and guaranteed issue policies.

CHAPTER 34.

PROVISIONS RELATING TO ACCIDENT AND SICKNESS INSURANCE.

Article 1.

General Provisions.

§ 38.2-3400. Application of chapter.—A. This chapter and Chapter 35 apply to insurance policies or contracts of the class described in § 38.2-109 delivered or issued for delivery in this Commonwealth except as provided in subsection B of this section.

B. Nothing in this chapter shall apply to or affect:

1. Any workers' compensation insurance policy;

2. Any liability insurance policy with or without supplementary expense coverage, including any motor vehicle liability insurance policy, providing weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, irrespective of the legal liability of the insured or any other person;

3. Any policy or contract of reinsurance;

4. Life insurance or annuities;

5. Any industrial sick benefit insurance; or

6. Any credit accident and sickness insurance policy.

Drafting Notes: 1. The section was changed from a "definition" section to a "scope" section in order to make it clear what the chapter applies to and does not apply to. The chapter would cover both individual and group accident and sickness insurance.

2. Existing § 38.1-360, presently listing what Article 2 does not apply to, was modified to become subsection B. Where it pertains to liability insurance, existing § 38.1-360 seems unnecessarily difficult to understand, so it was rewritten. Also, where it pertains to life insurance and annuities existing § 38.1-360 is unnecessarily long and seems to categorize accidental death and dismemberment insurance as accident and sickness insurance, but it can be either life or accident and sickness insurance. We have proposed using the defined terms life insurance and annuities.

§ 38.2-3401. Forms of insurance authorized.—Accident and sickness insurance shall be issued only in the following forms:

1. Individual accident and sickness policies; or

2. Group accident and sickness policies.

Drafting Note: This section has been added to clarify that a policy must be either individual or group.

Drafting Note: Section 38.1-347.1 has been moved and renumbered § 38.2-3408.

Drafting Note: Section 38.1-347.2 has been moved and renumbered § 38.2-3407.

Drafting Note: Section 38.1-348 has been moved and renumbered § 38.2-3500.

Drafting Note: Section 38.1-348.1 has been moved and renumbered § 38.2-3409.

§ 38.2-3402. Certification to accompany application.—A. Each application for an individual accident and sickness insurance policy shall contain a certification, signed by both the applicant and the agent soliciting the insurance, to the effect that: "The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy." If the application is to be used in a solicitation where no agent is involved, the certification may delete the reference to and signature of the agent soliciting the insurance.

B. Subsection A of this section shall also apply to an application by an individual for coverage under a group policy where individual underwriting is done.

C. If the certification is wholly or partially inapplicable to a particular form of policy, the insurer may modify or omit the certification with the approval of the Commission.

Drafting Notes: 1. The section has been changed to require the certificate to be part of the application.

2. This requirement has been extended to individual applications for coverage under group policies where individual underwriting is done because of the growing trend of individual underwriting in group accident and sickness insurance.

3. Subsection C has been added to provide flexibility for direct response and guaranteed issue policies where the certificate may not be appropriate.

§ 38.2-3403. Fraudulent procurement of policy.—A. No person shall knowingly secure, attempt to secure or cause to be secured an individual accident and sickness insurance policy on any person not in an insurable condition by means of misrepresentations or false or fraudulent statements.

B. An insurance agent who violates this section shall be subject to the penalties under § 38.2-1831 in addition to the penalties of § 38.2-218.

Drafting Notes: 1. This section has been broadened to include "attempt to secure."

2. The reference to "agents and physicians" was deleted because they would be included in "person" as it is defined in proposed § 38.2-100.

3. A reference to agents being subject to license revocation under proposed § 38.2-1831 has been added.

§ 38.2-3404. Commission may establish rules and regulations for simplified and readable accident and sickness insurance policies.—A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations establishing standards for simplified and readable accident and sickness insurance policy forms. Any such rules and regulations shall apply to any policy forms of accident and sickness insurance as defined in § 38.2-109, except credit accident and sickness insurance, issued on a nongroup basis or to groups with ten or fewer members.

B. The rules and regulations issued hereunder may permit an insurer to issue policies containing policy provisions that deviate in language from the policy provisions required by §§ 38.2-3500 through 38.2-3506 where applicable, provided the provisions in each instance are not less favorable to the insured or the beneficiary.

C. No insurer shall deliver or issue for delivery an accident and sickness insurance policy in this Commonwealth unless the Commission has determined that the policy form satisfies the readability standards established by the rules and regulations and is in compliance with other statutory requirements.

Drafting Note: The sentences relating to the advisory period have been deleted since it is over.

§ 38.2-3405. Certain subrogation provisions and limitations upon recovery in hospital, medical, etc., policies forbidden. A. No insurance contract providing hospital, medical, surgical and similar or related benefits, and no subscription contract or health services plan delivered or issued for delivery in this Commonwealth shall contain any provision providing for subrogation of any person's right to recovery for personal injuries from a third person.

B. No insurance contract, subscription contract or plan shall contain any provision denying or limiting the recovery from any claim against or settlement with a third person responsible for such personal injuries.

Drafting Note: Proposed § 38.2-3405 has been moved here from Chapter 8, Article 1, General Provisions (now proposed Chapter 3), since this section deals only with accident and sickness insurance and health care plans.

§ 38.2-3406. Accident and sickness benefits not subject to legal process.—The installment payments to the holder of any accident and sickness insurance policy or certificate shall not be subject to the lien of any attachment, garnishment proceeding, writ of fieri facias, or to levy or distress in any manner for any debt due by the holder of the policy or certificate.

Drafting Note: Proposed § 38.2-3406 has been moved here from existing Chapter 8, Article 1, General Provisions (now proposed Chapter 3) since this section deals only with accident and sickness insurance.

§ 38.2-3407. Health benefit programs.—A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

C. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

D. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

E. For the purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

Drafting Note: This section has been moved from existing § 38.2-347.2.

Mandated Benefits.

§ 38.2-3408. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.—A. If an accident and sickness insurance policy provides reimbursement for any service that may be legally performed by a person licensed in this Commonwealth as a chiropractor, optometrist, optician, psychologist, clinical social worker, podiatrist, or chiropodist, reimbursement under the policy shall not be denied because the service is rendered by the licensed practitioner. The provisions of this section relating to clinical social work services shall not apply unless insurance coverage for such services has been specifically contracted for under the policy, which coverage must be made available to the purchaser of such policy.

B. This section shall not apply to Medicaid, or any state fund.

Drafting Notes: The provision relating to chiropractic and contracts issued by plans organized pursuant to Chapter 11 (§ 32-195 et seq.), now Chapter 42, has been deleted. This section does not apply to Chapter 42 contracts, which are subject to a provision which is similar to proposed § 38.2-3408.

§ 38.2-3409. Coverage of dependent children.—A. Any group or individual accident and sickness insurance policy or subscription contract delivered or issued for delivery in this Commonwealth which provides that coverage of a dependent child shall terminate upon that child's attainment of a specified age, shall also provide in substance that attainment of the specified age shall not terminate the child's coverage during the continuance of the policy while the dependent child is and continues to be both: (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (ii) chiefly dependent upon the policyowner for support and maintenance.

B. Proof of incapacity and dependency shall be furnished to the insurer by the policyowner within thirty-one days of the child's attainment of the specified age. Subsequent proof may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the specified age.

C. The insurer may charge an additional premium for any continuation of coverage beyond the specified age. The additional premium shall be determined by the insurer on the basis of the class of risks applicable to the child.

Drafting Note: The effective date provision has been deleted as there will be one new effective date for the entire title.

Drafting Note: Section 38.1-348.4 has been moved and renumbered § 38.2-3502.

§ 38.2-3410. Construction of policy generally; words "physician" and "doctor" to include dentist.—Each accident and sickness insurance policy or subscription contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended or modified by any rider, endorsement, or application attached to and made a part of the policy. However, the word "physician" or "doctor" when used in any accident or sickness insurance policy, or subscription contract shall be construed to include a dentist performing covered services within the scope of his professional license.

§ 38.2-3411. Coverage of newborn children required.—A. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense incurred basis that provides coverage for a family member of the insured or the subscriber shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

B. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or subscription contract may require that notification of birth of a newly born child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or corporation issuing the subscription contract within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

Drafting Note: The effective date provision has been deleted as there will be one new effective date for the entire title.

§ 38.2-3412. Coverages for mental, emotional or nervous disorders.—A. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense incurred basis that provides coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a mental hospital or a general hospital, provide coverage for mental, emotional or nervous disorders. The limits of the benefits shall not be more restrictive than for any other illness except that the benefits may be limited to thirty days of active treatment in any policy year. The thirty days of inpatient care specified in this section for mental, emotional or nervous disorders shall include benefits for drug and alcohol rehabilitation and treatment necessary to restore any covered person to satisfactory emotional and physical health, whether the care is provided in a mental or general hospital or other licensed drug and alcohol rehabilitation facility. However, with respect only to the benefits for alcohol and drug rehabilitation: (i) the level of coverage available may be different from the coverage that is payable for the treatment of other mental, emotional and nervous disorders if the benefits cover the reasonable cost of necessary services, or provide an eighty dollar per

day indemnity benefit, and (ii) the benefits may be limited to ninety days of active inpatient treatment in the covered person's lifetime.

The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment is made.

B. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue hospital, medical or major medical subscription contracts shall, in the case of outpatient benefits, make additional benefits available for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for the policy or contract to select any alternative level of benefits that may be offered by the insurer or corporation. The additional outpatient benefits to be made available shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. However, the coinsurance factor need not exceed fifty percent or the coinsurance factor applicable for physical illness generally, whichever is less. The maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to no less than $1,000.

C. Subsection B shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies, or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. As used in this section:

"Outpatient benefits" means only those payable for (i) charges made by a hospital for the necessary care and treatment of mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, (ii) charges for services rendered or prescribed by a physician, psychologist or clinical social worker licensed to practice in this Commonwealth for the necessary care and treatment for mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, or (iii) charges made by a mental health treatment center, as defined herein, for the necessary care and treatment of a covered person provided in the treatment center.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician or a psychologist licensed to practice in this Commonwealth. The facility shall be: (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

E. "Mental, emotional or nervous disorders" as used in this section shall include physiological and psychological dependence upon alcohol and drugs. However, if the optional coverage made available pursuant to § 38.2-3413 is accepted by or on behalf of the insured or subscriber and included in a policy or contract, "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs.

Drafting Note: In subsection B technical corrections were made by changing "of" to "or" and "greater" to "less" in the sentence concerning the coinsurance factor. The reference to the effective date has been deleted as there will be one new effective date for the entire title.

§ 38.2-3413. Coverages for alcohol and drug dependence.—A. As used in this section:

"Treatment" includes diagnostic evaluation, medical, psychiatric and psychological care, counseling and rehabilitation for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs and is determined to be necessary by and is provided by a certified alcoholism counselor, certified drug counselor, professional counselor, psychologist, or social worker licensed or certified pursuant to Chapter 28 (§ 54-923 et seq.) of Title 54, or by a licensed physician.

" Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the State Mental Health and Mental Retardation Board pursuant to Chapter 8 (§ 37.1-179 et seq.) or Chapter 11 (§ 37.1-203 et seq.) of Title 37.1; (ii) an office or clinic of a licensed physician or clinical psychologist; (iii) a state agency or institution; or (iv) a facility accredited by the Joint Commission on Accreditation of Hospitals.

"Intermediate care facility" means a licensed, residential public or private alcohol or drug rehabilitation facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour-a-day state-approved program of inpatient treatment and care for inpatient alcoholics or drug addicts.

B. No group accident and sickness insurance policy providing coverage on an expense incurred basis and no group subscription contract which provides coverage of a family member of the insured or the subscriber shall be delivered or issued for delivery in this Commonwealth unless coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs was made available as an option. The coverage made available shall not have limits that are more restrictive than for any other illness and shall include as a minimum (i) treatment as an inpatient in any alcohol or drug rehabilitation facility and intermediate care facility for at least forty-five days during any given policy year or calendar year, and (ii) outpatient treatment in any alcohol or drug rehabilitation facility consisting of at

least forty-five sessions of individual, group, or family counseling during any given policy year or calendar year.

C. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

Drafting Note: The reference to an effective date has been deleted as there will be one new effective date for the entire title.

§ 38.2-3414 Optional coverage for obstetrical services.—A. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue group hospital, group medical or group major medical subscription contracts shall provide coverage for obstetrical services as an option available to the group policyholder or the contract holder in the case of benefits based upon treatment as an inpatient in a general hospital. The reimbursement for obstetrical services by a physician shall be based on the charges for the services determined according to the same formula by which the charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

B. This section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

Drafting Notes: 1. The reference to "usual, customary and reasonable" was deleted at the suggestion of the industry so that these services can be reimbursed on the basis of the same formula that is used for any other illness.

2. The reference to the effective date has been deleted as there will be one new effective date for the entire title.

§ 38.2-3415. Exclusion or reduction of benefits for certain causes prohibited.—No group accident and sickness insurance policy, nor any group subscription contract, delivered or issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain any provision excluding or reducing the benefits of any insured or subscriber because benefits have been paid or are payable under any individually underwritten and individually issued policy or subscription contract providing exclusively for accident and sickness benefits and for which the entire premium has been paid by the insured, a member of the insured's family, or the insured's guardian.

§ 38.2-3416. Conversion on termination of eligibility; insurer required to offer conversion policy or group coverage.—A. Before an insurer who delivers or issues for delivery in this Commonwealth or who renews, reissues or extends if already issued, any group hospital, medical and surgical or group major medical policy, the insurer shall be required to be able to offer without evidence of insurability to residents of this Commonwealth who are covered under the policy, whose eligibility may terminate under the policy other than due to termination of the group policy, and who may elect Option 1 under § 38.2-3541 a nongroup policy of accident and sickness insurance, either individual or family, whichever is appropriate, pursuant to the provisions of § 38.2-3541.

B. Any insurer who has in effect prior to January 1, 1985, any group policy described in subsection A of this section, may be exempted from the provisions of subsection A of this section. However, for persons affected by the termination of eligibility, the insurer shall be required to continue coverage under the existing group policy, without evidence of insurability and at the insurer's current rate applicable to the group policy, for as long as the affected persons elect or as long as the insurer is not required to offer an acceptable conversion policy.

Drafting Note: Section 38.1-348.11 has been moved and renumbered § 38.2-3541.

§ 38.2-3417. Deductibles and coinsurance options required.—A. An insurer issuing accident and sickness insurance or a corporation issuing subscription contracts on an expense incurred basis shall make available in offering such coverage or contract to the potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first $100 of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

2. Twenty percent of the first $1,000 of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

3. The first $100 and twenty percent of the next $1,000 of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision. However, the option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.2-3519.

B. As used in this section, "make available" means that the insurer or corporation shall disseminate information concerning the option or options and make a policy or contract containing the option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer

or corporation disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

C. This section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the United States Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

Drafting Note: The reference to the effective date has been deleted as there will be one new effective date for the entire title.

§ 38.2-3418. Coverage for victims of rape or incest.—A. Each hospital expense, medical-surgical expense, major medical expense or hospital confinement indemnity insurance policy issued by an insurer, each individual and group subscription contract providing hospital, medical, or surgical benefits issued by a corporation, and each contract issued by a health maintenance organization which provide benefits as a result of an "accident" or "accidental injury" shall be construed to include benefits for pregnancy following an act of rape of an insured or subscriber which was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The seven-day requirement shall be extended to 180 days in the case of an act of rape or incest of a female under thirteen years of age.

Drafting Note: 1. The reference to Chapter 26 implies that HMOs were to be subject to this law, but the present section appears technically deficient as the HMOs do not use an "indemnity type contract" and HMOs do not have to be "non-profit corporations." This is the only mandated benefit where a reference to HMOs is made. This section has been changed to include a correct reference to HMOs.

2. The effective date subsection has been deleted as there will be one new effective date for the entire title.

§ 38.2-3419. Additional mandated coverage made optional to group policy or contract holder.— Any new or existing group policy or contract holder for whom coverage under an accident and sickness insurance policy is issued or renewed by an insurer or for whom coverage under a contract is issued or renewed by a corporation licensed pursuant to Chapter 42 of this title, shall be given the option to purchase any coverage, benefits or services first mandated under this chapter on or after July 1, 1982, provided that all mandated coverages as of June 30, 1982, will not be affected.

Article 3.

Jurisdiction Over Providers of Health Care Services.

Drafting Note: Because of the broad definition of "person" in proposed § 38.2-100, the change of wording from "person or other entity" to "person" throughout the article does not change the meaning.

§ 38.2-3420. Authority and jurisdiction of Commission.— Except as provided in this article, any person providing coverage in this Commonwealth for health care services, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Commission unless the person shows that, while providing the services, it is subject to the jurisdiction of another agency of this Commonwealth, any subdivisions of this Commonwealth, or the federal government.

§ 38.2-3421. How to show jurisdiction of other state agency or federal government.—A person may show that it is subject to the jurisdiction of another agency of this Commonwealth, any subdivision of this Commonwealth, or the federal government by providing to the Commission the appropriate certificate, license or other document issued by the other governmental agency that permits or qualifies it to provide those services set forth in § 38.2-3420.

§ 38.2-3422. Examination.—Any person that fails to show that it is subject to the jurisdiction of another agency of this Commonwealth, any subdivision of this Commonwealth, or the federal government shall submit to an examination by the Commission to determine the organization and solvency of the person and whether or not the person is in compliance with the applicable provisions of this title.

§ 38.2-3423. When subject to this title.—Any person that fails to show that it is subject to the jurisdiction of another agency of this Commonwealth, any subdivision of this Commonwealth, or the federal government shall be subject to all appropriate provisions of this title regarding the conduct of its business.

§ 38.2-3424. Disclosure of extent and elements of coverage.—Any production agency or administrator that advertises, sells, transacts, or administers coverage for health care services in this Commonwealth where that coverage is provided by any person subject to the provisions of this article shall inform any purchaser, prospective purchaser, or covered person of the lack of insurance or other coverage, unless that coverage is fully insured or otherwise fully covered by an admitted life insurer, accident and sickness insurer, health services plan, dental or optometric services plan, or health maintenance organization.

Any administrator that advertises or administers coverage in this Commonwealth that is provided by any person subject to the provisions of this article shall inform any production agency of the elements of the coverage including the amount of "stop-loss" insurance in effect.

Title 38.2

CHAPTER 35.

Accident and Sickness Insurance Policies.

Existing articles 2, 2.2, and 2.3 have been reorganized. The plan is to have two separate (proposed Chapters 34 and 35) chapters for accident and sickness insurance with the following articles:

Chapter 34:

Provisions Relating to Accident and Sickness Insurance

Article 1 - General Provisions

Article 2 - Mandated Benefits

Article 3 - Jurisdiction Over Providers of Health Care Services

Chapter 35:

Accident and Sickness Insurance Policies

Article 1 - Individual Accident and Sickness Insurance

Article 2 - Individual Accident and Sickness Insurance Minimum Standards Act (now Article 2.3)

Article 3 - Group Accident and Sickness Insurance Policies.

Article 4 - Industrial Sick Benefit Insurance.

ARTICLE 1

General Provisions.

1. Existing § 38.1-348.4 (proposed § 38.2-3502) has been changed to require that the notice regarding claims and the ten day free look be printed on the policy instead of allowing an option to attach the notice to the policy. Also, a sentence has been added to provide flexibility for direct response and guaranteed issue policies. Also, this section has been changed to provide that if a policy is returned during the ten day free look period the policy is voided from inception.

2. The older NAIC model provisions in existing §§ 38.1-349 and 38.1-350 (proposed §§ 38.2-3503 and 38.2-3504) have been replaced by the NAIC model simplified policy provisions but the entire contract time limit on certain defenses, preexisting conditions, and reinstatement, notice of claim and proof of loss provisions have been modified after discussion with industry representatives.

3. For consistency, the five day requirement for delivering or mailing a written notice not to renew has been changed to the same amount of time as the grace period. A similar change has been made to the optional cancellation provision.

4. The $1,000 amount limitation has been raised to $2,000 in the optional facility of payment provision, item (9) of §38.1-349. (renumbered §38.2-3503)

ARTICLE 3.

Group Accident and Sickness Insurance Policies.

The current Virginia Code has no standard policy provision requirements for group accident and sickness insurance.

This proposed article essentially adopts the NAIC Health Insurance Standard Provisions Model Act. Some changes were made for clarity, which is consistent to that done under this project for the standard group life insurance policy provisions.

This proposed article has similar requirements for the types of groups as proposed in the Group Life Insurance Article.

ARTICLE 4.

Industrial Sick Benefit Insurance.

The only substantive change proposed in this article is to add a new section that would prohibit the sale of industrial sick benefit insurance on or after October 1, 1987, a year after the effective date of the law.

CHAPTER 35.

ACCIDENT AND SICKNESS INSURANCE POLICIES.

Article 1.

Individual Accident and Sickness Insurance Policies.

§ 38.2-3500. Form of policy.—A. No individual accident and sickness insurance policy shall be delivered or issued for delivery to any person in this Commonwealth unless:

1. The entire consideration for the policy is expressed in the policy;

2. The time at which the insurance takes effect and terminates is expressed in the polcy;

3. The policy insures only one person, except that it may insure eligible family members, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyowner;

4. The exceptions and reductions are set forth in the policy and, except those that are set forth in §§ 38.2-3503 through 38.2-3508, are printed with the benefit provisions to which they apply, or under an appropriate caption, but if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with that benefit provision;

5. Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form; and

6. It contains no provision making any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless that portion is set forth in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commission.

B. If any policy is issued by an insurer domiciled in this Commonwealth for delivery to a person residing in another state, and if the insurance supervisory official of the other state advises the Commission that any such policy is not subject to approval or disapproval by such official, the Commission may by ruling require that such policy meet the standards set forth in this chapter.

C. "Eligible family member" means the (i) spouse, (ii) dependent children, (iii) children under a specified age not greater than nineteen years, and (iv) any person dependent on the policyowner.

Drafting Note: Present item (4) has been deleted because this is now covered in more detail under the readability regulation issued under present § 38.2-3404.

§ 38.2-3501. Policy forms; powers of Commission.—Individual accident and sickness insurance policy forms and the rate manuals showing rules and classification of risks applicable to individual accident and sickness insurance policy forms shall be subject to the provisions of § 38.2-316. The Commission, subject to § 38.2-316, may disapprove or withdraw approval of any such policy form if it finds that the benefits provided in the policy form are or are likely to be unreasonable in relation to the premium charged. If the Commission disapproves a policy form or withdraws approval of a form, an insurer may proceed as indicated in § 38.2-1926.

§ 38.2-3502. Notice to be printed on policy; return of policy to insurer.—A. Any individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall have printed on it a notice stating substantially:

" THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This policy was issued based on the information entered in your application, a copy of which is attached to the policy. If you know of any misstatement in your application, or if any information concerning the medical history of any insured person has been omitted, you should advise the Company immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract.

RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason you are not satisfied with your policy, you may return this policy to the Company within ten days of the date you received it and the premium you paid will be promptly refunded."

B. If a policyowner returns the policy within ten days from the date of receipt, coverage under that policy shall become void from its inception upon the mailing or delivery of the policy to the insurer or its agent.

C. If the first paragraph of the notice required in subsection A of this section is inapplicable or partially inapplicable to a particular form of policy, the insurer may modify or omit the notice with the Commission's approval.

D. Nothing in this section shall prohibit an insurer from extending the right to examine period to more

than ten days if the period is stated in the policy.

Drafting Notes: 1. The section has been changed to require that the notice must be printed on the policy instead of allowing the option of attaching a separate notice.

2. The section has been changed to provide that if the policy is returned pursuant to the ten-day free look notice, the policy shall become void from its inception, as suggested by industry.

3. Subsection C has been added to provide flexibility for guaranteed issue policies.

4. Subsection D has been added to clarify that insurers have the option to have a free look period of longer than ten days.

§ 38.2-3503. Required accident and sickness policy provisions.--Except as provided in § 38.2-3505, each individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain the provisions specified in this section using the same words which appear in this section. An insurer may substitute corresponding provisions of different wording approved by the Commission that are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions shall be preceded individually by the caption "REQUIRED PROVISIONS" or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Drafting Note: The NAIC simplified model language was not used at the suggestion of industry.

2. Provision 2:

TIME LIMIT ON CERTAIN DEFENSES: (a) Misstatements in the application: After two years from the date of this policy, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts the two-year period.

Provision 2 shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of paragraphs 1, 2, 3, 4 and 5 of § 38.2-3505 in the event of misstatement with respect to age, occupation or other insurance.

Instead of Provision 2, a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age fifty or, (ii) for a policy issued after age forty-four, for at least five years from its date of issue, may contain the following provision, from which the clause in parentheses may be omitted at the insurer's option :

INCONTESTABLE:

(a) Misstatements in the application: After this policy has been in force for two years during the Insured's lifetime (excluding any period during which the Insured is disabled), the Company cannot contest the statements in the application.

PREEXISTING CONDITIONS:

(b) No claim for loss incurred or disability (as defined in the policy) that starts after two years from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

3. Provision 3:

GRACE PERIOD: This policy has a... day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following... days. During the grace period the policy shall continue in force.

In Provision 3 a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "a" and "day", and between "following" and "days."

A policy that contains a cancellation provision may add, at the end of Provision 3:

subject to the right of the Company to cancel in accordance with the cancellation provision.

A policy in which the insurer reserves the right to refuse any renewal shall have, in Provision 3, the following sentence:

The grace period will not apply if, at least... days before the premium due date, the Company has delivered or has mailed to the Insured's last address shown in the Company's records written notice of the Company's intent not to renew this policy.

In the above sentence a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "least" and "days."

Drafting Note: The five-day requirement for delivering or mailing a notice not to renew has been changed to be the same amount of time as the grace period.

4. Provision 4:

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved the policy will be reinstated as of the approval date. Lacking

such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written the Insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than ten days after such date. In all other respects the rights of the Insured and the Company will remain the same, subject to any provisions noted or attached to the reinstated policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty days prior to the date of reinstatement.

The last sentence of Provision 4 may be omitted from any policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age fifty, or (ii) for a policy issued after age forty-four, for at least five years from its effective date.
Drafting Note: "Issue date" was changed to "effective date."

5. Provision 5:
NOTICE OF CLAIM: Written notice of claim must be given within twenty days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Company at..... (insert the location of such office as the insurer may designate for the purpose), or to the Company's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the policy number.
Drafting Note: As a variation to the NAIC model, "and Claimant..." was added since the Insured may not always be the claimant.
Optional paragraph: If the Insured has a disability for which benefits may be payable for at least two years, at least once in every six months after the Insured has given notice of claim, the Insured must give the Company notice that the disability has continued. The Insured need not do this if legally incapacitated. The first six months after any filing of proof by the Insured or any payment or denial of a claim by the Company will not be counted in applying this provision. If the Insured delays in giving this notice, the Insured's right to any benefits for the six months before the date the Insured gives notice will not be impaired.

6. Provision 6:
CLAIM FORMS: When the Company receives the notice of claim, it will send the Claimant forms for filing proof of loss. If these forms are not given to the Claimant within fifteen days after the giving of such notice, the Claimant shall meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

7. Provision 7:
PROOFS OF LOSS: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the Company within ninety days after the end of each period for which the Company is liable. For any other loss, written proof must be given within ninety days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. Provision 8:
TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, the Company will pay.... (Insert period for payment which must not be less frequently than monthly) all benefits then due for.... (Insert type of loss). Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof.

9. Provision 9:
PAYMENT OF CLAIMS: Benefits will be paid to the Insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.
Optional paragraph: If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $..... (insert an amount which shall not exceed $2,000), to someone related to the Insured or beneficiary by blood or by marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any payment made in good faith.
Optional paragraph: The Company may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured directs otherwise in writing by the time proofs of loss are filed. The Company cannot require that the services be rendered by a particular health care services provider.

10. Provision 10:
PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

11. Provision 11:
LEGAL ACTIONS: No legal action may be brought to recover on this policy within sixty days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

12. Provision 12:
CHANGE OF BENEFICIARY:
The insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Drafting Note: The required policy provisions have been changed to NAIC simplified language versions, except for changes requested by industry representatives. Provision 13, which pertains only to air trip accident policies, is being made into a separate section (proposed § 38.2-3515).

§ 38.2-3504. Other provisions.–Except as provided in § 38.2-3505, no individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain provisions respecting the matters set forth below unless such provisions use the same words which appear in this section. The insurer may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the insured or the beneficiary. Any such provision shall be preceded individually by the appropriate caption OTHER PROVISIONS or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:
CHANGE OF OCCUPATION: If the Insured is injured or contracts sickness after having changed his occupation to one classified by the Company as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the Company will pay only the portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the Company for the more hazardous occupation. If the Insured changes his occupation to one classified by the Company as less hazardous than that stated in this policy, the Company, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the Company prior to the occurrence of the loss for which the Company is liable or prior to the date of proof of change in occupation with the state insurance supervisory official in the state where the Insured resided at the time this policy was issued; but if the filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the Company in the state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

2. Provision 2:
MISSTATEMENT OF AGE: If the Insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

3. Provision 3:
OTHER INSURANCE IN THIS COMPANY: If an accident or sickness or accident and sickness policy or policies previously issued by the Company to the Insured is in force concurrently herewith, making the aggregate indemnity for..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the Insured or to his estate.
Instead of Provision 3, the following provision may be used:
Insurance effective at any one time on the Insured under a like policy or policies in this Company is limited to the one such policy elected by the Insured, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

4. Provision 4:
INSURANCE WITH OTHER COMPANIES: If there is other valid coverage, not with this insurer Company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all such other valid coverages for the same loss of which this Company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If Provision 4 is included in a policy that also contains Provision 5, the phrase "-EXPENSE INCURRED BENEFITS-" shall be added to the caption of Provision 4. The insurer may include in this provision a definition of "other valid coverage," approved by the Commission. The definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this Commonwealth or any other jurisdiction of the United States or Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commission. In the absence of such definition the term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations, by union welfare plans, or employer or employee benefit organizations.

For the purpose of applying Provision 4, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage"

of which the company has had notice. In applying Provision 4 no third party liability coverage shall be included as "other valid coverage."

5. Provision 5:
INSURANCE WITH OTHER COMPANIES: If there is other valid coverage, not with this Company, providing benefits for the same loss on other than an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided under this policy for such loss as the like indemnities of which the Company had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

If Provision 5 is included in a policy that also contains Provision 4, the phrase "-OTHER BENEFITS-" shall be added to the caption of Provision 5. The insurer may include in this provision a definition of "other valid coverage," approved by the Commission. The definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this Commonwealth or any other jurisdiction of the United States or Canada, and to any other coverage approved by the Commission. In the absence of such definition the term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying Provision 5, any amount of benefit provided for the insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the Company has had notice. In applying Provision 5 no third party liability coverage shall be included as "other valid coverage."

6. Provision 6:
RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the Insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the Insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which a claim is made, whichever is greater, the Company will be liable only for the proportionate amount of the benefits under this policy as the amount of the monthly earnings or the average monthly earnings of the Insured bears to the total amount of monthly benefits for the same loss under all the coverage upon the insured at the time the disability commences and for the return of the part of the premiums paid during such two years that exceeds the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all the coverage upon the Insured below the sum of $200 or the sum of the monthly benefits specified in the coverages, whichever is less, nor shall it operate to reduce benefits other than those payable for loss of time.

Provision 6 may be inserted only in a policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age fifty or (ii) for a policy issued after age forty-four, for at least five years from its date of issue. The insurer may include in this provision a definition of "valid loss of time coverage" approved by the Commission. The definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this Commonwealth or any other jurisdiction of the United States or Canada, or to any other coverage the inclusion of which may be approved by the Commission or any combination of coverages. In the absence of such definition the term shall not include any coverage provided for the Insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

7. Provision 7:
UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

8. Provision 8:
CANCELLATION: The Company may cancel this policy at any time by written notice delivered to the Insured, or mailed to his last address as shown by the records of the Company, stating when, no less than ... days thereafter, the cancellation shall be effective; and after the policy has been continued beyond its original term the Insured may cancel this policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Company will return promptly the unearned portion of any premium paid. If the Insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state insurance supervisory official in the state where the Insured resided when the policy was issued. If the Company cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

In Provision 8 a number no less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "than" and "days."
Drafting Note: The five-day requirement for delivering or mailing a cancellation notice has been changed to the same amount of time as the grace period.
9. Provision 9:
CONFORMITY WITH STATE STATUTES: Any provision of this policy that on its effective date is in

conflict with the laws of the state in which the Insured resides on that date is hereby amended to conform to the minimum requirements of the laws.

10. Provision 10:
ILLEGAL OCCUPATION: The Company will not be liable for any loss that results from the Insured's committing or attempting to commit a felony or from the Insured's engaging in an illegal occupation.

11. Provision 11:
INTOXICANTS AND NARCOTICS: The Company will not be liable for any loss resulting from the Insured's being drunk, or under the influence of any narcotic unless taken on the advice of a physician.
Drafting Note: NAIC simplified language versions have been used where they were available.

§ 38.2-3505. Inapplicable or inconsistent provisions.—If any provision of this article is inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the Commission's approval, shall omit or modify the inapplicable or inconsistent provision to make that provision consistent with the coverage provided by the policy.

§ 38.2-3506. Order of certain policy provisions.—The provisions that are the subject of §§ 38.2-3503 and 38.2-3504, or any corresponding provisions that are used instead of them in accordance with these sections, shall be printed in the consecutive order of the provisions in such sections. However, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

§ 38.2-3507. Third-party ownership.— The word "insured," as used in this article, shall not be construed to prevent a person with a proper insurable interest from applying for and owning a policy covering another person or from being entitled to any indemnities, benefits and rights provided under the policy.

§ 38.2-3508. Requirements of other jurisdictions.—A. Any individual accident and sickness insurance policy delivered or issued for delivery to any person in this Commonwealth by a foreign or alien insurer may contain any provision that is prescribed or required by the insurer's domiciliary jurisdiction and that is not less favorable than the provisions of this article to the insured or the beneficiary.

B. Any individual accident and sickness insurance policy delivered or issued for delivery by a domestic insurer in any other jurisdiction may contain any provision permitted or required by the laws of the other jurisdiction.
Drafting Note: Section 38.1-354.1 has been moved and renumbered § 38.2-3404.

§ 38.2-3509. Denial or reduction of benefits because of existence of other like insurance.—A. No individual accident and sickness insurance policy, nor any subscription contract as provided for in Chapter 42 of this title, delivered or issued for delivery in this Commonwealth shall contain any provision for the denial or reduction of benefits because of the existence of other like insurance except to the extent that the aggregate benefits, with respect to the covered medical expenses incurred under the policy or plan and all other like insurance with other insurers, exceed all covered medical expenses incurred.

B. The term "other like insurance" may include group insurance or coverage provided by hospital or medical service organizations, union welfare plans, employer or employee benefit organizations, or workers' compensation insurance.

§ 38.2-3510. Conforming to statute.—No individual accident and sickness insurance policy provision that is not subject to this article shall make an individual accident and sickness insurance policy, or any portion of the policy, less favorable in any respect to the insured or the beneficiary than the provisions that are subject to this article.
Drafting Note: The second paragraph has been deleted because the subject is covered by § 38.2-318.
Drafting Note: Section 38.1-356.01 has been moved and renumbered § 38.2-3542.
Drafting Note: Subsection A of this existing § 38.1-356.1 has been moved to Chapter 18 (§ 38.2-1807). Subsections B and C were deleted because they were not necessary with the general penalties and rules and regulations sections in proposed Chapter 2.

§ 38.2-3511. Application.—A. The insured shall not be bound by any statement made in an application for an individual accident and sickness policy unless a copy of the application is attached to or endorsed on the policy when issued as a part of the policy. If any such policy delivered or issued for delivery in this Commonwealth is reinstated or renewed, and the insured, beneficiary or assignee of the policy makes a written request to the insurer for a copy of the reinstatement or renewal application, if any, the insurer shall within fifteen days after the receipt of the request, deliver or mail to the person making the request, a copy of the application. If a copy is not so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in a manner indicating clearly that such insertions are not to be ascribed to the applicant.

C. The falsity of any statement in the application for any policy covered by this article may not bar

the right to recovery under the policy unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

§ 38.2-3512. Notice; waiver.–The acknowledgment by any insurer of the receipt of notice given under any individual accident and sickness insurance policy, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy.

§ 38.2-3513. Age limit.–A. If any individual accident and sickness insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if the date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after the date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which the premium has been accepted.

B. If the age of the insured has been misstated, and if according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Drafting Note: Section 38.1-360 has been modified to become subsection B of § 38.1-347 (proposed § 38.2-3400) to make it clearer what the chapter applies to.

Drafting Note: Section 38.1-361 has been deleted in accordance with the decision to have one general penalties provision. License suspensions and revocations are already covered separately in Title 38.1 for insurers and for agents.

§ 38.2-3514. When liability not to be denied because of preexisting disease, physical impairment or defect.–No insurer that has delivered or issued for delivery in this Commonwealth an accident and sickness insurance policy pursuant to the provisions of this article shall deny liability on any claim otherwise covered under such policy because of the existence of a disease or physical impairment or defect, congenital or otherwise, at the time of the making of the application for such policy, unless it is shown that the applicant knew or might reasonably have been expected to know of such disease, impairment or defect.

§ 38.2-3515. Required coverage on connecting or returning planes.–In each airtrip accident policy, issued in this Commonwealth through a mechanical vending machine or otherwise, the coverage of the policy, according to its terms and provisions, shall extend to an accident on a connecting or returning plane on which the insured's initial airtrip ticket entitles him to ride, if it is shown that the insured would be entitled to recover under the policy had the accident occurred while the insured was riding on the initial plane designated on the ticket.

Drafting Note: Section 38.1-362 was moved from item (13) of existing § 38.1-349.

Drafting Note: This section was eliminated as it is outdated.

Article 2.

Individual Accident and Sickness Insurance

Minimum Standards.

§ 38.2-3516. Purpose.–The purpose of this article is to authorize the Commission, pursuant to the authority granted in § 38.2-223, to issue rules and regulations to:

1. Provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies;

2. Facilitate public understanding and comparison;

3. Eliminate provisions contained in individual accident and sickness insurance policies which may be misleading or unreasonably confusing in connection either with the purchase of coverages or with the settlement of claims; and

4. Provide for full disclosure in the sale of individual accident and sickness policies.

§ 38.2-3517. Definitions.–As used in this article:

"Form" means policies, contracts, riders, endorsements, and applications.

"Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements, and the application, if attached.

Drafting Note: "Medicare" has been moved to the general definitions article in Chapter 1. "Accident and sickness insurance" is also defined in Chapter 1.

§ 38.2-3518. Standards for policy provisions.–A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations to establish specific standards, including standards of full and fair disclosure, for the sale of individual accident and sickness insurance policies. These rules and

regulations shall be in addition to and in accordance with applicable laws of this Commonwealth, including Chapter 34 and Articles 1 and 2 of this chapter which may cover but shall not be limited to:

1. Terms of renewability;

2. Initial and subsequent conditions of eligibility;

3. Nonduplication of coverage provisions;

4. Coverage of dependents;

5. Coverage of persons eligible for Medicare by reason of age;

6. Preexisting conditions;

7. Termination of insurance;

8. Probationary periods;

9. Limitations;

10. Exceptions;

11. Reductions;

12. Elimination periods;

13. Requirements for replacement;

14. Recurrent conditions; and

15. Definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and noncancellable.

For the purposes of this article, licensed health care practitioners, to the extent required by law, shall be deemed physicians.

B. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute that in the opinion of the Commission are unjust, unfair, or unfairly discriminatory to the policyowner, beneficiary, or any person insured under the policy.

Drafting Note: Subsection C has been moved to Chapter 36 and renumbered § 38.2-3604.

§ 38.2-3519. Minimum standards for benefits.—A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations establishing minimum standards for benefits under each of the following categories of coverage in individual policies of accident and sickness insurance:

1. Basic hospital expense coverage;

2. Basic medical-surgical expense coverage;

3. Hospital confinement indemnity coverage;

4. Major medical expense coverage;

5. Disability income protection coverage;

6. Accident only coverage;

7. Specified disease or specified accident coverage;

8. Medicare supplement coverage; and

9. Limited benefit health coverage.

B. Nothing in this section shall preclude the issuance of any policy that combines two or more of the categories of coverage enumerated in paragraphs 1 through 6 of subsection A of this section.

C. No policy shall be delivered or issued for delivery in this Commonwealth that does not meet the prescribed minimum standards for the categories of coverage listed in paragraphs 1 through 9 of subsection A of this section or does not meet the requirements set forth in § 38.2-3501.

D. The Commission may prescribe the method of identification of policies based upon coverages provided.

Drafting Note: In subsection D, "Commissioner" was changed to "Commission" for consistency with the

rest of the title.

§ 38.2-3520. Coverage of preexisting conditions.—Notwithstanding the provisions of § 38.2-3503, if an insurer elects to use a simplified application form, with or without a specific question as to the applicant's health, but without any detailed questions concerning the insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve months from the effective date of coverage from any preexisting condition not specifically excluded from coverage by terms of the policy. Except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.

Drafting Note: In subsection A, the words "general" and "specific" were added for clarity to refer to the types of health questions asked. Subsection B has been moved to Chapter 36 as proposed § 38.2-3605.

Drafting Note: Section 38.2-362.16 has been moved and renumbered § 38.2-3606.

Drafting Note: Section 38.2-362.17 has been moved and renumbered § 38.2-3607.

Article 3.

Group Accident and Sickness Insurance Policies.

§ 38.2-3521. Definitions.—As used in this article:

"Group credit accident and sickness insurance" means group accident and sickness insurance issued to a creditor or its parent holding company, or to a trustee, trustees or agent designated by two or more creditors, who shall be deemed the policyholder, to insure the debtor by providing for payments on a specific loan or other credit transaction of more than ten years' duration.

§ 38.2-3522. Insurance shall meet requirements of this article.—No group accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth unless it conforms to the requirements of this article.

§ 38.2-3523. Group requirements.—A. A group accident and sickness insurance policy shall comply with the following requirements:

1. The members eligible for insurance under the policy shall be all the members of the group, or all of any class or classes of the group. However, an insurer may exclude or limit coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

2. A group accident and sickness insurance policy shall cover at least two persons, other than spouses or minor children, at the issue date and at each policy anniversary date.

B. In addition to the requirements of subsection A of this section, group credit accident and sickness insurance as defined in § 38.2-3521 shall be subject to the following requirements:

1. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" shall include (i) borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction; (ii) the debtors of one or more subsidiary corporations; and (iii) the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control.

2. The premium for the policy shall be paid by the policyholder either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in paragraph 3 of this subsection, a policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

5. The insurance shall be payable to the creditor, or any successor of the right, title or interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

6. Notwithstanding the provisions of paragraphs 1 through 5 of this subsection, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

§ 38.2-3524. Trustee groups.—One or more eligible groups may be insured under one group accident and sickness insurance policy issued to a trustee or trustees.

§ 35.2-3525. Group accident and sickness insurance coverages of spouses or dependent children.—A. Coverage under a group accident and sickness insurance policy, except a group credit accident and sickness insurance policy, may be extended to insure the spouse and any child who is under the age of nineteen years or who is a dependent and a full-time student under twenty-five years of age, or any class of spouse and dependent children, of each insured group member who so elects. The amount of accident and sickness insurance for the spouse or dependent child shall not exceed the amount of accident and sickness insurance for the insured group member.

B. Notwithstanding the provisions of § 38.2-3538, one certificate may be issued for each family unit if a statement concerning any spouse's or dependent child's coverage is included in the certificate.

§ 38.2-3526. Standard provisions required; exceptions. —A. No group accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains the standard provisions prescribed in this article.

B. The provisions of § 38.2-3531, subsection A of § 38.2-3533, and § 38.2-3538 shall not apply to group credit accident and sickness insurance policies.

§ 38.2-3527. Grace period.—Each group accident and sickness insurance policy shall contain a provision that the policyowner is entitled to a grace period of not less than thirty-one days for the payment of any premium due except the first premium. The provision shall also state that during the grace period the accident and sickness coverage shall continue in force unless the policyowner has given the insurer written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance. The policy may provide that the policyowner shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

§ 38.2-3528. Incontestability.—A. Each group accident and sickness insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue.

B. The provision shall also state that no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and

2. Unless the statement is contained in a written instrument signed by him.

B. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

§ 38.2-3529. Entire contract; statements deemed representations.—A. Each group accident and sickness insurance policy shall contain a provision that the policy, and any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. A copy of any application of the policyowner shall be attached to the policy when issued;

2. All statements made by the policyowner or by the persons insured shall be deemed representations and not warranties; and

3. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

§ 38.2-3530. Evidence of individual insurability. — Each group accident and sickness insurance policy shall contain a provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

§ 38.2-3531. Additional exclusions and limitations.—A. Each group accident and sickness insurance policy shall contain a provision specifying all additional exclusions or limitations applicable under the policy for any disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy.

B. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. The exclusion or limitation shall not apply to loss incurred or disability commencing after the earlier of (i) the end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during which the person receives no medical advice or treatment in connection with the disease or physical condition, or (ii) the end of the two-year period commencing on the effective date of the person's coverage.

§ 38.2-3532. Misstatement of age.—Each group accident and sickness insurance policy where the

premiums or benefits vary by age shall contain a provision that an equitable adjustment of premiums, benefits or both shall be made if the age of a person insured has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.

§ 38.2-3533. Individual certificates.—A. Each group accident and sickness insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided;

2. To whom the insurance benefits are payable;

3. Any family member's or dependent's coverage; and

4. The rights and conditions set forth in § 38.2-3541.

B. Each group credit accident and sickness policy, where any part of the premium is paid by debtors from identifiable charges collected from the insured debtors not required of an uninsured debtor, shall contain a provision that the insurer will furnish to the policyholder for each debtor insured under the policy a form that will contain a statement describing the debtor's coverage and that the benefits payable shall be applied to reduce or extinguish the indebtedness.

§ 38.2-3534. Notice of claim.—Each group accident and sickness insurance policy shall contain a provision that written notice of a claim shall be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within that time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.

§ 38.2-3535. Claim forms.—Each group accident and sickness insurance policy shall contain a provision that the insurer will furnish forms for filing proof of loss to the person making a claim or to the policyholder for delivery to that person. If the forms are not furnished within fifteen days after the insurer received notice of any claim under the policy, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy of filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which a claim is made.

§ 38.2-3536. Proofs of loss.—A. Each group accident and sickness insurance policy shall contain a provision that written proof of the loss shall be furnished to the insurer within ninety days after the date of the loss. In the case of a claim for loss of time for disability, each group accident and sickness insurance policy shall contain a provision that written proof of the loss shall be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable. Subsequent written proof of the continuance of the disability shall be furnished to the insurer at reasonable intervals required by the insurer.

B. Failure to furnish such proof within the prescribed time shall not invalidate or reduce any claim if it was not reasonably possible to furnish the proof within that time and the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity of the claimant, shall such proof be furnished later than one year from the time proof is otherwise required.

§ 38.2-3537. Time of payment of claims.—Each group accident and sickness insurance policy shall contain a provision that all benefits payable under the policy other than benefits for loss of time shall be payable within sixty days after receipt of proof of loss. The provision shall also state that, subject to proof of loss, all accrued benefits payable under the policy for loss of time shall be paid at least monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible.

§ 38.2-3538. Payment of benefits.—Each group accident and sickness insurance policy shall contain a provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of those benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

§ 38.2-3539. Physical examinations and autopsy. — Each group accident and sickness insurance policy shall contain a provision that the insurer shall have the right (i) to examine the person for whom a claim is made when and as often as it may reasonably require during the pendency of claim under the policy and (ii) to make an autopsy where it is not prohibited by law.

§ 38.2-3540. Legal actions.—Each group accident and sickness insurance policy shall contain a provision that no action at law or in equity shall be brought to recover on the policy within sixty days after proof of loss has been filed in accordance with the policy requirements and that no such action shall be brought

after the expiration of three years from the time that proof of loss was required to be filed.

§ 38.2-3541. Conversion or continuation on termination of eligibility.—Each group hospital policy, group medical and surgical policy or group major medical policy delivered or issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain, subject to the policyholder's selection, one of the options set forth in this section. These options shall apply if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage other than due to termination of the group policy, prior to that person becoming eligible for Medicare or Medicaid benefits.

1. Option 1: To have the insurer issue him, without evidence of insurability, an individual accident and sickness insurance policy in the event that the insurer is not exempt under § 38.2-3416 and offers such policy, subject to the following requirements:

a. The application for the policy shall be made, and the first premium paid to the insurer within thirty-one days after the termination;

b. The premium on the policy shall be at the insurer's then customary rate applicable: (i) to such policies, (ii) to the class of risk to which the person then belongs, and (iii) to his or her age on the effective date of the policy;

c. The policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;

d. The benefits under the policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;

e. The policy shall extend coverage to the same family members that were insured under the group policy; and

f. Coverage under this option shall be effected in such a way as to result in continuous coverage during the thirty-one-day period for such insured.

2. Option 2: To have his present coverage under the policy continued for a period of ninety days immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

a. The application for the extended coverage is made to the group policyholder and the total premium for the ninety-day period is paid to the group policyholder prior to the termination.

b. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy.

c. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility.

Drafting Note: § 38.1-348.11 was moved so that all the provisions pertaining only to group accident and sickness insurance are in one article.

§ 38.2-3542. Notice to employees upon termination of coverage; penalty for failure to remit funds.—A. Any employer who (i) assumes part or all of the cost of providing group accident and sickness insurance or a group health services plan for his employees under a group insurance policy or subscription contract, or (ii) provides for health and medical care or reimbursement of medical expenses for his employees as a self-insurer, shall give written notice to participating employees in the event of termination or upon the receipt of notice of termination of any such policy, contract or self-insurance not later than fifteen days after the termination or receipt of the notice of termination.

B. Any employer who collects from his employees any part of the cost of any of the policies, contracts or coverages specified in subsection A of this section and who fails to remit the funds to the insurer or plan in accordance with the policy or contract provisions under which the employees are covered shall be guilty of a Class 3 misdemeanor.

Drafting Note: Existing § 38.1-356.01 has been moved here so that all the sections pertaining to group accident and sickness are in one article.

§ 38.2-3543. Provisions required by other jurisdictions. —A. Group accident and sickness insurance policies of a foreign or alien insurer, delivered or issued for delivery in this Commonwealth, may contain any provision that is not less favorable to the insured or the beneficiary than the provisions required by this article and that is prescribed by the laws of its domiciliary jurisdiction.

B. Any group accident and sickness insurance policy of a domestic insurer may, when delivered or issued for delivery in any other jurisdiction, contain any provision permitted or required by the laws of that jurisdiction.

Drafting Note: This section is similar to § 38.2-3508 and allows policies to contain provisions required by other jurisdictions.

Article 4.

Industrial Sick Benefit Insurance.

§ 38.2-3544. Definition of industrial sick benefit insurance.—Industrial sick benefit insurance means life insurance combined with accident and sickness insurance under which:

1. Premiums, dues or assessments are payable weekly;

2. A $10 maximum weekly indemnity is paid to members or policyowners in the event of sickness or accident;

3. A $250 maximum death benefit is provided, and the named beneficiary is confined to the spouse of the insured, a relative of the insured by blood, marriage or adoption, a person bound in a pledge of marriage to the insured, or any person dependent on the insured; and

4. The issuing insurer is not required by its charter, bylaws, or by statute to maintain the legal reserve for death benefits.

§ 38.2-3545. Further restrictions as to beneficiaries.—Within the permitted classes of beneficiaries prescribed in § 38.2-3544, the issuing insurer may designate the classes of beneficiaries. No change of beneficiary shall be made by assignment, will, or otherwise to any person outside the designated classes without the consent of the insurer. If no person within the classes of beneficiaries prescribed in § 38.2-3544 survives the insured, the insurer may discharge its liability by payment of the proceeds of the policy to any person appearing to the insurer to be equitably entitled to the proceeds because of having incurred expense for the maintenance, medical attention or burial of the insured.

§ 38.2-3546. Cancellation of sick benefit portion of policy.—Every policy of industrial sick benefit insurance issued in this Commonwealth after June 18, 1922, shall contain a provision that:

1. The sick benefit portion of the policy may be cancelled by either the insurer or the insured and the life portion continued by a payment of twenty percent of the original premium;

2. If the cancellation is by the insurer, it shall be without prejudice to any claim arising on account of disability commencing prior to the date on which the cancellation takes effect; and

3. Written notice of the cancellation and payment for the unearned portion of the premium shall be delivered to the insured or mailed to him at his last known address.

§ 38.2-3547. Excessive insurance; remedy.—Any person holding industrial sick benefit insurance policies of several insurers, that, in the aggregate, provide sick benefits in excess of 150 percent of his weekly salary, wages or earnings, shall not be permitted to recover the excess, nor shall the insurer be compelled to pay the excess, unless the existence of all previous policies was admitted by the insured in all applications for insurance in excess of such sum. If by misstatements, or by the failure to admit the existence of previous policies, the insured has obtained such excess additional policies, and has received benefits under such policies in excess of the amount specified above the excess paid may be deducted from the death benefit provided for in the policies.

B. This section shall not apply in any case where the application for the excess policy did not contain any question in regard to the amount of insurance already carried by the applicant, nor where the application blank was printed in less than ten-point type.

§ 38.2-3548. Agents subject to other insurance laws.—Each person representing any insurer in the sale of industrial sick benefit insurance shall be subject to the laws governing agents of insurers.

§ 38.2-3549. Benefits not subject to legal process.—The payments in weekly or monthly installments to the holder of any policy of industrial sick benefit insurance shall not be subject to the lien of any attachment, garnishment proceeding, writ of fieri facias, or to levy or distress in any manner, for any debt due by the holder of the policy.

§ 38.2-3550. Effective date.—No industrial sick benefit insurance policy as defined in § 38.2-3544 shall be delivered or issued for delivery in this Commonwealth after June 30, 1986.

Drafting Note: This section prohibits the sale of any new industrial sick benefit insurance policies one year after the law becomes effective assuming an July 1, 1986, effective date. (The basic benefit is $10 per week. There are many of these types of policies on the books but industry sources indicate that this type of policy is no longer being sold.)

CHAPTER 36.

Medicare Supplement Policies.

1. All of the Medicare supplement insurance sections and subsections presently in Articles 2.2 and 2.3 of Chapter 8 have been moved to this new chapter.

2. In conformance with the decision to have a unified rules and regulations section, existing § 38.1-362.9 was deleted and the references to rules and regulations in other sections have been modified.

3. In proposed § 38.2-3604 (existing subsection C of § 38.1-362.13), Free look notice required, the notice must now be printed on the policy instead of "printed on or attached to" the policy. As is being changed in other free look provisions, the provision has been changed to provide that if the policy is returned during the free look period, there is no coverage.

CHAPTER 36.

MEDICARE SUPPLEMENT POLICIES.

§ 38.2-3600. Medicare supplement policy; definition. – "Medicare supplement policy" means an individual or group accident and sickness insurance policy which is (i) designed primarily to supplement Medicare by providing benefits for payment of hospital, medical or surgical expenses, or (ii) advertised, marketed or otherwise purported to be a supplement to Medicare.

For group policies, the term does not include:

1. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employees and labor organizations, for employees, former employees, or a combination of employees and labor organizations or for members or former members, or combination thereof, of the labor organizations; or

2. A policy or contract of any professional, trade or occupational association for its members or former members, or combination thereof, if the association:

a. Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

b. Has been maintained in good faith for purposes other than obtaining insurance; and

c. Has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.

Drafting Note: Subsection B of existing § 38.1-362.7 has been moved so that all the Medicare supplement sections will be together.

§ 38.2-3601. Medicare supplement policies; minimum return for group policies generally.–Group Medicare supplement policies shall be expected to return to policyholders in the form of aggregate benefits at least seventy-five percent of the aggregate amount of premiums collected.

Drafting Note: Existing § 38.1-362.8:1 has been moved here so that all the Medicare supplement sections will be together.

§ 38.2-3602. Same; minimum return for certain group policies.–Notwithstanding § 38.2-3601, Medicare supplement policies issued as a result of solicitation of individuals through the mails or by mass media advertising shall be expected to return to policyholders in the form of aggregate benefits at least sixty percent of the aggregate amount of premiums collected.

Drafting Note: Existing § 38.1-362.8:2 has been moved here so that all the Medicare supplement sections will be together.

§ 38.2-3603. Same; minimum return for individual policies.–Medicare supplement policies sold on an individual basis shall be expected to return to policyowners in the form of aggregate benefits at least sixty percent of the aggregate amount of premiums collected.

Drafting Note: Existing § 38.1-362.8:3 has been moved here so that all the Medicare Supplement sections will be together.

§ 38.2-3604. Free look notice required. – Notwithstanding the provisions of § 38.2-3502, Medicare supplement policies issued pursuant to a direct response solicitation shall have printed on the policy a notice stating substantially: "RIGHT TO RETURN POLICY WITHIN THIRTY DAYS. If for any reason you are not satisfied with your policy you may return this policy to the company within thirty days of the date you received it and the premium paid will be promptly refunded."

A policy returned pursuant to the notice shall be void upon the mailing or delivery of the policy to the insurer.

Nothing in this section shall prohibit an insurer from extending the right to examine period to more than thirty days if the period is specified in the policy.

Drafting Note: Existing subsection C of § 38.1-362.13 has been moved here so that all Medicare supplement sections will be together. The notice must now be printed on the policy instead of "printed on or attached to" the policy. As is being changed in other free look provisions, the provision has been changed to provide that if the policy is returned during the free look period, there is no coverage.

§ 38.2-3605. Coverage of preexisting conditions; Medicare supplement policies.–Notwithstanding paragraph 2b of § 38.2-3503, an insurer that issues a Medicare supplement policy shall not deny a claim for losses incurred more than six months from the effective date of coverage on the grounds that a condition existed prior to the effective date of coverage regardless of the application form used. Except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

Drafting Note: Existing § 38.1-362.15 B has been moved here so that all Medicare supplement sections will be together.

§ 38.2-3606. Outline of coverage.–Pursuant to the authority granted in § 38.2-223 the Commission may issue rules and regulations that may (i) require that an outline of coverage for Medicare supplement

policies be delivered to the insured at the time the application is made or at the time the policy is delivered and (ii) prescribe the format and content of the outline of coverage.

Drafting Note: Existing § 38.1-362.16 has been moved here so that all Medicare supplement sections will be together.

§ 38.2-3607. Group Medicare supplement policies; minimum standards.—The provisions of §§ 38.2-3604, 38.2-3605, 38.2-3606 and 38.2-3516 through 38.2-3520 shall be applicable to group Medicare supplement policies. The term "policy" as used in this article shall include a certificate issued under a group Medicare supplement policy which has been delivered or issued for delivery in this Commonwealth.

Drafting Note: Existing subsection A of § 38.1-362.17 has been moved here so that all Medicare supplement sections will be together.

Title 38.2

CHAPTER 37.

Credit Life Insurance and Credit Accident and Sickness Insurance.

The following substantive changes have been proposed:

1. In § 38.1-482.3:1 (proposed § 38.2-3702), the requirements of existing § 38.1-480 that apply to credit transactions of ten years or less and that are not provided for elsewhere in this chapter have been moved to this section as subsection B.

2. In § 38.1-482.6 (proposed § 38.2-3707), disclosure of the nature of the coverage for policies providing critical period or truncated coverage will be required in contrasting color ink in 12 point type.

3. In subsection B of proposed § 38.2-3708, Prohibited policy provisions, no individual or group credit life insurance or credit accident and sickness insurance application forms shall contain a question of general good health without questions concerning the applicant's health history or medical treatment history.

CHAPTER 37.

CREDIT LIFE INSURANCE AND CREDIT ACCIDENT

AND SICKNESS INSURANCE.

§ 38.2-3700. Application of chapter.—A. This chapter shall apply to credit life insurance and credit accident and sickness insurance except such insurance issued in connection with first mortgages or deeds of trust on primary residences, insurance issued in connection with a loan or other credit transaction of more than ten years' duration, mortgage redemption insurance, and classes of insurance that are age-rated.

B. Credit life insurance and credit accident and sickness insurance issued as an isolated transaction on the part of the insurer and not related to an agreement or plan for insuring debtors of the creditor shall not be subject to this chapter.

Drafting Note: The last paragraph of this section has been moved to a new section, § 38.2-3716.

§ 38.2-3701. Definitions.—As used in this chapter:

"Creditor" means a lender of money, or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

"Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;

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

Drafting Note: The definitions of "credit life insurance," "credit accident and sickness insurance," "Commission" and "credit life and health insurance agent" have been eliminated because they are defined, respectively, in Chapter 1 and Chapter 18.

§ 38.2-3702. Forms of credit life insurance and credit accident and sickness insurance.—A. Credit life insurance and credit accident and sickness insurance shall be issued only in the following forms:

1. Individual credit life insurance policies issued to debtors on a term plan;

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

3. Group credit life insurance policies issued to creditors providing insurance on the lives of debtors on a term plan, subject to the requirements of subsection B of this section; or

4. Group credit accident and sickness insurance policies issued to creditors on a term plan insuring debtors subject to the requirements of subsection B of this section, or disability benefit provisions in group credit life insurance policies to provide such coverage.

B. A policy of group credit life insurance or group credit and sickness insurance may be issued to a creditor or its parent holding company or to a trustee, trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insurer debtors of the creditor or creditors, subject to the following requirements:

1. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes of the group. The policy may provide that the term "debtors" shall include (i) borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction; (ii) the debtors of one or more subsidiary corporations; and (iii) the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control.

2. The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in pargraph 3 of this section, a policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors.

An insurer may exclude any debtors for whom evidence of individual insurability is not satisfactory to the insurer.

Drafting Note: The requirements of existing § 38.1-480 that apply to credit transactions of ten years or less that are not provided for elsewhere in this chapter have been moved to this section as subsection

38.2-3703. . Amount of credit life insurance. —A. The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness. If an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual

amount of the unpaid indebtedness, whichever is greater.

B. The amount of insurance shall be payable to the creditor to reduce or extinguish the unpaid indebtedness of the debtor.

C. Insurance on agricultural loan commitments that do not exceed one year may be written up to the amount of the loan commitment, on a nondecreasing or level term plan.

D. Insurance on educational credit transaction commitments may be written for the entire commitment.

E. The amount of credit life insurance on an indebtedness of any debtor insured under a group policy shall not exceed $50,000.

Drafting Note: This subsection has been moved to a new section numbered § 38.2-3704.

§ 38.2-3704. Amount of credit accident and sickness insurance.—A. The total amount of periodic indemnity payable by credit accident and sickness insurance in the event of disability shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness. The amount of each periodic payment shall not exceed the original indebtedness divided by the number of periodic installments.

B. The amount of insurance shall be payable to the creditor to reduce or extinguish the unpaid indebtedness of the debtor.

§ 38.2-3705. Variable interest rate indebtedness; amount; disclosure; refunds.—A. Notwithstanding the terms of § 38.2-3703 and subsection A of § 38.2-3704, if the credit transaction provides for a variable interest rate and the insurance premiums are calculated and charged on a single premium basis, the initial amount of insurance coverage shall not exceed the scheduled amounts of unpaid indebtedness based upon the initial contract interest rate; and the death benefit shall be equal to the scheduled amount of insurance at the date of death or the amount required to liquidate the indebtedness in accordance with the terms of the contract of indebtedness, whichever is greater. If the actual interest rate charged at any time exceeds the original contract interest rate the term of the insurance shall continue without additional charge for a period not to exceed three months. No additional premiums shall be charged for any additional coverage provided beyond that included in the single premium charge.

B. Each individual policy or group certificate of credit insurance issued in connection with credit transactions involving variable interest rates shall include a disclosure (i) that the death benefit shall in no case be less than the insured scheduled amount of coverage or the amount required to liquidate the insured indebtedness in accordance with the terms of the contract of indebtedness, whichever is greater; and (ii) that the term of insurance shall continue for a period not to exceed three months if the actual interest rate charge at any time exceeds the original contract interest rate.

C. Each individual policy or group certificate of credit insurance issued in connection with credit transactions involving variable interest rates shall provide that in the event of termination of the insurance prior to the original scheduled maturity date of the indebtedness, a refund of any amount paid by the debtor for such insurance shall be made in accordance with subsection B of § 38.2-3711. Such refund shall be based on the terms of the original loan and the actual elapsed time. Computation of such refund using the Rule of 78 shall be deemed to comply with the requirements hereof.

Drafting Note: Former § 38.1-482.4:1 was repealed and this new section was added during the 1985 legislative session.

§ 38.2-3706. Term of insurance; termination.—A. The term of credit life insurance or credit accident and sickness insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor. However, if a group policy provides coverage for existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy.

B. If evidence of insurability is required and the evidence is furnished more than thirty days after the date on which the debtor becomes obligated to the creditor, the term of the credit life insurance or credit accident and sickness insurance may commence on the date that the insurer determines the evidence to be satisfactory. In such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance.

C. The term of credit life insurance or credit accident and sickness insurance shall not extend more than fifteen days beyond the scheduled maturity date of the indebtedness, except (i) when extended without additional cost to the debtor or (ii) where the indebtedness on which such insurance is issued is extended by agreement between the creditor and the debtor and does not constitute a discharge of the indebtedness. An additional premium may be charged for the insurance covering an extension under (ii) of this subsection.

D. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness.

E. If an indebtedness is terminated before its scheduled maturity date, the credit life insurance or credit accident and sickness insurance on such indebtedness shall terminate and a refund shall be paid or credited as provided in § 38.2-3711.

F. Each credit life insurance or credit accident and sickness insurance policy or certificate shall contain a provision that the insurance may be terminated upon written request of the debtor except if the insurance was required as security for any indebtedness at the time of the credit transaction. If insurance is required, the debtor shall have the right to terminate the insurance by furnishing evidence of other insurance that is at least equal in coverage and protection to the creditor.

§ 38.2-3707. Policy provisions; disclosure to debtors.—A. Credit life insurance and credit accident and sickness insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance. The policy or certificate of insurance shall be delivered to the debtor.

B. Each policy or certificate of credit life insurance or credit accident and sickness insurance shall set forth:

1. The name and address of the insurer;

2. The name or names of the debtor or, in the case of a certificate, the identity by name or otherwise of the debtor;

3. The age of the debtor;

4. The premium or amount payable by the debtor separately for credit life insurance and credit accident and sickness insurance;

5. A description of the coverage including the amount and term of the coverage, and any exceptions, limitations or restrictions;

6. A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness; and

7. A statement that if the amount of insurance exceeds the amount necessary to discharge the indebtedness, any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

C. If a credit life or a credit accident and sickness insurance policy or certificate provides truncated or critical period coverage or any other type of similar coverage that does not provide benefits or coverage for the entire term of the indebtedness, a statement printed on the face of the policy or first page of the certificate shall clearly describe the limited nature of the insurance. The statement shall be printed in capital letters in contrasting color ink and in bold 12-point or larger type.

D. No individual or group credit life insurance or credit accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth unless the policy complies with the following requirements:

1. Each policy shall contain a provision (i) that the policy, or the policy and any application endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties, and (ii) that all statements made by the creditor or by the individual debtors shall, in the absence of fraud, be deemed representations and not warranties;

2. Each policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force for a period of two years during such person's lifetime, and prior to the date on which the claim thereunder arose;

3. Each policy shall contain a provision that when a claim for the death or disability of the insured arises, settlement shall be made upon receipt of due proof of such death or disability;

4. On the face of each policy there shall be a title that briefly and accurately describes the nature and form of the policy;

5. Each policy, including any rider or endorsement, shall be identified by a form number in the lower left-hand corner of the first page of the form. The type size of the text of the policy form, including any rider and endorsement or certificate , shall not be less than 10-point type, 1- point leaded; and

6. Each individual policy or group certificate shall meet the readability standards established by rules and regulations promulgated by the Commission.

Drafting Note: 1. The age of the debtor would be required to be set forth in the policy or certificate. This requirement was inadvertently omitted during an earlier revision of this section.

2. This subsection requires disclosure to the consumer when critical period or truncated coverage is provided.

3. Existing subsection (d) has been made into a new section, § 38.2-3708, and existing subsections (e), (f) and (g) have been made into proposed § 38.2-3709.

§ 38.2-3708. Prohibited policy provisions.—A. No individual or group credit life insurance or credit accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth if it

contains any provision:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues;

2. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person so insured under the policy; or

3. With respect to credit life insurance, (i) excluding coverage other than in the event of suicide within one year from the date the indebtedness was incurred or (ii) making ineligible for coverage debtors under the age of sixty-five at the time the indebtedness is incurred unless such debtors will have attained the age of sixty-five by the maturity date of the indebtedness.

B. No individual or group credit life insurance or credit accident and sickness insurance application form shall contain a question of general good health unless the application form contains appropriate specific questions concerning the applicant's health history or medical treatment history.

Drafting Note: The Bureau has proposed a prohibition against statements of general good health in applications without any questions concerning the applicant's health history or medical treatment history. There is concern about post-claim underwriting which involves deciding after a claim is made that coverage for a person should not have been provided initially because of information found out during the processing of the claim. If an insurer is going to underwrite on the basis of health, detailed questions should be asked.

§ 38.2-3709. Delivery of policy or certificate.—A. An individual credit life insurance or credit accident and sickness insurance policy or certificate of insurance shall be delivered or mailed to the insured debtor at the time the indebtedness is incurred or within ten business days thereafter except as provided in subsection B of this section. For open-end credit transactions, agricultural or educational loan commitments, or where no direct charge is made to the debtor for his insurance, the individual policy or group certificate of insurance may be delivered to the insured debtor at the time he first becomes eligible for the insurance and need not be delivered again each time new indebtedness is added.

B. If the individual policy or certificate of insurance is not delivered or mailed to the debtor at the time indebtedness is incurred, or within ten business days thereafter, a copy of the application for the policy signed by the debtor or a notice of proposed insurance, setting forth (i) the name and address of the insurer if available at that time, (ii) the name or names of the debtor, (iii) the age of the debtor, (iv) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and sickness insurance, and (v) the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time the indebtedness is incurred. If the name and address of the insurer are not furnished as required by this subsection, then the name and address of the insurer shall be furnished to the debtor within ten business days of the time the indebtedness is incurred. The copy of the application for or notice of proposed insurance shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan or credit transaction, unless the information required by this subsection is prominently set forth in the application for the loan agreement or conditional sales credit transaction. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall deliver or mail the individual policy or group certificate of insurance to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer the insurance shall become effective as provided in § 38.2-3706.

C. If the policy or certificate is issued by any insurer other than the insurer listed on the application or notice of proposed insurance, the debtor shall receive a policy or certificate of insurance setting forth the name and address of the substituted insurer and the amount of the premium to be charged. If the amount of the premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made.

§ 38.2-3710. Policy forms to be filed with Commission; approval or disapproval by Commission.—A. As used in this section, "form" means any policy, contract, rider, endorsement, amendment, certificate, application or notice of proposed insurance pertaining to credit life insurance or credit accident and sickness insurance.

B. No form shall be delivered or issued for delivery in this Commonwealth until a copy of each form has been filed with and approved by the Commission.

C. The Commission shall disapprove or withdraw approval previously given to any form if:

1. It does not comply with the laws of this Commonwealth;

2. It contains any provision or has any title, heading, backing or other indication of the contents of any or all of its provisions which encourage misrepresentation or are unjust, unfair, misleading, deceptive or contrary to the public policy of this Commonwealth; or

3. The premium rates or charges are not reasonable in relation to the benefits provided.

D. The benefits provided by any credit life insurance form shall be deemed reasonable in relation to the premium charged or to be charged based on rates not in excess of those adopted by the Commission in accordance with the criteria herein set forth. Such rates may be amended by the Commission after

allowing an opportunity for all interested parties to be heard. In adopting any rate and in establishing reasonableness, the Commission shall give due consideration to the following factors: (i) past and prospective loss experience and mortality rates, (ii) necessary and reasonable costs and expenses attributable to the credit life insurance business, and (iii) any other relevant factors, including a fair return to the creditor and insurer. No change in the rate shall be made unless it is established by a preponderance of the evidence that the current rate is not reasonable.

E. The benefits provided by any credit accident and sickness insurance form shall be deemed reasonable in relation to the premium charged or to be charged if the rate produces a ratio of losses incurred to premiums earned, based on credible data, of not less than fifty percent or may reasonably be expected to produce at least such a loss ratio. The ratio of losses incurred to premiums earned may be amended by the Commission after allowing an opportunity for all interested parties to be heard. In adopting any rate and in establishing reasonableness, the Commission shall give due consideration to the following factors: (i) past and prospective loss experience and morbidity rates, (ii) necessary and reasonable costs and expenses attributable to the credit accident and sickness insurance business, and (iii) any other relevant factors, including a fair return to the creditor and insurer.

F. An insurer may file a petition, which shall be accompanied by the filing of supporting evidence, to increase its rate for a specific category of insurance which can, in the opinion of the Commission, reasonably be placed in a specific category for this purpose. The Commission, after a public hearing which shall be promptly scheduled, and a review of the credible evidence filed and credible evidence adduced at the hearing, shall grant an increase in the rate for the category of insurance if it is shown that the insurer writing the business in this Commonwealth is not receiving a fair return considering the factors set forth in subsections D and E of this section with respect to the category of insurance.

G. The Commission shall, within thirty days after the filing of any form requiring approval, notify the insurer filing the form of the form's approval or disapproval. If a form is disapproved, the Commission shall also notify the insurer of its reasons for disapproval. The Commission may extend the period within which it shall indicate its approval or disapproval of a form by thirty days. Any form received but not approved or disapproved by the Commission shall be deemed approved at the expiration of the thirty days, or sixty days if the period is extended.

H. If the Commission proposes to withdraw approval previously given to any form, it shall notify the insurer in writing not less than thirty days prior to the proposed effective date of withdrawal and give its reasons for withdrawal. No insurer shall issue such forms or use them after the effective date of withdrawal, except as provided in subsection I of this section.

I. Any insurer aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

§ 38.2-3711. Schedule of premium rates to be filed; refund of premiums; payments by debtor.—A. Each insurer issuing credit life insurance or credit accident and sickness insurance shall file with the Commission its schedules of premium rates for use in connection with such insurance. Any insurer may revise the schedules, and shall file the revised schedules with the Commission. No insurer shall issue any credit life insurance policy or credit accident and sickness insurance policy for which the premium rate exceeds that shown by the schedules of the insurer as then approved by the Commission.

B. Each individual policy or certificate of insurance shall provide that if the insurance is terminated prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto. The refund of premiums for decreasing term credit life insurance shall be no less than the amount computed by the Rule of 78 or the Actuarial Method, whichever method is consistent with the original method of premium calculation. The refund of premiums for credit accident and sickness insurance shall be no less than the amount computed by the Rule of 78. The refund of premiums for level term credit life insurance shall be no less than the pro rata unearned gross premium. No refund need be made if the amount to be refunded is less than two dollars.

Drafting Note: Under single premium net coverage, calculating refunds by the Rule of 78 is satisfactory but if net balances are computed on a true interest basis (the so-called "Actuarial Method"), the refund must be calculated consistently.

C. If a creditor requires a debtor to make any payment for credit life insurance or credit accident and sickness insurance and an individual policy or certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account.

D. The amount charged by the creditor to the debtor for any credit life or credit accident and sickness insurance shall not exceed the premiums charged by the insurer, as computed according to its schedule of premium rates then on file with the Commission for the coverage provided.

§ 38.2-3712. Portion of premium may be allowed to creditor; insurance may be provided and serviced at creditor's place of business.—

A. A portion of the premium for credit life insurance or credit accident and sickness insurance may be allowed by the insurer to a creditor for providing and servicing such insurance. Such portion of the premium so allowed shall not be deemed as a rebate of premium or as interest or charges or consideration or an amount in excess of permitted charges in connection with the loan or other credit

transaction.

B. All of the acts necessary to provide and service credit life insurance and credit accident and sickness insurance may be performed within the same place of business in which is transacted the business giving rise to the loan or other credit transaction.

Drafting Note: Section 38.1-482.10 has been deleted as it appears to be unnecessary because of §§ 38.2-1024 through 38.2-1038 and Chapter 18.

§ 38.2-3713. Claims.—A. All claims shall be promptly reported to the insurer or its designated claim representative. The insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid or credited by: (i) electronic means to the account of the claimant to whom payment of the claim is due pursuant to the policy provisions or to an account or person specified by such claimant; or (ii) draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or to a person specified by such claimant.

C. No plan or arrangement shall be used where any person other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims. A group policyholder may, by arrangement with the insurer, draw drafts or checks, or credit by electronic means in payment of claims due to the group policyholder subject to audit and review by the insurer. The insurer shall periodically review claims payments made on its behalf by claim representatives or group policyholders.

§ 38.2-3714. Debtor to have option of furnishing insurance through existing policies or other insurers.—If credit life insurance or credit accident and sickness insurance is required as security for any indebtedness, the debtor shall have the option of (i) furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or (ii) procuring and furnishing the required coverage through any insurer authorized to transact insurance in this Commonwealth. The creditor shall inform the debtor of this option in writing and shall obtain the debtor's signature acknowledging that he understands this option.

§ 38.2-3715. Reserves.—A. Each insurer licensed to write credit life insurance in this Commonwealth shall establish and maintain reserves on all such business written in this Commonwealth. At valuation date the reserves shall be not less than 130 percent of the aggregate reserves on all such business calculated by the net premium method on the basis of the Commissioners' 1958 Standard Ordinary Mortality Table or, at the option of the insurer, 100 percent of such reserves calculated on the Commissioners' 1958 Standard Ordinary Mortality Table with 130 percent mortality, with interest at five and one-half percent for single premium insurance and four and one-half percent for all other insurance annually. Reserves may be calculated on an annual or a monthly basis with a reasonable assumption, subject to statistical proof, as to average ages at issue or at expiration. Tables used in calculating reserves must be filed with and approved by the Commission.

B. Each insurer licensed to write credit accident and sickness insurance in this Commonwealth shall establish and maintain reserves on all such business written in this Commonwealth, which shall at all times be no less than the total unearned gross premiums calculated by the pro rata method or by the Rule of 78. It may be assumed that all business written in any calendar month was written as of the fifteenth of such month.

§ 38.2-3716. What laws applicable.—In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling. Paragraphs 1 and 2 of § 38.2-508 shall not apply to the insurance subject to the provisions of this chapter where application of these paragraphs would conflict with the requirements of any federal agency.

Drafting Note: This was moved from existing § 38.1-482.1; no substantive changes were intended. Proposed § 38.2-508 is existing § 38.1-52.7.

Drafting Note: Section 38.1-482.13 has been deleted because of the decision to have one rules and regulations section, § 38.2-223.

Drafting Note: Section 38.1-482.14:1 has been deleted in favor of the revised general penalties section, proposed § 38.2-218, the new cease and desist order section, proposed § 38.2-219, and the various sections dealing with license suspensions and revocations.

Drafting Note: Section 38.1-482.15 has been deleted in favor of having one appeals section, proposed § 38.2-222.

Drafting Note: Section 38.1-482.16:1, which contains a severability provision, has been deleted in favor of one severability provision for the entire title.

Drafting Note: There wil be an effective date for the entire title. A separate section is not specifically needed for credit life insurance and credit accident and sickness insurance.

CHAPTER 38.

Cooperative Nonprofit Life Benefit Companies.

1. Existing § 38.1-500 is being deleted to eliminate the annual license fee because Chapter 38 companies pay a premium tax.

2 Existing § 38.1-501 is being deleted and the general insurance laws governing revocation or suspension of a license will be applicable.

3. In proposed § 38.2-3804, the existing language is stricken and language is substituted to clearly state that Chapter 38 companies must comply with the general insurance laws. The proposed change in this section makes the deletion of some existing sections possible.

4. Existing § 38.1-509 is being deleted and with the change in proposed § 38.2-3804, Chapter 38 companies will be subject to the investment laws controlling regular life insurance companies.

5. Existing § 38.1-513 is being deleted. Proposed Chapter 40 specifies the provisions which apply to Fraternals.

6. Existing § 38.1-518 is being deleted and all policy forms must be filed because of the change in § 38.2-3804.

7. Existing § 38.1-520 is being deleted because it relates only to companies licensed prior to 1928 and the two remaining companies were licensed after that year.

8. Existing § 38.1-521 is being deleted because it applies to new companies desiring to do business in Virginia and companies licensed prior to 1928. No new companies will be licensed and the companies presently operating were licensed after 1928.

CHAPTER 38.

COOPERATIVE NONPROFIT LIFE BENEFIT COMPANIES.

Article 1.

General Provisions.

§ 38.2-3800. Scope of chapter.– This chapter applies to cooperative nonprofit life benefit companies as defined in § 38.2-3801 , and to the classes of insurance and insurance benefits those companies are authorized to provide.

§ 38.2-3801. Cooperative nonprofit life benefit company defined.–A. Any company that (i) is organized without capital stock, (ii) has a representative form of government, (iii) conducts its business under the provisions of this chapter without profit and for the sole benefit of its members and their beneficiaries, (iv) issues benefit certificates or policies of life insurance, annuities, or accident and sickness insurance, or any combination of those classes of insurance, upon its members, and (v) maintains the reserves required in this chapter on all contracts issued by it to its members, shall be a cooperative nonprofit life benefit company.

B. As used in this chapter, "company" means a cooperative nonprofit life benefit company as defined in subsection A of this section.

§ 38.2-3802. Continuation of existing companies.–Any company licensed and doing business in this Commonwealth on July 1, 1952, may continue to do business in accordance with the powers contained in its certificate of incorporation, subject to the provisions of this chapter, but no such company shall be permitted to extend its powers.

§ 38.2-3803. Licensing of additional companies prohibited.– Any company that was not licensed and doing business in this Commonwealth on July 1, 1952, shall not be issued a license to do the business of insurance in this Commonwealth. On or after July 1, 1952, only a renewal of a license held by the company for the preceding year will be issued.

Drafting Note: The fee specified in § 38.1-500 is being eliminated because Chapter 38 companies pay a premium tax.

Drafting Note: Section 38.1-501 is being deleted and §§ 38.2-1040 and 38.2-1041 will be applicable to the revocation or suspension of a license.

§ 38.2-3804. What laws applicable.– All companies shall comply with all of the provisions of this title relating to insurance companies generally. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

Drafting Note: The existing language is being deleted and the language above is being added to clarify that cooperative nonprofit life benefit companies must comply with the laws regulating regular life insurance companies except where this chapter contains a provision to the contrary.

§ 38.2-3805 General powers of company; limitation on increase in rates.– Each company shall make a constitution, laws or bylaws for its government, the admission of its members, the management of its affairs and the fixing and readjustment of the rates of contribution of its members. It may change, add to, or amend the constitution, laws or bylaws and shall have the other powers necessary and incidental to effect the objects and purposes of the company. It may make refunds to its members from any surplus funds of the company, but it may only increase rates or make extra assessments against members whose contracts include provisions for rate increases and extra assessments.

Drafting Note: "May" is being changed to "shall" in the first sentence for consistency with the use of "shall" in § 38.2-3806.

§ 38.2-3806. Constitution and bylaws.– Each company shall provide in its constitution, laws or bylaws for:

1. A representative form of government for the management of the company, to be carried on either with or without a lodge, or with membership in the lodge optional;

2. A legislative or governing body composed of its officers and representatives to be elected either by the adult members or by delegates elected directly or indirectly by the adult members; and

3. The manner of selecting representatives of the members for membership in its legislative body.

§ 38.2-3807. Governing body; board of directors.–The governing body of each company shall meet at least once every four years. Meetings of the governing body may be held in any state where the company is authorized to do business. The members of the governing body shall not vote by proxy.

A board of directors to conduct the business of the company shall be elected by the governing body for a period of not more than four years or until the next quadrennial meeting of the body. The board of directors shall elect the officers to conduct the business of the company under its direction. No officer shall be elected for a period beyond that for which the board of directors has been elected.

§ 38.2-3808. Filing copies of constitution and bylaws. —Each company shall file with the Commission a duly certified copy of its constitution, laws or bylaws and all amendments or additions. Printed copies of the constitution, laws or bylaws, certified by the secretary or corresponding officer of the company, shall be prima facie evidence of their legal adoption and filing.

§ 38.2-3809. How a company may become legal reserve life insurer.—Any company filing with the Commission a resolution of its board of directors or similar body, or of its legislative body, making a request to become a legal reserve life insurer, upon submitting proof satisfactory to the Commission that the request is properly authorized and that the condition of its business qualifies it under the laws of this Commonwealth to be classed as a legal reserve life insurer, shall become a legal reserve life insurer under the name and the plan provided by proper amendment of its charter or certificate of incorporation.

§ 38.2-3810. Institutions maintainable; company a charitable institution.—Any company may maintain homes for aged members, or children's homes, hospitals or recreational centers, or any other charitable institution, and may provide for the erection of monuments or memorials to deceased members. Such a company is hereby classified as a charitable institution.

Drafting Note: With the revision proposed for § 38.2-3804, proposed Chapter 14 will clearly apply, and § 38.1-509 becomes unnecessary.

§ 38.2-3811. Benefits not subject to process.—Any money, other benefit, charity, relief or aid to be paid, provided or rendered by any company shall not be liable to attachment, garnishment or other process, or be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, his beneficiary, or any other person who may have a right thereunder, either before or after payment.

§ 38.2-3812. Tax on gross premium receipts.—The officers of each company shall, at the time of making the annual statement, file with the Commission a sworn statement of its gross premium receipts collected from members residing in this Commonwealth for the preceding year ending December 31. Each company shall pay into the state treasury by March 1 of each year, a tax of one percent on its gross premiums, collected on legal reserve policies. The tax shall be in lieu of all other taxes, state, county or municipal, based on such gross premium receipts. No city, town, municipality or other subdivision of the Commonwealth shall impose any license fee on the company or any of its agents for the privilege of conducting business in any portion of this Commonwealth. In determining such gross premium receipts, the company shall not take credit for any expenditures.

Drafting Note: The April 1 date for payment of the gross premium tax has been changed to March 1 to be consistent with the treatment of other insurance companies.

§ 38.2-3813. Suits against company.—A. A suit or an action at law may be instituted against any company in any county or city in this Commonwealth.

Drafting Note: Section 38.1-513 is being deleted since Fraternals are subject to the provisions of their own chapter (proposed Chapter 40).

Article 2.

Reserves, Policies and Benefits.

§ 38.2-3814. Contracts in writing; fees.—All contracts of any company for insurance or other benefits shall be in writing. No company or any of its officers or agents shall include in the sum charged a member, any fee, compensation, or other charge. However, a local medical examiner's fee and a policy fee on accident and sickness contracts may be charged.

§ 38.2-3815. What benefits policies may provide.—Any company may provide for (i) stipulated premiums, (ii) death, annuity, endowment and disability benefits, and (iii) cash surrender and loan values to an amount not exceeding the reserve, or its equivalent, in paid-up or extended term insurance, based upon the mortality standards set forth in this chapter.

§ 38.2-3816. Policies companies may issue; reserves required; provisions concerning increase of rates and extra assessments.—Any company may issue contracts of life, accident and sickness insurance or combinations of them. The reserves for such policies or contracts shall be based upon the American Experience Table of Mortality, with an interest assumption of no more than four percent, or some higher standard, or upon any minimum standard allowed by law in this Commonwealth for legal reserve life insurers. It may provide in its laws or bylaws and membership contracts that the rates shall not be increased or extra assessments made.

§ 38.2-3817. Paid-up insurance or extended term insurance.—Any company shall provide for automatic paid-up or extended term insurance in the event of the default in premium payments of any contract that has been in force for at least two years from the date of issue. The amount of such insurance shall not exceed the amount which the reserve that is credited to the member will purchase. The company shall carry the liability on its books.

Drafting Note: For consistency with other insurers, existing § 38.1-518 is being deleted so that proposed § 38.2-316 will apply.

§ 38.2-3818. Officers and members not individually liable for payment.—Officers and members of the supreme, grand or any subordinate body of any company shall not be individually liable for the payment of

any disability or death or other benefits provided for in the laws, bylaws and contracts of the company. Benefits shall be payable out of the funds of the company and in the manner provided by its laws and bylaws.

Drafting Note: Section 38.1-520 is being deleted because it relates only to companies licensed prior to 1928. The two remaining companies were licensed in 1934 and 1937.

Drafting Notes: The first sentence of § 38.1-521 is being deleted because it applies to companies applying to do business in Virginia and the licensing of additional Chapter 38 companies is prohibited.

The last sentence is deleted because it applies only to companies licensed prior to 1928 and there are none presently operating.

Title 38.2

CHAPTER 39.

Mutual Assessment Life, Accident and Sickness Insurance Companies.

This chapter was completely rewritten and enacted in the 1985 session of the General Assembly. Consequently, only minor editorial changes have been made.

CHAPTER 39

MUTUAL ASSESSMENT LIFE, ACCIDENT AND SICKNESS INSURERS.

Article 1.

General Provisions.

§ 38.2-3900. Scope of chapter.—This chapter applies to mutual assessment life, accident and sickness insurers and to the classes of insurance written by these insurers.

§ 38.2-3901. Definitions.—As used in this chapter:

"Mutual assessment life, accident and sickness insurance" means life, accident and sickness insurance and annuities provided by an insurer which has a right to assess its members for contributions and which is licensed under this chapter.

"Mutual assessment life, accident and sickness insurer " means a nonstock corporation that provides life, accident or sickness insurance or annuity contracts for which the following provisions are applicable:

1. All benefits payable to beneficiaries are mainly provided for by (i) assessments upon members made when needed by the insurer, or (ii) advance premiums paid at fixed dates, with the right reserved by the insurer to make additional assessments; or

2. If definite periodic premiums are used without the right to make additional assessments, premiums must be sufficient to pay average claims in accordance with standards applicable to insurers licensed pursuant to Chapter 10 of this title.

§ 38.2-3902. Classes of insurance that may be written by mutual assessment life, accident and sickness insurers.—The following classes of insurance can be written by mutual assessment life, accident and sickness insurers:

Category A

1. Life insurance as defined in § 38.2-102;

2. Industrial life insurance as defined in § 38.2-104; and

3. Accident and sickness insurance as defined in § 38.2-109 except Medicare supplement insurance as defined in § 38.2-3600.

Category B

1. Credit life insurance as defined in § 38.2-103;

2. Variable life insurance as defined in § 38.2-105 ;

3. Credit accident and sickness insurance as defined in § 38.2-108; and

4. Medicare supplement insurance as defined in § 38.2-3600.

Category C

1. Annuities as defined in § 38.2-106.

2. Variable annuities as defined in § 38.2-107.
Drafting Note: Variable annuities have been added to parallel the addition of this class as defined in Chapter 1.

§ 38.2-3903. What laws applicable.—Except as provided in this section, all mutual assessment life, accident and sickness insurers shall comply with all provisions of this title relating to insurers generally. Until July 1, 1990, those classes of insurance specified in Category A of § 38.2-3902 shall be exempt from this title, except this chapter and Chapters 5 and 6 of this title. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

§ 38.2-3904. Conversion of mutual assessment life, accident and sickness insurers.—A. Any mutual assessment life, accident and sickness insurer which chooses to remove itself from the provisions of this chapter by becoming an insurer licensed pursuant to Chapter 10 of this title may do so by meeting the requirements of that chapter. When applying for a license pursuant to Chapter 10, an insurer shall submit

an application to the Commission that shows that each requirement of Chapter 10 has been met. If the applicant does not meet these requirements, the applicant may submit for approval a plan that includes a schedule for meeting these requirements. The schedule must provide for compliance with these requirements within five years of the approval of the application. The Commission may grant an additional period in order to achieve compliance with the requirements of Chapter 10 after an informal hearing.

B. If the Commission approves the application, the insurer shall have all the rights, privileges and responsibilities of a licensed insurer not subject to the provisions of this chapter.

C. The Commission, upon failure of the applicant to comply with the terms of an approved schedule, may require the applicant to adhere to the requirements of this chapter.

Article 2.

Organization and Licensing of Companies.

§ 38.2-3905. Incorporation of companies.—Any insurer that was licensed and transacting in this Commonwealth the business of mutual assessment life, accident and sickness insurance on July 1, 1985, may continue to transact that business in accordance with its license.

§ 38.2-3906. Licensing of additional companies prohibited.—Any insurer that was not licensed and engaged in the business of mutual assessment life, accident and sickness insurance in this Commonwealth under the provisions of former Title 38.1 on July 1, 1952, shall not be issued a license pursuant to this chapter to transact the business of insurance in this Commonwealth. On or after that date a license shall not be issued except for renewal of a license held by the insurer for the preceding year.

§ 38.2-3907. Directors; terms; annual meetings; voting; executive committee.—A. As provided in its certificate of incorporation and as provided in its bylaws, the management of any mutual assessment life, accident and sickness insurer shall be vested in a board of at least five directors, each of whom shall be a member of the insurer. Each director shall hold office for one year or for a longer term if specified by the bylaws, and thereafter until his successor is elected and has qualified. Vacancies on the board may be filled for the unexpired term by the remaining directors.

B. The annual meeting of the members of the insurer shall be held as provided by the certificate of incorporation or the bylaws. A quorum shall consist of the larger of ten members or the number of members specified by either the certificate of incorporation or bylaws. In all meetings of members, each member of the insurer shall be entitled to one vote, or a number of votes based upon insurance in force, the number of policies held, or the amount of premiums paid as provided in the bylaws of the insurer. Votes by proxy may be received in accordance with the certificate of incorporation or the bylaws. The date of the annual meeting shall be stated in the policy, or notice of the date and location of the annual meeting shall be provided annually.

C. Notwithstanding the provisions of the charter of any insurer to the contrary, upon a resolution adopted by the board of directors of the insurer and approved by a majority of its members present in person or by proxy, the directors of the insurer may be divided into classes, and only a portion may be elected each year. Pursuant to the provisions of § 13.1-869 the directors may appoint an executive committee to exercise the powers and perform the duties set out in that section.

§ 38.2-3908. Officers.—Unless the certificate of incorporation provides otherwise, the directors shall elect from their number a president and may elect a chairman, and shall also elect a secretary and a treasurer and any additional officers as they determine necessary, who may or may not be members of the insurer. The offices of secretary and treasurer may be held by one person. Unless otherwise provided in the certificate of incorporation, the term of these officers shall be not less than one year nor more than three years or until their successors are elected or qualified.

§ 38.2-3909. Inspection of books and papers.—The books and papers of the insurer shall be open for examination by members or their representatives at all reasonable times.

Article 3.

Policy Provisions and Benefits.

§ 38.2-3910. Policy forms to be filed.—Every mutual assessment life, accident and sickness insurer shall file with the Commission a copy of all policy forms and standard endorsements which the insurer intends to use. These companies shall be exempt from form approval requirements regarding those lines of insurance specified in Category A of § 38.2-3902 until July 1, 1990.

§ 38.2-3911. Time limit on certain defenses.—Every insurance policy or contract shall contain a provision that after two years from the effective date of the policy or contract, only fraudulent misstatements in the application may be used to void the policy or contract or deny any claim for a loss incurred or a disability that starts after the two-year period. This provision may be omitted if the incontestable clause referred to in § 38.2-3912 is included.

§ 38.2-3912. Incontestability of policies.—Every insurance policy or contract shall contain a provision that it shall be incontestable after it has been in force during the lifetime of the insured for two years from its date of issuance, except for nonpayment of the policy's assessments or premiums. In the case of life policies and at the option of the insurer, provisions relating to benefits in the event of disability and provisions which grant additional insurance specifically against accidental death, may be excepted in the incontestability provision. This provision may be omitted if the time limit on the certain defense clause specified in § 38.2-3911 is included.

§ 38.2-3913. Required grace periods.—Each insurance policy shall have a provision that the insured is entitled to a thirty-one-day period within which the payment of any premium or assessment after the first payment may be made. At the option of the insurer this may be subject to a reasonable interest charge for the number of days of grace elapsing before the payment of the premium or assessment. The provision shall also state that during the grace period the policy shall continue in full force, but if a claim arises under the policy during the grace period before the overdue premium or assessment is paid, the amount of such premium or assessment, with applicable interest, may be deducted from any amount payable under the policy in settlement.

§ 38.2-3914. Policy to specify amount of payment and when to be paid.—Each policy shall specify the sum of money payable upon the occurrence of the insured risk. Each policy shall also state that payment shall be made within thirty days after showing proof of the occurrence of the insured risk.

Article 4.

Insurance Transactions.

§ 38.2-3915 Assessment contract.—Contracts issued by a mutual assessment life, accident and sickness insurer shall be on forms prescribed by the insurer and shall be substantially uniform among members of the respective classes of insurance written by the insurer. Each member shall pay his pro rata share of all losses or damages sustained, expenses of operations of the insurer, and the maintenance of an adequate surplus to policyowners as determined by the board of directors. Periodic assessments may be collected as advance premiums, or by past assessments, or by both methods. The amount of assessments shall be established by the board of directors of the insurer. When a contract is subject to assessment, the contingent liability of each member of an insurer shall be clearly stated in the contract. Contracts omitting the right of contingent assessment shall be deemed to be nonassessable.

§ 38.2-3916 Classification of risks; rates.—Any insurer writing mutual assessment life, accident and sickness insurance may classify the risks insured against, and fix the rate of assessment of premium for such insurance in accordance with the classifications.

§ 38.2-3917. Right to limit assessment liability; when contingent assessment liability waived.—Any mutual assessment life, accident and sickness insurer having a surplus to policyowners of at least $100,000 may limit the contingent assessment liability of members, or classes of members, to an amount not more than one additional current annual assessment. Any insurer having surplus to policyowners of at least $300,000 may issue contracts omitting the right to make contingent assessment against members if reserves for these contracts are established and maintained in the same manner as would be required by an insurer licensed pursuant to Chapter 10 of this title. Contracts so issued shall be treated in all respects as nonassessment contracts.

§ 38.2-3918 Notice of assessment; how given.—After an assessment is made, the insurer shall give each member subject to the assessment written notice stating the amount of the assessment and the date when payment is due. Except where the provisions of the bylaws or the policy provide otherwise, the time of payment shall not be less than thirty days nor more than sixty days from the service of the notice. This notice may be served personally or mailed with the United States Postal Service. If sent by mail, notice shall be considered given at the time of mailing and shall be sent to the member at his address shown on the insurer's records.

§ 38.2-3919 Agents' licenses required.—A. Except as provided in subsection B, each individual who is a resident of this Commonwealth who desires to obtain a license to solicit, negotiate or effect any of the classes of insurance specified in § 38.2-3902 shall obtain that license only when that individual has passed a written examination prescribed by the Commission.

B. Any individual who is licensed prior to July 1, 1990, and whose license is restricted to the classes of insurance specified in Category A of § 38.2-3902 shall be exempted from the written examination provision noted above.

Drafting Note: The Commission no longer issues a certificate of qualification.

Article 5.

Financial Provisions.

§ 38.2-3920. Surplus to policyowners.—A. A mutual assessment life, accident and sickness insurer shall have a minimum surplus to policyowners of $100,000.

B. In order to write the classes of insurance referred to in Category C of § 38.2-3902, minimum surplus to policyowners shall be $800,000.

§ 38.2-3921. Limitation on single risk to be assumed.—No single risk shall be assumed by a mutual assessment life, accident and sickness insurer if the risk exceeds fifteen percent of the company's total surplus to policyowners. Any risk or portion of any risk that has been reinsured in accordance with § 38.2-3922 shall be deducted in determining the limitation of risk prescribed by this section. For the purposes of this section the amount of surplus to policyowners shall be determined on the basis of the last sworn statement of the insurer, or the last report of examination filed with the Commission, whichever is more recent at the time the risk is assumed. Mutual assessment life, accident and sickness insurers licensed on July 1, 1985, shall conform to this limitation by July 1, 1990. Until July 1, 1986, the single risk limit, after deducting for reinsurance, shall be twenty-five percent of surplus to policyowners. Between July 1, 1986, and July 1, 1988, single risk limits, after deducting for reinsurance, shall be twenty percent of surplus to policyowners. This section shall not apply to insurance coverages defined in §§ 38.2-108 and 38.2-109 and Medicare supplement insurance defined in § 38.2-3600.

§ 38.2-3922. Reinsurance.—Any mutual assessment life, accident and sickness insurer may reinsure the whole or any part of its risks with any solvent insurer licensed in this Commonwealth or licensed in any other state having standards of solvency, at least equal to those required in this Commonwealth. However, the reinsurance shall be ceded without contingent liability on the part of the reinsured insurer. Any mutual assessment life, accident and sickness insurer having a surplus in excess of $800,000 may accept or assume reinsurance from any licensed insurer.

§ 38.2-3923. Reserves required.—In addition to providing for claims incurred but not settled, mutual assessment life, accident and sickness insurers shall maintain the following reserve liabilities:

1. Life policies written with the right to make additional assessments shall have reserves established as a single group in the same manner as group annual renewable term insurance is reserved for insurers licensed pursuant to Chapter 10 of this title.

2. Life or annuity policies written without the right to make additional assessments shall have reserves established using the standard valuation provisions required of insurers licensed under Chapter 10 of this title issuing similar types of policies.

3. Accident and sickness policies shall have reserves established in accordance with regulations promulgated by the Commission for insurers licensed pursuant to Chapter 10 of this title.

4. The foregoing reserve computations for statutory accounting purposes shall be applicable to all policies hereafter in existence and shall supersede any separate reserve requirement or separate mortuary funds that have been previously used, pursuant to statute, custom or policy provision.

Title 38.2

CHAPTER 40.

Burial Societies.

1. In proposed § 38.2-4004, the existing language is stricken and language is substituted to clearly state that Chapter 40 companies must comply with the general insurance laws. The change in this section makes the deletion of some present sections possible.

2. Existing § 38.1-555 is being deleted. This section made certain sections in former Chapter 11 applicable to existing Chapter 12 (proposed Chapter 40) companies. Chapter 11 was reorganized into Chapter 11.1 by the 1985 legislative session so the sections previously referred to are being added into this chapter.

3. Existing § 38.1-556.1 is being deleted because it is an outdated provision.

4. Existing § 38.1-557 is being deleted because with the change in proposed § 38.2-4004 it is no longer needed.

5. The bond requirements in proposed § 38.2-4008 are being increased.

6. The first paragraph of existing § 38.1-559 is being deleted because with the additions of §§ 38.2-4010 and 38.2-4011 it is no longer needed. The second paragraph is being deleted because it is not applicable to the Chapter 40 company operating.

7. The second sentence of proposed § 38.2-4013 is being deleted so that all forms will need Commission approval.

8. Existing § 38.1-561 (proposed § 38.2-4019) is being amended so that the insurable interest requirements applicable to other life insurance policies will apply to Chapter 40 policies.

9. Another criterion is being added before a certificate can be considered invalid in proposed § 38.2-4020.

10. Existing § 38.1-564 is being deleted because it is not necessary to restrict the payment of claims to money with the language in proposed § 38.2-4013.

11. Existing § 38.1-566 is being deleted to remove the restriction of burial society officers or agents having an interest in or being employed by a mortician or undertaker.

12. Existing §§ 38.1-567 and 38.1-568 are being deleted. Their provisions, which deal with fines, suspension or revocation of license, and rehabilitation and liquidation, will still essentially apply through the applicability of other parts of the title under proposed § 38.2-4004.

CHAPTER 40.

BURIAL SOCIETIES.

§ 38.2-4000. Societies to which chapter applies.—The provisions of this chapter apply to every person designated as a "burial society". A "burial society" is any person engaged in the business of providing benefits for any payment of funeral, burial or other expenses of deceased members, by levying assessments or dues that are collected or are to be collected from the members of the society, or from the members of a class of the society.

§ 38.2-4001. Society may be incorporated.— Any existing burial society licensed and operating in this Commonwealth that is an unincorporated association may be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1 and, except as otherwise provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred upon such corporations by law. All burial societies shall be under the supervision and control of the Commission.

§ 38.2-4002. Continuation of existing societies.—Any burial society that was licensed and operating as a burial society on July 1, 1952, in this Commonwealth may continue to operate as a burial society as long as it complies with the provisions of this chapter and all other applicable statutes.

§ 38.2-4003. Licensing of additional societies prohibited.—Any burial society that was not licensed and operating as a burial society in this Commonwealth on July 1, 1952, shall not be issued a license as a burial society in this Commonwealth. On or after July 1, 1952, only a renewal of a license held by a society for the preceding year will be issued.

§ 38.2-4004. What laws applicable.—

All burial societies shall comply with all of the provisions of this title relating to insurance companies generally. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

Drafting Note: The existing language is being deleted and the language above is being added to clarify that burial societies must comply with the laws regulating regular life insurance companies except where this chapter contains a provision to the contrary.

This revision is similar to the revision to Chapter 38 (proposed § 38.2-3804).

Drafting Note: Section 38.1-555 is being deleted because of changes to proposed Chapter 39 and the provisions referred to are being added here in their entirety.

§ 38.2-4005. License may be renewed annually.— Each license to a burial society shall expire on the June 30 next occurring after its effective date and may be renewed by the Commission annually.

Drafting Note: Section 38.1-556.1 is outdated and is no longer needed.

Drafting Note: Section 38.1-557 is being deleted because the second sentence does not apply to the existing company. The first sentence refers to the deposit requirements in proposed Chapter 10 and is unnecessary because of the change in proposed § 38.2-4004 clarifying that burial societies must comply with the general insurance laws.

§ 38.2-4006. Annual meeting.—Each burial society shall hold, within the city or county in which the principal office is located in this Commonwealth, a stated annual meeting of its members, or representatives of local boards or subordinate bodies, subject to any regulations, restrictions and provisions the constitution or bylaws of the society may provide.

Drafting Note: This section was previously referenced in existing § 38.1-555 as § 38.1-531. It is now a part of this chapter.

§ 38.2-4007. Adoption of bylaws.—Each burial society now authorized to do business in this Commonwealth shall, before the adoption of any bylaw or amendment, mail the proposed bylaw or amendment to the members and directors of the society, together with a notice of the time and place when the proposed bylaw or amendment will be considered.

Drafting Note: This section was previously referenced in existing § 38.1-555 as § 38.1-532. It is now a part of this chapter.

§ 38.2-4008. Fidelity bond required.— The officers of each burial society who are charged with the duty of handling its funds shall, before receiving any funds, file with the Commission a surety bond with corporate security approved by the Commission. The bond shall be not less than $10,000 nor more than $100,000, to be fixed by the Commission. The bond shall secure to the society and its members the faithful performance of its officers' duties and a proper accounting of its funds.

Drafting Note: This bond requirement is being increased to adjust for inflation and to strengthen this requirement.

§ 38.2-4009. Inspection of books and papers.—The books and papers of the burial society shall be open for examination by members or their representatives at all reasonable times.

Drafting Note: This section was previously referenced in § 38.1-555 as § 38.1-533. It is now a part of this chapter.

§ 38.2-4010. Accumulation of reserve for an emergency fund.—A. In addition to provision for liability incurred on account of claims reported but not settled, claims incurred but not reported, and premiums, dues or assessments collected in advance, every company shall accumulate and maintain a reserve for an

emergency fund, which in the preparation of financial statements shall be considered a liability of the corporation, of at least $10,000.

B. Each burial society shall, in each calendar year, add to that reserve for an emergency fund at least five percent of its net receipts from premiums, dues or assessments from policies of life insurance until the total accumulated reserve fund equals twenty percent of the total benefits provided in the outstanding certificates of life insurance. However, when the corporation has issued policies of life insurance on a legal reserve basis, the net receipts from those policies shall not be considered in the calculation of the reserve for an emergency fund, but the burial society shall be required to maintain only the reserve provided for in the certificates.

Drafting Note: The provisions of this section are from former § 38.1-534 and are being added to include the means for accumulating the reserve fund required by this chapter in existing § 38.1-559, which has been deleted.

§ 38.2-4011. Maintenance of reserve for an emergency fund. --When the reserve for an emergency fund accumulated in accordance with the provisions of § 38.2-4010 equals the maximum amount provided in subsection B of that section, it shall be maintained at not less than that amount. However, no burial society shall be required, in any one year, to set aside more than five percent of its net receipts from premiums, dues or assessments from certificates of life insurance, other than certificates issued on a legal reserve basis.

Drafting Note: The provisions of this section are from former § 38.1-535 and are being added to include the means for maintaining the reserve fund required by this chapter in proposed § 38.2-4010.

§ 38.2-4012. Disposition of reserve for an emergency fund; discontinuance of business; receiver.--The reserve for an emergency fund required by § 38.2-4010, together with the income earned on that fund, shall be a trust fund for the payment of death claims. Whenever the reserve for an emergency fund exceeds the amount of the maximum sum provided by the certificates issued and in force by the society, the investment income generated by the reserve or an emergency fund shall be added back into that fund. It may apply that excess, or any portion of that excess, (i) in reduction of assessments upon certificate holders, or (ii) in any other equitable division or apportionment that its rules or contracts provide for the payment of claims. When any society discontinues business, delinquency proceedings against the society may be instituted and conducted as provided in Chapter 15 of this title. In the delinquency proceedings, any unexhausted portion of the reserve for an emergency fund shall be used in payment of accrued claims upon certificates. If this amount is insufficient to pay the claims in full, then the payment of the claims shall be on a pro rata basis; and if a balance remains, the payment of claims shall then be made in the order of their occurrence. Any remaining balance shall be distributed among the members in proportion to their respective premium payments during the latest full year of active business of the society.

Drafting Note: The provisions of this section are from former § 38.1-537 and are being added to include the means for disposing of the reserve fund required by this chapter in proposed § 38.2-4010.

Drafting Note: The first paragraph of § 38.1-559 is being deleted because with §§ 38.2-4010 and 38.2-4011 being added, it is unnecessary.

The second paragraph is being deleted because it does not apply to the Chapter 40 company presently operating.

§ 38.2-4013. Certificates of membership. - Each burial society shall issue certificates of membership to each member of the society. Each certificate shall state the amount of the benefit payable and the name of the beneficiary.

Drafting Note: The second sentence is being deleted and all forms will now need Commission approval.

§ 38.2-4014. Required grace period.--Each certificate shall have a provision that the certificate holder is entitled to a grace period of thirty-one days within which the payment of any call or assessment may be paid after the first month. The provision shall also state that during the grace period the certificate shall continue in full force, but if a claim arises under the policy during the grace period but before the call or assessment is paid, the amount of the call or assessment may be deducted from the amount payable under the certificate.

Drafting Note: This section was previously referenced in existing § 38.1-555 as § 38.1-543. It is now a part of this chapter.

§ 38.2-4015. Certificate to specify amount of payment and when to be paid.--Each certificate issued by any burial society shall specify the sum of money payable upon the occurrence of the risk insured against. The amount payable shall not be larger than one assessment upon the entire membership. Each certificate shall also state that within thirty days after due proof of the occurrence of the insured risk, payment shall be made.

Drafting Note: This section was previously referenced in existing § 38.1-555 as § 38.1-544. It is now a part of this chapter.

§ 38.2-4016. Payments become liens on society's property. --Upon the occurrence of the risk insured against, the burial society shall be obligated to the beneficiary for payment of the claim unless the contract is invalid because of fraud or other reason. This indebtedness shall be a lien upon all the property, effects and bills receivable of the society. This indebtedness shall have priority over all future incurred indebtedness, except as provided in this chapter in the case of the distribution of assets of an insolvent corporation, and as to rights of third parties.

Drafting Note: This section was previously referenced in existing § 38 1-555 as § 38.1-545. It is now a part of this chapter.

§ 38.2-4017. Notice of assessment.--Each notice of assessment made by any burial society upon any of

its members shall state the cause and purpose of the assessment.

Drafting Note: This section was previously referenced in existing § 38.1-555 as § 38.1-547. It is now a part of this chapter.

§ 38.2-4018. Liability on officers and directors for failing to levy assessments.—The officers or directors of any society who, after due proof of death has been filed, for sixty days refuse or neglect to levy an assessment to pay a claim not disputed by reason of fraud or validity when the death or emergency fund is insufficient to pay the claim, shall be liable to the beneficiary of the certificate. The liability of the officers or directors shall be for a sum not exceeding the face amount of the claim.

Drafting Note: This section was previously referenced in existing § 38.1-555 as § 38.1-549. It is now a part of this chapter.

§ 38.2-4019. Beneficiaries.—No person other than a wife, husband, relative by blood to the fourth degree, father-in-law, mother-in-law, son-in-law, daughter-in-law, stepfather, stepmother, stepchild, or child by legal adoption of the member, or one who is dependent upon the member or one who has an insurable interest in the life of the member as described in § 38.2-301, shall be named a beneficiary of the member's certificate. Within the above limitations, each member shall have the right to designate his beneficiary and to change his beneficiary, upon due notice to the society. If the beneficiary is not living or if no allowable beneficiary has been designated, any proceeds otherwise payable shall be payable to the member's estate.

Drafting Note: The changes in this section will give the insured more flexibility in naming a beneficiary and will provide a remedy if an incorrect beneficiary is named.

§ 38.2-4020. When certificate invalid.— A certificate of membership shall be invalid if:

1. The certificate holder was ill at the time the certificate was procured;

2. Any person concerned in the procurement of the certificate had reason to believe that the illness existed at that time;

3. The illness continued to the death of the holder and was a contributing cause of death;

4. Health questions were not asked on the application for coverage; and

5. The certificate holder died within sixty days from the date the certificate was issued.

Drafting Note: Another criterion is being added because the society would have the protection of contestability if health questions were asked.

§ 38.2-4021. Interest in benefits; assignability; liability to attachment, etc.—No beneficiary shall have or obtain any vested interest in a benefit until the benefit has become due and payable upon the death of the member. No certificate of membership in any burial society, nor any interest or rights in the certificate shall be assigned unless the assignment is to a person authorized by § 38.2-4019 to be named as a beneficiary. No money or other benefit provided by any burial society shall be liable to attachment, garnishment or other process, or be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right to the benefit, either before or after payment.

Drafting Note: Section 38.1-564 is no longer needed with requirements for benefit certificates in proposed § 38.2-4013.

§ 38.2-4022. Certain contracts with undertakers, etc., forbidden.—No burial society shall contract to pay or pay benefits provided under certificates of membership, to any official or designated undertaker or mortician or person engaged in the business of conducting and servicing funerals, so as to deprive the representatives or family of the deceased member from, or in any way control them in, obtaining funeral supplies and services in an open competitive market.

Drafting Note: Section 38.1-566 is being deleted to eliminate the prohibition of a professional serving as an officer on the board of a burial society when it might have a mortician, etc. as an occasional client.

Drafting Note: Section 38.1-567 is being deleted and the title-wide penalties section (proposed § 38.2-218) will apply.

Drafting Note: Section 38.1-568 is being deleted and the general penalties section and rehabilitation and liquidation sections will apply.

Title 38.2

CHAPTER 41.

Fraternal Benefit Societies.

This chapter has been reorganized and rewritten to be consistent with the Model Fraternal Code approved by the National Fraternal Congress of America and adopted by the Congress in October, 1983.

Major changes include:

1. The inclusion of a definition section in proposed § 38.2-4103.

2. Language is included to indicate that fraternals may have subsidiaries or affiliated organizations which are operated in furtherance of the purposes of the society to benefit members and their beneficiaries in proposed § 38.2-4104.

3. The increase of the bond requirement from $5,000 to a minimum of $50,000 to a maximum of $200,000 in proposed § 38.2-4109.

4. The inclusion of the authority of a fraternal to apply to provide benefits, authorized for life insurance companies in the future, which are not inconsistent with the fraternal chapter in proposed § 38.2-4116.

5. The amount of funeral benefits payable to a person who incurs the burial expenses for a member has been increased to $2,000 in proposed § 38.2-4117.

6. Fraternals are governed by Chapter 13, Article 5 (proposed §§ 38.2-1322 - 38.2-1334) Insurance Holding Companies when acquiring subsidiary corporations in proposed § 38.2-4121.

7. The authority of a fraternal to apply to the Commission to establish separate accounts and issue variable contracts is included in proposed § 38.2-4122.

8. Proposed § 38.2-4123 designates the sections in proposed Title 38.2 which apply to fraternals.

9. The valuation section remains substantively the same, however, language is included to clarify that valuation standards for other life insurers may be used in proposed § 38.2-4125.

CHAPTER 41.

FRATERNAL BENEFIT SOCIETIES.

Article 1.

Structure and Purpose.

§ 38.2-4100. Fraternal benefit societies.—Any society, order or supreme lodge without capital stock, including one exempted under the provisions of paragraph 6 of subsection A of § 38.2-4135 of this chapter, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and providing benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

Drafting Note: There is no substantive change in this section.

§ 38.2-4101. Lodge system.—A. A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and rituals. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once each month in furtherance of the purposes of the society.

B. A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Drafting Note: 1. Subsection A is substantively the same as existing § 38.1-638.2.

2. Subsection B of this section is similar to the second sentence of existing § 38.1-638.29. It appears more logical to place it in this section.

§ 38.2-4102. Representative form of government.—A society has a representative form of government when:

1. It has a supreme governing body constituted in one of the following ways:

a. Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected, meet at least once every four years, and elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

b. Direct election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws.

A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

2. The officers of the society are elected either by the supreme governing body or by the board of directors.

3. Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly.

4. Each voting member shall have one vote; no vote may be cast by proxy.

Drafting Note: This language is similar to the existing language in § 38.1-638.13.

The existing language does not include voting for delegates by mail and it requires the first election of officers not later than one year from the issuance of a license.

Drafting Note: The exemption from general laws is now in proposed § 38.2-4123.

§ 38.2-4103. Definitions.—As used in this chapter:

"Benefit contract" means the agreement for provision of benefits authorized by § 38.2-4116, as that agreement is described in § 38.2-4119.

"Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

"Certificate" means the document issued as written evidence of the benefit contract.

"Laws" means the society's articles of incorporation, constitution and bylaws, however designated.

"Lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

"Premiums" means premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

"Rules" means all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

"Society" means fraternal benefit society, unless otherwise indicated.

Drafting Note: The definitions section is completely new. However, the terms were used in the existing chapter.

Drafting Note: The exemption of certain societies is now in proposed § 38.2-4135.

§ 38.2-4104. Purposes and powers.—A. A society shall operate for the benefit of members and their beneficiaries by:

1. Providing benefits as specified in § 38.2-4116; and

2. Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others. Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

B. Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have any other powers necessary and incidental to effecting the objects and purposes of the society.

Drafting Note: Paragraph 2 of subsection A is similar to the first paragraph of existing § 38.1-638.36. Subsection B is similar to existing § 38.1-638.25.

The last sentence of subsection A indicates that fraternals may have subsidiaries or affiliated organizations which are operated in furtherance of the kinds of purposes stated in A1 and A2 and for the benefit of members and their beneficiaries. These organizations are operated primarily for member service and not primarily for investment purposes as are the subsidiaries in proposed § 38.2-4121.

Drafting Note: The liability of officers is now in proposed § 38.2-4107.

Article 2.

Membership.

§ 38.2-4105. Qualifications for membership.—A. A society shall specify in its laws or rules:

1. Eligibility standards for every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen and not greater than age twenty-one;

2. The process for admission to membership for each membership class; and

3. The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

B. A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

C. Membership rights in the society are personal to the member and are not assignable.

Drafting Note: Subsection A1 is in existing § 38.1-638.29 (first paragraph). The other subsections are not in the existing chapter.

Drafting Note: Mergers and reinsurance are now addressed in proposed §§ 38.2-4113 and 38.2-4114.

§ 38.2-4106. Location of office; meetings, communications to members; grievance procedures.—A. The principal office of any domestic society shall be located in this Commonwealth. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one subordinate lodge, or in any other location determined by the supreme governing body. All business transacted at such meetings shall be as valid in all respects as if such meetings were held in this Commonwealth. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

B.1. A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a

separate copy.

2. Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall either (i) be printed and mailed to each benefit member of the society or (ii) published in the society's official publication.

C. A society may provide in its laws or rules for grievance or complaint procedures for members.

Drafting Note: Subsection A is in existing § 38.1-638.8. Subsection B 2 is similar to existing § 38.1-638.47. Subsection C is not in the existing chapter.

Drafting Note: This provision is now subsection A of proposed § 38.2-4106.

§ 38.2-4107. No personal liability.—A. The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

B. Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, or threat of such, in which the person may be involved because he or she is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed in relation to any matter in (i) such action, suit or proceeding as to which he or she was finally adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society or (ii) such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in (i) or (ii) of this subsection may be made only by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors, and administrators.

C. A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

Drafting Note: Subsection A is in existing § 38.1-638.6. Subsections B and C are new language.

Drafting Note: Taxation is now in proposed § 38.2-4124.

§ 38.2-4108. Waiver.—The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Drafting Note: This section is substantively the same as existing § 38.1-638.26.

Drafting Note: The penalties section is now proposed § 38.2-4134.

Article 3.

Governance.

§ 38.2-4109. Organization of domestic society on or after October 1, 1986.—A. On or after October 1, 1986, seven or more citizens of the United States, a majority of whom are citizens of this Commonwealth, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation, which shall state:

1. The proposed corporate name of the society, which shall not so closely resemble the name of any other society or insurer as to be misleading or confusing;

2. The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter;

3. The names and residences of the incorporators and the names, residences and official titles of all officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

B. Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all

proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Commission, which may require any further information it deems necessary. The bond, with sureties approved by the Commission, shall be not less than $50,000 nor more than $200,000, as required by the Commission. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the Commission shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

C. No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the Commission upon cause shown, unless the 500 required applicants have been secured and the organization has been duly completed. The articles of incorporation and all other proceedings under those articles shall become void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business.

D. Upon receipt of a preliminary certificate of authority from the Commission, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

1. Actual bona fide applicants for benefits have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

2. At least ten subordinate lodges have been established into which the 500 applicants have been admitted;

3. There has been submitted to the Commission, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and their premiums; and

4. It has been shown to the Commission, by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have each paid in cash at least one regular monthly premium, which shall total at least $150,000. Advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to the applicants.

E. The Commission may examine and require any further information it deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to do business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The Commission shall cause a record of such certificate of authority to be made. A certified copy of such record shall have the same effect as the original certificate of authority.

F. Any incorporated society authorized to do business in this Commonwealth at the time this chapter becomes effective shall not be required to reincorporate.

Drafting Note: The existing chapter has similar provisions in §§ 38.1-638.14, 38.1-638.15, 38.1-638.16, 38.1-638.17, 38.1-638.18 and 38.1-638.19.

Paragraph 1 of subsection A is not in the existing chapter; it is elsewhere in the Code. The number of applicants required for a preliminary certificate are 250 in existing Code (500 in this section). The bond requirement has been increased.

§ 38.2-4110. Incorporation of fraternal benefit societies.—Domestic fraternal benefit societies may be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, as modified by the provisions of this title, and, except as otherwise provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred by law upon companies so incorporated.

Drafting Note: This section is being moved to proposed § 38.2-4136.

§ 38.2-4111. Admendments to laws.—A. A domestic society may amend its laws in accordance with the provisions of those laws by action of its supreme governing body at any regular or special meeting or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission of the amendment, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

B. No amendment to the laws of any domestic society shall take effect unless filed with the Commission.

C. Within ninety days from the filing specified in subsection B of this section, all such amendments, or a synopsis of the amendments, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis of the amendments, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or their synopsis have been furnished the addressee.

D. Every foreign or alien society authorized to do business in this Commonwealth shall file with the Commission a duly certified copy of all amendments of, or additions to, its laws within ninety days after their enactment.

E. Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of their legal adoption.

Drafting Note: Existing §§ 38.1-638.25 and 38.1-638.27 contain the provisions in this section. However, the present language does not provide for the specific methods of amending the laws or for voting.

Drafting Note: The election of officers is now a part of proposed § 38.2-4102.

§ 38.2-4112. Institutions.—A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by paragraph 2 of subsection A of § 38.2-4104. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement. No society shall own or operate funeral homes or undertaking establishments.

Drafting Note: This section is substantially the same as existing § 38.1-638.36.

Drafting Note: Preliminary certificates are now a part of proposed § 38.2-4109.

§ 38.2-4113. Reinsurance.—A. A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this Commonwealth, or if not so authorized, one which is approved by the Commission, but no such society may reinsure substantially all of its insurance in force without the written permission of the Commission. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this chapter, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

B. Notwithstanding the limitation in subsection A, a society may reinsure the risks of another society in a consolidation or merger approved by the Commission under § 38.2-4114.

Drafting Note: Subsection A of this section is substantively the same as the last paragraph of existing § 38.1-638.7. Subsection B is not in the current Code.

Drafting Note: The bond requirement is now in subsection B of proposed § 38.2-4109. It has been increased to a minimum of $50,000.

§ 38.2-4114. Consolidations and mergers.—A. A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the Commission:

1. A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger

2. A sworn statement by the president and secretary or corresponding officers of each society showing its financial condition on a date fixed by the Commission but not earlier than December 31 next preceding the date of the contract;

3. A certificate of such officers, duly verified, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws permit, by mail; and

4. Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

B. If the Commission finds that the contract conforms to the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the Commission shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be effective unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event, the consolidation or merger shall not become effective until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the Commission. If the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective until it has been approved by the Commission of such state or territory and a certificate of such approval filed with the Commission.

C. When the consolidation or merger becomes effective, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property and things in action belonging to the societies shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument. Conveyances of real property, however, may be evidenced by proper deeds,

and the title to any real estate or interest therein, vested under the laws of this Commonwealth in any of the societies consolidated or merged, shall not revert or be in anyway impaired by reason of the consolidation or merger but shall vest absolutely in the society resulting from or remaining after such consoldiation or merger.

D. The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

Drafting Note: Existing § 38.1-638.7 contains all of the provisions in subsection A except 4. The last sentence of subsection B, subsection C and subsection D are not in the existing chapter.

Drafting Note: Beginning solicitation is now a part of proposed § 38.2-4109.

§ 38.2-4115. Conversion of fraternal benefit society into mutual life.—A. Any domestic fraternal benefit society organized or operated under this chapter may, upon a two-thirds vote of its supreme governing body, amend its articles of incorporation and laws if already incorporated, or, if not incorporated, may incorporate, in a manner to transform itself into a mutual life insurer. It may use the name by which it is already known, or another name, as its supreme governing body shall determine. However, the proposed plan for reorganization or reincorporation shall be submitted to and approved by the Commission. Upon so doing, and upon procuring from the Commission a license to do the business of insurance in this Commonwealth as a mutual life insurer, it shall incur the obligations and enjoy the benefits of a mutual life insurer as if originally incorporated as a mutual life insurer. Any such corporation under its articles and bylaws as so framed or amended shall be a continuation of the original organization, and the officers of the organization shall serve through their respective terms as provided in the original articles and laws. However, their successors shall be elected and serve as the laws of this Commonwealth and the articles of incorporation or bylaws of the reorganized company provide. The incorporation, amendment or reincorporation shall not affect existing suits, rights or contracts. The organization, after reorganization, shall have the power to do business of the same nature done by it before reorganization, as well as the powers conferred in this section and contemplated by its articles of incorporation, in order to protect and perform rights and contracts existing before reorganization, but all new business written shall be as a mutual life insurer.

B. All assets, other than general or expense fund assets, belonging to any reorganized insurer, prior to reorganization or arising or accruing from benefit certificates issued prior to the reorganization, shall be used only for the benefit of the holders of the benefit certificates or their beneficiaries.

C. If at the time of reorganization, or at any time after reorganization, it appears from the last preceding annual report of any such organization, filed with the Commission, or any investigation made by the Commission, that the present value of the contributions to be received from the holders of the benefit certificates, together with all assets, other than general or expense fund assets, owned by the insurer that have been accumulated from payments made by members holding such certificates, are not equal to the present value of the benefits promised to be paid, including all matured liabilities on any benefit certificates, then the insurer so reorganized shall establish, provide for, and maintain a fund, which with the present value of contributions and assets will equal the present value of the benefits, together with all matured liabilities. The fund shall be used for the payment of matured liabilities arising on the benefit certificates when other assets applicable thereto are exhausted. The fund need not be maintained unless required by conditions expressed in this chapter.

D. Members in good standing in any society prior to reorganization shall have the right after reorganization to transfer their insurance in the society to the mutual life plan without further medical examination for the same or lesser amount, and at legal reserve or level premium rates. The interest in the assets of the society of any person so transferring, as determined by the board of directors, trustees or corresponding body, shall be transferred to, and be a part of, the assets of the insurer on the legal reserve or level premium plan.

E. The insurer so organized, and its officials, shall exercise all the rights and powers and perform all the duties conferred or imposed by law upon organizations writing the kinds of insurance written by the insurer so organized. The organization and its officials shall exercise all the rights and powers and have full authority to perform all the duties necessary to protect rights and contracts existing prior to reorganization. The Commission shall exercise the powers and discharge the duties concerning any such insurer so reorganized that are applicable to insurers writing insurance or issuing policies of the same class, organized or operating in this Commonwealth. The Commission shall issue a certificate of authority to any solvent insurer so reorganized that has fully complied with the laws of this Commonwealth to do such insurance business in this Commonwealth.

F. Any fraternal benefit society reorganized to do mutual life insurance business as provided in this chapter shall value its benefit certificates according to the standard of valuation for fraternal benefit societies used in this Commonwealth, and its legal reserve or level premium policies according to the standard of valuation for those policies in this Commonwealth. The various classes of insurance shall be governed by the law applicable to each class of insurance.

G. The expense of operation and maintenance of a reorganized insurer shall be apportioned between those holding benefit certificates issued before the reorganization and those holding policies issued after the reorganization as may be determined by the board of directors, trustees or corresponding body.

Drafting Note: Existing §§ 38.1-638.53– 38.1-638.59 have been consolidated into this single section. The only changes have been editorial.

Drafting Note: This provision is now part of subsection C of proposed § 38.2-4109.

Article 4.

Contractual Benefits.

§ 38.2-4116. Benefits.--A. A society may apply to the Commission to provide the following contractual benefits in any form:

1. Death benefits;

2. Endowment benefits;

3. Annuity benefits;

4. Temporary or permanent disability benefits;

5. Hospital, medical or nursing benefits;

6. Monument or tombstone benefits to the memory of deceased members; and

7. Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

B. A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection A, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

Drafting Note: § 38.1-638.31 of the existing chapter contains subsection A (1)-(6) and subsection B. A(7) is not in the existing chapter.

This section carries forward the listing of benefit authority in the current Code, and also provides through 7 that the current parity between the types of products that fraternals and other life insurers can provide be maintained in the future. Under this provision, any new product authorities granted to life insurers will also be available to fraternals to apply to provide if such new products are not inconsistent with fraternal Code provisions, such as membership, representative form of government, etc. Since such developments are difficult to predict, and since fraternals would rather not be in a position of having to go back and seek Code amendments whenever such things happen, subsection A7 has been added.

Drafting Note: The license requirements are now a part of proposed § 38.2-4109.

§ 38.2-4117. Beneficiaries.--A. The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

B. A society may provide for the payment of funeral benefits from the proceeds of a certificate of no more than $2,000 to any person equitably entitled to them because of expenses incurred by the burial of the member.

C. If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds are payable, the amount of such benefit, except to the extent that funeral benefits may be paid as previously provided, shall be payable to the personal representative of the deceased insured; however, if the owner of the certificate is other than the insured, the proceeds shall be payable to such owner.

Drafting Note: Existing § 38.1-638.32 contains the provisions in this section. The limit of the facility of payment is $1,200. It is being changed to $2,000 in the general life insurance provisions.

Drafting Note: This provision is now a part of subsection E of proposed § 38.2-4109.

§ 38.2-4118. Benefits not attachable.--No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

Drafting Note: This section is the same as existing § 38.1-638.33.

Drafting Note: This provision is now in proposed § 38.2-4127.

§ 38.2-4119. The benefit contract.--A. Every society authorized to do business in this Commonwealth shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any attached riders or endorsements, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

B. Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

C. Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that the owner shall pay to the society his equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made, either (i) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (ii) in lieu of or in combination with (i), the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

E. Copies of any documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

F. No certificate shall be delivered or issued for delivery in this Commonwealth unless a copy of the form has been filed with and approved by the Commission in the manner provided for in § 38.2-316. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after July 1, 1986, shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this Commonwealth, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

G. Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto. Ownership rights prior to such transfer shall be specified in the certificate.

H. A society may specify the terms and conditions on which benefit contracts may be assigned.

Drafting Note: This section contains provisions in existing §§ 38.1-638.28, 38.1-638.29, 38.1-638.30, and 38.1-638.35.

D(ii) and the last sentence of subsection F are not in the existing chapter. Subsection G is also not in the existing chapter with the exception of the second sentence.

Drafting Note: These provisions are now in proposed § 38.2-4129.

§ 38.2-4120. Nonforfeiture benefits, cash surrender values, certificate loans and other options.—A. A society may grant paid-up nonforfeiture benefits, cash surrender values, certificate loans, and any other options its laws permit. Certificates issued on and after June 28, 1968, must contain at least one paid-up nonforfeiture benefit, except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term insurance contracts or contracts of level term insurance for fifteen years or less expiring before age sixty-six.

B. For certificates, other than those for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table or the Commissioners 1958 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurance companies, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than any excess of (1) over (2) as follows:

(1) The reserve under the certificate determined on the basis specified in the certificate; and

(2) The sum of any indebtedness to the society on the certificate, including interest due and accrued, and a surrender charge equal to two and one-half percent of the face amount of the certificate, which, in the case of insurance on the lives of persons under the minimum age for adult membership, shall be the ultimate face amount of the certificate, if death benefits provided in the certificate are graded.

C. For certificates issued on a substandard basis or for certificates with reserves computed upon the American Men Ultimate Table of Mortality, the term of any extended insurance benefit granted, including any accompanying pure endowment, may be computed upon the rates of mortality not greater than 130 percent of those shown by the mortality table specified in the certificate for the computation of the reserve.

D. For certificates with reserves computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table or the Commissioners 1958 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurance companies, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the provisions of the laws of this Commonwealth applicable to life insurers issuing policies containing like insurance benefits based upon such tables.

Drafting Note: This section is being moved but is not being changed substantively.

Drafting Note: This provision is a part of proposed § 38.2-4129. The assets must be invested in accordance with the chapter in the new section.

Article 5.

Financial Requirements.

§ 38.2-4121. Investments.—A society shall invest its funds only in investments authorized by Chapter 14 of this title for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this Commonwealth which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

Drafting Note: The language in this section is subtantively the same as existing § 38.1-638.43.

This section indicates that fraternal societies are governed by the life insurer investment provisions and insurance holding company provisions found in Chapters 13 and 14 of the insurance code including authorization to organize, acquire and hold stock of subsidiary corporations as is permitted by those chapters.

Drafting Note: The licensure of foreign societies is now in proposed § 38.2-4129.

§ 38.2-4122. Funds.—A. All assets shall be held, invested, and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

B. A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

C. A society may apply to the Commission, pursuant to resolution of its supreme governing body, to establish and operate one or more separate accounts and issue contracts on a variable basis, subject to Chapter 14, Article 3 (§ 38.2-1443 et seq.) of this title. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued under those laws, the society may (i) adopt special procedures for the conduct of the business and affairs of a separate account; (ii) for persons having beneficial interest therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and (iii) issue contracts on a variable basis to which subsections B and D of § 38.2-4119 of this chapter shall not apply.

Drafting Note: Subsections A and B are the same as the first and second paragraphs of existing § 38.1-638.42. Subsection C is not in the existing chapter.

New subsection C was added to clarify the authority of a fraternal to establish separate accounts, and to provide that the open contract and maintenance of solvency provisions may be deleted from contracts issued on a variable basis if so required to be consistent with other state or federal laws regulating variable contracts. The establishment of a separate account for variable products may be difficult to integrate into a society's existing mechanisms of representative form of government, so the statute emphasizes the care that must be taken in the decision by requiring that the supreme governing body authorize the establishment of the account.

Drafting Note: This is an outdated grandfather provision and is completely deleted.

Drafting Note: The requirement of a written decision is now in proposed § 38.2-4130 and the general appeals section is applicable to this chapter.

Article 6.

Regulation.

§ 38.2-4123. Exemptions.—Except as herein provided, societies shall be governed by this chapter and §§ 38.2-100 through 38.2-134, Chapters 2, 3, and 5 through 9, §§ 38.2-1304, 38.2-1307 through 38.2-1315, and 38.2-1322 through 38.2-1340, Chapters 14, 15, and 18, §§ 38.2-3100 through 38.2-3125, and 38.2-3300 through 38.2-3317, Chapter 34, §§ 38.2-3500 through 38.2-3520, and Chapter 36 and shall be exempt from all other provisions of this title unless expressly designated therein, or unless they are specifically made applicable by this chapter.

Drafting Note: This section designates the specific sections of this title that apply to fraternals.

Drafting Note: This provision is now a part of proposed § 38.2-4111.

§ 38.2-4124. Taxation.—Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from every state, county,

district, municipal and school tax other than taxes on real estate and office equipment.

Drafting Note: This section is the same as § 38.1-638.9 of the existing chapter, except the license tax is not included as an exception. The fee for a license is not a tax.

Drafting Note: This provision is now in proposed § 38.2-4108.

§ 38.2-4125. Valuations.—A. The report of valuation shall show, as reserve liabilities, the difference between the present midyear value of the promised benefits provided in the certificates of the society in force and the present midyear value of the future net premiums as they are in practice actually collected, not including any value for the right to make extra assessments and not including any amount by which the present midyear value of future net premiums exceeds the present midyear value of promised benefits on individual certificates. At the option of any society, the valuation may show the net tabular value instead of the above value. The net tabular value as to certificates issued prior to June 28, 1969, shall be determined in accordance with the provisions of law applicable prior to June 28, 1968, and as to certificates issued on or after June 28, 1969, shall not be less than the reserves determined according to the Commissioners' reserve valuation method as defined in subsection B of this section. If the premium charged is less than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in the premiums shall be set up and maintained as a liability. The reserve liabilities shall be properly adjusted in the event that the midyear or tabular values are not appropriate.

B. A society may value its certificates in accordance with valuation standards authorized by the laws of this Commonwealth for the valuation of policies issued by life insurers.

C. Reserves according to the Commissioners' reserve valuation method, for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be any excess of the present value, at the date of valuation, of the future guaranteed benefits provided for by those certificates, over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate shall be a uniform percentage of the respective contract premiums for the benefits that the present value, at the date of issue of the certificate, of all modified net premiums shall equal the sum of the then present value of the benefits provided for by the certificate and the excess of 1 over 2, as follows:

1. A net-level premium equal to the present value, at the date of issue, of the benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annual annuity of one dollar payable on each anniversary of the certificate on which a premium falls due. However, the net-level annual premium shall not exceed the net-level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at any age one year higher than the age at issue of the certificate; and

2. A net one-year term premium for the benefits provided for in the first certificate year. Reserves according to the Commissioners' reserve valuation method for (i) life insurance benefits for varying amounts of benefits or requiring the payment of varying premiums, (ii) annuity and pure endowment benefits, (iii) disability and accidental death benefits in all certificates and contracts, and (iv) all other benefits except life insurance and endowment benefits, shall be calculated by a method consistent with the principles of this subsection.

D. The present value of deferred payments due under incurred claims or matured certificates shall be deemed a liability of the society and shall be computed upon mortality and interest standards prescribed in subsections E through G of this section.

E. The valuation and underlying data shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

F. The minimum standards of valuation for certificates issued prior to June 28, 1969, shall be those provided by the law applicable immediately prior to June 28, 1968, but not lower than the standards used in the calculating of rates for those certificates.

G. The minimum standard of valuation for certificates issued after June 28, 1969, shall be three and one-half percent interest and the following tables:

1. For certificates of life insurance—American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof or with the consent of the Commission, the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Mortality Table or the Commissioners 1958 Standard Ordinary Mortality Table, using actual age of the insured for male risks and an age not more than three years younger than the actual age of the insured for female risks;

2. For annuity and pure endowment certificates, excluding any disability and accidental death benefits in the certificates—the 1937 Standard Annuity Mortality Table or the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the Commission;

3. For total and permanent disability benefits in or supplementary to life insurance certificates—Hunter's Disability Table, or the Class III Disability Table (1926) modified to conform to the contractual waiting period, or the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries with due regard to the type of benefit. Any of these tables shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance certificates;

4. For accidental death benefits in or supplementary to life insurance certificates—The Inter-Company Double Indemnity Mortality Table or the 1959 Accidental Death Benefits Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance certificates; and

5. For noncancellable accident and health benefits—the Class III Disability Table (1926) with conference modifications or, with the consent of the Commission, tables based upon the society's own experience.

H. The Commission may, in its discretion, accept other standards for valuation if it finds that the reserves produced by those standards will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The Commission may, in its discretion, vary the standards of mortality applicable to all certificates of insurance on substandard lives or other extra hazardous lives by any society licensed to do business in this Commonwealth. Whenever the mortality experience under all certificates valued on the same mortality table exceeds the expected mortality according to that table for a period of three consecutive years, the Commission may require additional reserves that it deems necessary on account of the certificates.

I. Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under any conditions he may impose, may establish and maintain reserves on its certificates in excess of the reserves required by the state. However, the contractual rights of any insured member shall not be affected by the excess reserves.

Drafting Note: This section is existing language and is being moved for improved organization. Language is also added to clearly state that the valuation standards for other life insurers may be used. The first sentence in existing subsection A is in proposed § 38.2-4126.

Drafting Note: The filing of amendments is now contained in proposed § 38.2-4111.

§ 38.2-4126. Reports to be filed.—A. Every society doing business in this Commonwealth shall annually, by March 1, unless the Commission extends the time for cause shown, file with the Commission a true statement of its financial condition, transactions and affairs for the preceding calendar year. The statement shall be in general form and content as approved by the National Association of Insurance Commissioners for fraternal benefit societies or other form required by the Commission and as supplemented by additional information required by the Commission.

B. As part of the required annual statement, each society shall, by March 1, file with the Commission a valuation of its certificates in force on December 31 of the previous year, provided the Commission may, in its discretion for cause shown, extend the time of filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in § 38.2-4125. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

Drafting Note: Subsections A and B are in the existing language in §§ 38.1-638.44 and 38.1-638.45.

Drafting Note: The qualifications for membership are now contained in proposed § 38.2-4105. It requires the society to provide in its laws for the rights and privileges and process of admission. Subsection C of proposed § 38.2-4119 provides for the binding of minors.

§ 38.2-4127. Annual license.—Societies now authorized to do business in this Commonwealth may continue such business until June 30, 1987. The authority of such societies and all societies hereafter licensed may thereafter be renewed annually, but in all cases will terminate on June 30. However, a license so issued shall continue in effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the Commission twenty dollars. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

Drafting Note: This section is the same as existing § 38.1-638.20.

Drafting Note: The provisions of this section are now in subsection B of proposed § 38.2-4101, subsection B of proposed § 38.2-4116 and subsection A of proposed § 38.2-4117.

§ 38.2-4128. Examination of societies; no adverse publications.—A. The Commission, or any person the Commission may appoint, may examine any domestic, foreign or alien society doing business or applying for admission to do business in this Commonwealth in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public, as provided in the laws regulating insurers, shall also be applicable to the examination of societies.

B. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commission.

Drafting Note: The language in this section is contained in existing §§ 38.1-638.48, 38.1-638.50 and 38.1-638.51.

Drafting Note: The provisions of this section are now included in proposed § 38.2-4119.

§ 38.2-4129. Admission; foreign or alien society.— No foreign or alien society shall do business in this Commonwealth without a license issued by the Commission. Any such society desiring admission to this Commonwealth shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to do business in this Commonwealth upon showing that its assets are invested in accordance with the provisions of this chapter and filing with the Commission:

1. A duly certified copy of its articles of incorporation;

2. A copy of its bylaws, certified by its secretary or corresponding officer;

3. A statement of its business in a form prescribed by the Commission, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the Commission;

4. Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to do business therein;

5. Copies of its certificate forms; and

6. Such other information as the Commission may deem necessary.

Drafting Note: The provisions of this section are simlar to §§ 38.1-638.21, 38.1-638.22 and 38.1-638.23 of the existing Code.

Drafting Note: The provisions of the first paragraph are now in proposed § 38.2-4116.

§ 38.2-4130. Injunction; liquidation; receivership of domestic society.—No domestic society shall:

1. Exceed its powers;

2. Fail to comply with any provisions of this chapter;

3. Fail to fulfill its contracts in good faith;

4. Have a membership of less than 400 after an existence of one year or more; or

5. Conduct business fraudulently or in a manner hazardous to its members, creditors, the public or the business.

If the Commission, upon investigation, finds such deficiencies, it shall issue a written notice to the society citing the deficiencies, stating the reasons for dissatisfaction, and requiring that the deficiencies be corrected within the period it designates. The period shall be at least thirty days but not more than six months from the service of the notice. If the Commission believes the interest of the certificate holders of the society will be best served by extending the period of time beyond six months, it may do so for the period of time it considers best. If the society does not correct the deficiency to the satisfaction of the Commission, the Commission may institute delinquency proceedings against the society in the manner set out in Chapter 15 of this title. If the Commission institutes a delinquency proceeding, all the provisions of Chapter 15 of this title with respect to the rehabilitation, liquidation, conservation and reorganization of insurers generally shall be applicable to the society.

Drafting Note: This section is substantially the same as § 38.1-638.49 and includes the requirement for a decision in writing from § 38.1-638.24.

Drafting Note: The provisions of this section are in proposed § 38.2-4117 with the exception of the second paragraph, which is not in the revised chapter. The specific individuals who may be designated a beneficiary are not listed.

§ 38.2-4131. Suspension, revocation or refusal of license of foreign or alien society.—No foreign or alien society doing business or applying to do business in this Commonwealth shall:

1. Exceed its powers;

2. Fail to comply with any of the provisions of this chapter;

3. Fail to fulfill its contracts in good faith; or

4. Conduct its business fraudulently or in a manner hazardous to its members or creditors or the public.

If the Commission, upon investigation, finds such deficiencies, it shall notify the society in writing of its findings, and after reasonable notice require the society to show cause on a date designated in the notice why its license should not be suspended, revoked or refused. If, on the date named in the notice, the grounds for the proposed suspension, revocation or refusal of the society's license have not been removed to the satisfaction of the Commission, or the society does not present good and sufficient reasons why its authority to do business in this Commonwealth should not at that time be suspended, revoked, or refused the Commission may suspend, revoke or refuse the license of the society to do business in this Commonwealth.

Drafting Note: This section is substantially the same as existing § 38.1-638.52.

Drafting Note: This provision is now in proposed § 38.2-4118.

§ 38.2-4132. Licensing of agents.—A. Agents of societies shall be licensed in accordance with Chapter 18 of this title regulating the licensing, revocation, suspension or termination of licenses of resident and nonresident agents.

B. No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

Drafting Note: This section is substantially the same as existing § 38.1-638.37.

Drafting Note: Subsection F of proposed § 38.2-4119 contains the requirements for filing and approval of contracts.

§ 38.2-4133. Unfair methods of competition and unfair and deceptive acts and practices.—Every society authorized to do business in this Commonwealth shall be subject to the provisions of Chapter 5 of this title. However, nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

Drafting Note: This section is similar to existing § 38.1-638.60.

Drafting Note: Proposed § 38.2-4112 contains the provisions of this section.

§ 38.2-4134. Penalties.—A. Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society shall upon conviction be fined not less than $100 nor more than $500 or be imprisoned not less than thirty days nor more than one year, or both.

B. Any person who willfully makes a false or fraudulent statement in any verified report or declaration required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

C. Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this Commonwealth shall upon conviction be fined not less than $50 nor more than $200.

D. Any other violation of this chapter shall be subject to § 38.2-218.

Drafting Note: This section is substantially the same as existing § 38.1-638.10. The reference to the general penalties section has been added and will cover violations not specifically named.

Drafting Note: Licensing of agents is now in proposed § 38.2-4132.

§ 38.2-4135. Exemption of certain societies.—A. Nothing contained in this chapter shall be construed to affect or apply to:

1. Grand or subordinate lodges of Masons, Odd Fellows, or Knights of Pythias, exclusive of the insurance department of the Supreme Lodge Knights of Pythias, or the Junior Order of United American Mechanics, exclusive of the beneficiary degree or insurance branch of the National Council, Junior Order [of] United American Mechanics;

2. Similar societies which do not issue insurance certificates;

3. An association of local lodges of a society now doing business in this Commonwealth which provides death benefits of not more than $500 to any one person, or disability benefits of not more than $300 in any one year to any one person, or both;

4. Contracts of reinsurance business on benefits of fraternal benefit societies in this Commonwealth;

5. Grand or subordinate lodges of societies, orders or associations now doing business in this Commonwealth which provide benefits exclusively through local or subordinate lodges;

6. Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

7. Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than $400 to any one person, or disability benefits of not more than $350 to any one person in any one year, or both; or

8. Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than $100 or for disability benefits of not more than $150 to any one person in any one year, or both.

B. Any such society or association described in paragraphs 7 and 8 of subsection A which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in paragraph 8 of subsection A which has more than 1,000 members, shall comply with all provisions of this chapter.

C. No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in paragraph 6 of subsection A of this section, shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

D. Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits, shall have all privileges

and be subject to the applicable provisions and regulations of this chapter except that the provisions relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society.

E. The Commission may require from any society or association, by examination or otherwise, such information as will enable the Commission to determine whether such society or association is exempt from the provisions of this chapter.

F. Societies exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this Commonwealth.

Drafting Note: This section contains the exemptions in existing § 38.1-638.5 with the addition of number 5. Subsections B, C, and D are new language.

§ 38.2-4136. Societies previously existing; reincorporation; amendments.—Any incorporated society doing business in this Commonwealth on June 19, 1914, may exercise all of the rights conferred by this chapter, and all of the rights, powers and privileges exercised or possessed by it under its charter or articles of incorporation not inconsistent with law; or, if a voluntary association, it may incorporate as provided herein. No society organized prior to June 19, 1914, shall be required to reincorporate under this section. Any society may amend its certificate of incorporation in the manner provided by law.

Drafting Note: This section is § 38.1-638.12 in the existing Code and is being moved.

§ 38.2-4137. Exemption of member representatives of certain societies.—The provisions of this article shall not apply to the member representatives of any society organized or licensed under this chapter which insures its members against death, dismemberment and disability resulting from accident only, and which pays no commission or other compensation for the solicitation and procurement of such contracts.

Drafting Note: This section is an outdated grandfather clause.

Drafting Note: This section is not necessary because proposed § 38.2-4132 requires licensure in accordance with Chapter 18.

Drafting Note: Fraternals are subject to Chapter 18 which prohibits payment of commissions to unlicensed agents.

Drafting Note: The first and second paragraphs of this section have been moved to proposed § 38.2-4122.

Drafting Note: This section is being moved to proposed § 38.2-4121.

Drafting Note: Proposed § 38.2-4126 requires annual reports.

Drafting Note: This section is being deleted. Proposed §§ 38.2-4130 and 38.2-4131 will provide for the suspension and revocation of license for failure to maintain financial requirements.

Drafting Note: Proposed § 38.2-4106 contains a requirement for the mailing of a statement of the society's financial condition and a synopsis of the annual statement.

Drafting Note: Proposed § 38.2-4128 provides for the examination of societies.

Drafting Note: Proposed § 38.2-4130 provides for the liquidation of a domestic society. It is substantially the same as this section.

Drafting Note: Proposed § 38.2-4128 provides for the examination of domestic, foreign and alien societies and proposed § 38.1-4131 provides for suspension or refusal of license.

Drafting Note: Proposed § 38.2-4128 provides for no adverse publication of the results of a financial examination until requiremnts of notice and opportunity to respond are given as provided for other insurers.

Drafting Note: Proposed § 38.2-4131 contains substantially the same language as this section.

Drafting Note: This section is being moved to proposed § 38.2-4115 as subsection A.

Drafting Note: This section has been moved to proposed § 38.2-4115 as subsection B.

Drafting Note: This section has been moved to proposed § 38.2-4115 as subsection C.

Drafting Note: This section has been moved to proposed § 38.2-4115 as subsection D.

Drafting Note: This section has moved to proposed § 38.2-4115 as subsection E.

Drafting Note: This section has been moved to proposed § 38.2-4115 as subsection F.

Drafting Note: This section has been moved to proposed § 38.2-4115 as subsection G.

Drafting Note: Proposed § 38.2-4133 makes proposed Chapter 5 (existing Chapter 1, Article 6) applicable to fraternals.

Drafting Note: This section is being deleted. The general appeals section is made applicable in proposed § 38.2-4123.

Title 38.2

CHAPTER 42.*

~~Contracts~~ And Health Services Plans ~~For Future Hospitalization, Medical And Surgical Services.~~

The major substantive changes proposed for this Chapter are:

1. The title has been changed to Health Services Plans. The word "future" has been deleted because it is not used in the chapter.

2. Presently, the word "plan" is used in this chapter with two meanings, one referring to the sponsoring organization and the other referring to which types of services are covered under a subscriber contract. Where plan has been used to refer to the sponsoring organization, "corporation" has been substituted. In addition, the plans are no longer described as prepaid plans. These changes were requested by the Blue Cross and Blue Shield representatives.

3. The deletion of "nonstock" in this chapter allows a corporation to be either a stock or nonstock corporation. Additional requirements apply if a plan decides to become a stock corporation.

4. Proposed § 38.2-4204 (existing § 38.1-812) has been amended to provide that Blue Cross and Blue Shield corporations may merge.

5. A new section, proposed § 38.2-4205 has been added to provide that dental services and optometric services may be provided by either subscription contract or endorsement in a plan.

6. In proposed § 38.2-4214, the list of sections within this title that apply to which health services plans has been updated and expanded. These sections include loans and payments to officers and directors, general penalties, appeals, rules and regulations sections, distributions by a nonstock corporations, and approval of mergers. Additional sections are also applicable to health plans that become stock corporations. These sections include the sections providing for regulation and solicitation of proxies, the Commission to approve management and exclusive agency contracts, restitution upon purchase and sale of equity securities of domestic stock insurers, and the insurance holding companies article.

7. The ten day free look provision for Medicare supplement contracts (existing § 38.1-818.1) has been expanded to cover all individual subscriber contracts by deleting that section and making existing §38.1-348.4 (proposed § 38.2-3502) applicable by reference in proposed § 38.2-4214.

8. In proposed § 38.2-4222, a $500 nonrefundable application fee will be required instead of the $50 license fee. (This change accords with other licensing sections.)

9. In proposed [illegible] license renewal fees have been [illegible] This change accords with other renewal sections.)

10. The requirement [illegible] 8.1-827 that only those persons soliciting subscription contracts outside the principal office of a plan must be licensed has been changed in proposed § 38.2-4224 to require that all persons who solicit subscription contracts must be licensed as health agents. Salaried officers of the home office are exempt from the licensure requirement.

11. A stock corporation shall be required to have any acquisition approved by the Commission and this approval shall be based upon the financial impact on the corporation, the type of business and the economic and competitve environment facing the corporation or holding company. (No additional restrictions have been placed on nonstock corporations.)

12. In proposed § 38.2-4227, the reference to advertising matter has been deleted because misleading advertising is covered in the Unfair Trade Practices Chapter (Chapter 5, § 38.1-500 et seq.) which applies to health services plan through the reference in proposed § 38.2-4214.

13. Existing §§ 38.1-830 (Injunctions), 38.1-831 (Penalties) and 38.1-832 (Appeals) have been deleted because the appropriate general provisions will apply. These sections that will be applied title-wide have been cross referenced in proposed § 38.2-4214.

14. A new section, § 38.2-4229, Reinsurance, has been added at the request of the Blues to allow them to cede risks.

15. A new section, §38.2-4230, has been proposed to grant the Commission authority to approve a conversion plan for converting a nonstock corporation to a stock corporation.

***Some changes are still being made to this chapter at the request of the Attorney General.**

CHAPTER 42.

HEALTH SERVICES PLANS.

§ 38.2-4200. Applicability of chapter.—A. Except as otherwise provided by law, no plan shall be organized, conducted or offered in this Commonwealth other than in the manner set forth in this chapter.

B. Nothing contained in this chapter shall prohibit any physician (i) as an individual, (ii) in partnership with other physicians, or (iii) as part of a professional corporation of physicians, from entering into agreements directly with his own patients, or with a parent, guardian, spouse or other family member acting in a patient's behalf, involving payment for professional services to be rendered or made available in the future.

Drafting Note: To improve the organization of this chapter, existing § 38.1-813.1 has been moved to the beginning of this chapter to create this new section. No substantive changes were made.

§ 38.2-4201. Definitions.—As used in this chapter:

"Contract holder" means a person entering into a subscription contract with a nonstock corporation.

"Nonstock corporation" means a foreign or domestic nonstock corporation which is subject to regulation and licensing under this chapter and which offers or administers subscription contracts to contract holders as part of a plan.

"Health services plan" or "plan" means any arrangement for offering or administering health services or similar or related services by a nonstock corporation licensed under this chapter.

"Hospital services plan" means a health services plan for providing hospital and similar or related services.

"Medical or surgical services plan" means a health services plan for providing medical or surgical services or both, and similar or related services.

"Subscriber" means any person entitled to benefits under the terms and conditions of a subscription contract.

"Subscription contract" means a written contract which is issued to a contract holder by a nonstock corporation and which provides health services or benefits for health services.

Drafting Note: This section has been added to define the key terms used in this chapter. For clarity, "health services plan" and "plan" are defined as interchangeable terms because both are used throughout the chapter.

§ 38.2-4202. Hospital services plans.—A hospital or a group of hospitals may conduct through a nonstock corporation as agent for them a hospital services plan as defined in § 38.2-4201.

§ 38.2-4203. Medical or surgical services plans.—A group of physicians may conduct through a nonstock corporation as agent for them a medical or surgical services plan as defined in § 38.2-4201.

§ 38.2-4204. Merger of nonstock corporations.—A nonstock corporation operating a hospital services plan pursuant to § 38.2-4202 may be combined with a nonstock corporation operating a medical or surgical services plan pursuant to § 38.2-4203. The nonstock corporation created by such combination may be licensed to conduct a combination plan furnishing both hospital services and similar or related services and medical or surgical services, or both, and similar or related services.

Drafting Note: This section allows Blue nonstock corporations to combine.

§ 38.2-4205. Dental and optometric services.—Dental services and optometric services may be provided by either subscription contract or endorsement in a plan.

Drafting Note: At the request of the Blue Cross and Blue Shield organizations a new section has been added to provide, as an addition to an existing plan or as a new plan, that they may offer separate subscription contracts for dental services and optometric services.

Drafting Note: This section is now the first section in the chapter (§ 38.2-4200).

§ 38.2-4206. Nonstock corporation required.—Each plan shall be conducted either by or through (i) a nonstock corporation organized pursuant to the laws of this Commonwealth or (ii) a foreign nonstock corporation that is subject to regulation and licensing under the laws of its domiciliary jurisdiction that are substantially similar to those provided by this chapter.

This section shall not apply to any foreign nonstock corporation already licensed in this Commonwealth as of July 1, 1980.

Drafting Note: This section has been changed to clarify that a plan must be conducted by a domestic nonstock corporation or by a foreign nonstock corporation which is subject to regulation under laws similar to those of this chapter.

§ 38.2-4207. Existing foreign nonstock corporation.—Any foreign nonstock corporation licensed in the Commonwealth as of July 1, 1980, may conduct a plan directly.

§ 38.2-4208 Nonstock corporation not required to act as agent.—A. A nonstock corporation may offer or administer a plan without being required to act as an agent for providers of health care services.

B. A nonstock corporation applying for its initial license pursuant to this chapter in order to offer or administer a plan must elect in its application whether to act (i) as agent for providers of health care services, in which case §§ 38.2-4210 and 38.2-4211 shall apply, or (ii) as a nonagent, in which case the provisions of subsection D of this section shall apply.

C. A nonstock corporation operating a plan pursuant to §§ 38.2-4202, 38.2-4203, 38.2-4204 or 38.2-4208 prior to June 30, 1985, and any successor nonstock corporation shall continue to operate as either an agent or nonagent nonstock corporation, in accordance with the manner in which it was operating as of that date, provided that it may petition the Commission to change its status as an agent or nonagent nonstock corporation, and if it does so, it shall give notice of the petition to all interested parties. The Commission shall conduct a hearing on the petition if requested by any interested party. A nonstock corporation seeking to change its status shall make application to the Commission within ninety days following the end of any calendar year. A change in status shall only be effective as to subscriber contracts issued or renewed on and after the date of a change in status. The Commission shall enter an order in response to the nonstock corporation's petition.

D. If any nonstock corporation offers or administers a plan without acting as an agent for providers of health care services, the Commission may elect to (i) require the nonstock corporation to maintain its contingency reserves above a minimum level set by the Commission, or (ii) subject the nonstock corporation, notwithstanding the provisions of § 38.2-1700, to the requirements of Chapter 17 of this title, or (iii) both. The minimum level for contingency reserves shall not exceed thirty days of anticipated operating expenses and claims receipts computed as the Commission requires.

Drafting Note: 1. Subsectons C and D are existing paragraph 4 of § 38.1-816 passed by the 1985 General Assembly. This provision is more appropriately located under this section as it relates to the nonstock corporation's agent/nonagent status. This change is for organizational purposes only.

2. The rest of the existing section pertaining to PPO's has been put into a new section, § 38.2-4209.

§ 38.2-4209. Preferred provider subscription contracts.—A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

Drafting Note: This language was taken from the original § 38.1-813.4 to create a separate section governing PPO's. Minor editorial changes have been made.

§ 38.2-4210. Liability of participants.—A. All hospitals, persons, nonstock corporations, and physicians participating in a plan shall be jointly and severally liable on all contracts made for the purposes of the plan by the nonstock corporation as agent for them. Each contract may be executed and signed by their agent on their behalf. A contract so signed shall be binding on the principals and not on the agent.

B. Actions for breach of these contracts may be brought against the principals by naming the agent as the sole defendant. A judgment in favor of the plaintiff may be satisfied out of the assets of the nonstock corporation in the custody of the agent or out of the assets of each of the principals.

C. Each participant shall be liable for his own torts and not for the torts of any other participant or of the agent.

§ 38.2-4211. Change of participants.—A. Any participating hospital, person, nonstock corporation or physician may resign from a plan at any time but will continue to be liable on each subscription contract then in effect. However, this liability shall not extend beyond the end of each such subscription contract's current contract year.

B. Hospitals, persons, nonstock corporations and physicians may be admitted to a plan at any time and will then automatically become liable on all its outstanding contracts.

§ 38.2-4212. Board of directors of nonstock corporation operating plan.—A. Notwithstanding the provisions of §§ 13.1-853, 13.1-854 and 13.1-855, a nonstock corporation operating a plan pursuant to §§ 38.2-4202, 38.2-4203, 38.2-4204, or 38.2-4208 shall be subject to the following:

1. The board of directors of the nonstock corporation shall consist of no more than fifteen members. However, if two or more nonstock corporations merge, the board of directors of the new or surviving nonstock corporation may consist of no more than twenty members. Further, the board of directors may be increased to a size not exceeding the aggregate number of directors on the merging nonstock corporations' boards for the balance of the year in which merger occurs and for the following five years.

2. Except as permitted by subsection B of this section, a majority of the members of the board of directors of the nonstock corporation shall be persons who are covered by subscription contracts issued by the nonstock corporation and who are not providers of health care services, or employees or salaried officers of the nonstock corporation.

B. Notwithstanding the provisions of §§ 13.1-853, 13.1-854 and 13.1-855, any nonstock corporation operating a plan pursuant to § 38.2-4203 may have a board of directors consisting of a majority of providers of health care services.

C. As used in this section, " providers of health care services" shall include, but not be limited to, physicians, pharmacists, nurses, physical therapists, hospital administrators, employees or majority or controlling stockholders of hospitals, and other persons furnishing health-related services.

D. This section shall not apply to any foreign nonstock corporation licensed in this Commonwealth on or before July 1, 1980.

Drafting Note: 1. In paragraph 2 of proposed subsection A, the prohibition against a board member's serving on the board for more than eight consecutive years has been deleted. The Blue Cross and Blue Shield corporations prefer the ability to retain board members who have served for long periods and have become knowledgeable in the operation of the plans.

2. Existing item 3 of this section concerning merger has been moved to a new section, § 38.2-4213.

3. Existing § 38.1-817 concerning boards of directors for medical or surgical plans has been moved to this section as subsection B.

4. Proposed subsection C is the same as the last paragraph of existing § 38.1-816 except that the former reference to stockholders has been changed to majority or controlling stockholders. The phrase "of hospitals" has been added for clarity.

5. Existing paragraph 4, passed in 1985, has been moved to § 38.2-4208 which relates to a nonstock corporation operating a nonagent plan. The change is purely for organizational purposes and no substantive change is intended.

6. A new subsection D has been added to provide that foreign nonstock corporations already licensed in Virginia will not be required to adjust their board composition in order to do business in Virginia.

7. The cross-reference to § 13.1-220 has been updated to reflect the revision of the Nonstock Corporation Act.

§ 38.2-4213. Liability of participating providers upon merger of nonstock corporation.—If two or more nonstock corporations merge, §§ 38.2-4210 and 38.2-4211 shall not apply to the new or surviving nonstock corporation, its plans or its providers unless the nonstock corporations to be merged notify the Commission in writing at least thirty days prior to the date of the merger that the new or surviving nonstock corporation will remain subject to §§ 38.2-4210 and 38.2-4211. If notice is not given, the Commission may (i) require the new or surviving nonstock corporation to maintain its contingency reserves above minimum level, (ii) subject it, notwithstanding the provisions of § 38.2-1700, to the requirements of Chapter 17 of this title or (iii) both. The minimum level of contingency reserves shall not exceed thirty days of anticipated operating expenses and claims receipts computed as the Commission requires. If the nonstock corporation elects not to file the notice permitted by this section, the nonstock corporation and not its providers shall be liable for the obligations of the plan.

Drafting Note: The language of item 3 in existing § 38.1-816 has been moved to create this new section. The reference to "by regulation" has been deleted at the end of the third sentence to provide that the thirty days of anticipated operating expenses and claims receipts shall be computed as the Commission requires.

Drafting Note: Section 38.1-817 has been moved to subsection B of proposed § 38.2-4212.

§ 38.2-4214. Application of certain provisions of law.—No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1310, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1321, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, §§ 38.2-3400, 38.2-3404, 38.2-3405, 38.2-3409, 38.2-3411 through 38.2-3419, 38.2-3501, 38.2-3502, 38.2-3516 through 38.2-3520 as they apply to Medicare, 38.2-3541, and 38.2-3600 through 38.2-3607 shall apply to the operation of a plan.

Drafting Note: 1. Identification of and cross-references for the additional sections that are being made applicable to health service plans are as follows:

a) § 38.2-210 (existing § 38.1-33). Loans to officers, directors, etc., prohibited.

b) § 38.2-211 (existing § 38.1-34). Other interests of officers, directors, etc., prohibited.

c) § 38.2-212 (existing § 38.1-35). Certain compensation prohibited.

d) § 38.2-213 (existing § 38.1-36). Violation of § 38.2-210 or § 38.2-211.

e) § 38.2-218 (existing § 38.1-40). Civil penalties and restitution.

f) § 38.2-219 (new section). Violations; procedures; cease and desist orders.

g) § 38.2-220 (new section). Injunctions.

h) § 38.2-221 (existing § 38.1-41). Enforcement of penalties.

i) § 38.2-222 (new section). Appeals generally.

j) § 38.2-223 (new section). Rules and regulations; orders.

k) § 38.2-224 (new section). Procedures.

l) § 38.2-225 (existing § 38.1-42). Penalties to Literary Fund.

m) § 38.2-230 (existing § 38.1-39.1). Distributions by nonstock corporations.

n) §§ 38.2-600 through 38.2-620 (existing § 38.1-57.2 through 38.1-57.28). Insurance Information and Privacy Protection.

o) §§ 38.2-700 through 38.2-705 (existing §§ 38.1-58 through 38.1-62). Antitrust Provisions.

p) §§ 38.2-900 through 38.2-904 (existing §§ 38.1-43.1 through 38.1-43.6). Transition Provisions. Provides the manner in which a stock insurer may be converted to a nonstock company.

q) Article 3 of Chapter 10, §§ 38.2-1017 and 38.2-1018 (existing §§ 38.1-80 and 38.1-81). Requires the Commission to approve a plan of merger.

r) §§ 38.2-1800 through 38.2-1836 (existing §§ 38.1-327.1 through 38.1-327.45. Insurance Agents). This would include existing § 38.1-165.1 which is now proposed § 38.2-1810; Reports of acts deemed larceny under § 18.2-111; privileged communications; Commonwealth's Attorney to be informed.

s) § 38.2-3418 (existing § 38.1-348.4). Coverage for victims of rape or incest.

t) § 38.2-3502 (exisiting § 38.1-348.4). Notice to be printed on or attached to policy; return of policy to insurer.

2. The cross references for the applicable sections from the existing code are as follows:

Existing Section Numbers	Proposed Section Numbers
38.1-29	38.2-200
38.1-44 to 38.1-57	38.2-400 et seq. and 38.2-500 et seq.
38.1-97.2	38.2-1038
38.1-99 to 38.1-103	38.2-1040 through 38.2-1044
(38.1-104 deleted)	
38.1-159 to 38.1-165	38.2-1300 through 38.2-1306
38.1-166 to 38.1-169	38.2-1307 through 38.2-1310
38.1-171	38.2-1312
38.1-173	38.2-1314
38.1-348.12:1	and 38.2-3537
38.1-348.14	38.2-3419
38.1-354.1	38.2-3404
38.1-360	38.2-3400
38.1-362.7 to 38.1-362.9, 38.1-362.16, 38.1-362.17	38.2-3501,38.2-3600 et seq.
38.1-362.10 to 38.1-362.15	38.2-3516 through 38.2-3520

2. The last portion of this section dealing with payments by plans has been moved to proposed § 38.2-4215.

§ 38.2-4215. Payments by nonstock corporation. - No payments shall be made by a nonstock corporation to a person included in a subscription contract unless the payment is for breach of contract or for contractually included costs incurred by that person or for services received by that person and rendered by a nonparticipating

Drafting Note: The language in existing § 38.1-818 was moved here to create this new section.

Drafting Note: The ten-day free look provision has been expanded to cover all individual subscriber contracts by making existing § 38.1-348.4 (proposed § 38.2-3502) apply by reference in proposed § 38.2-4214. (Existing § 38.1-362.13 C presently provides a 30-day free look for other Medicare supplement policies issued pursuant to a direct response solicitation. This provision has been renumbered § 38.2-3604 and is also cross-referenced.)

§ 38.2-4216. Open enrollment.—A. In addition to such other community services as it may provide, a nonstock corporation licensed under this chapter, and subject to § 38.2-4226, shall make available to citizens of the Commonwealth an open enrollment program under the terms set forth in this section. The program shall be available at all times to any person residing in the nonstock corporation's service area within the Commonwealth, regardless of the person's health history. However, such person shall not be an employee of an employer which provides, in whole or in part, hospitalization or other health coverage to some or all of its employees. In lieu of having an open enrollment program open at all times, a nonstock corporation may elect to have an open enrollment period of shorter time if credit is given toward any applicable waiting period for coverage of preexisting conditions for the period of time a person has been continuously enrolled under a nonstock corporation's coverage immediately prior to the effective date of his open enrollment coverage. The subscription charge for contracts issued pursuant to the program shall be reasonable in relation to the benefits provided, as determined by the Commission. Any contract issued pursuant to the program, and any advertising related to the program, shall in a prominent fashion advise the purchaser that the coverage provided is available to anyone who applies, subject to the residence requirement, the payment of subscription charges, compliance with other terms of the contract, and applicable waiting periods of twelve months or less, if any.

B. If a nonstock corporation licensed under this chapter elects to discontinue its open enrollment program provided under this section, it may do so only after giving written notice to the Commission at least twelve months in advance of the effective date of termination. Upon termination of the program §§ 38.2-4225 and 38.2-4226 shall no longer be applicable to such nonstock corporation, and the nonstock corporation shall be subject to the provisions of § 58.1-2501.

Drafting Note: This section is a result of 1985 legislative action.

§ 38.2-4217. Quarterly reports.—In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting any additional reports, exhibits or statements. The Commission may require verification by any officers of the nonstock corporation the Commission designates.

§ 38.2-4218. Subscriber to have free choice of medical practitioners available.—A plan shall be organized and operated to assure that any subscriber shall have free choice of the medical practitioners available and participating in the plan.

§ 38.2-4219. Subscriber to be advised in writing as to benefits and limitations thereon.— A nonstock corporation shall, prior to and during the term of the subscription contract, fully, fairly and currently advise the subscriber in writing of the benefits available under the contract and all limitations on the benefits available under the contract.

§ 38.2-4220. Interplan arrangements.—A nonstock corporation may enter into contracts with similar nonstock corporations for the interchange of services to those included in subscription contracts and may provide in subscription contracts for the substitution of services instead of those recited in its subscription contracts.

§ 38.2-4221. Services of certain practitioners other than physicians to be covered. — A nonstock corporation shall not fail or refuse, either directly or indirectly, to allow or to pay to a subscriber for all or any part of the health services rendered by any doctor of podiatry, doctor of chiropody, optometrist, optician, psychologist, or clinical social worker licensed to practice in Virginia, if the services rendered (i) are services provided for by the subscription contract and, in the case of services by a clinical social worker, have been specifically contracted for by the contract holder, which coverage must be made available to the contract holder, and (ii) are services which the doctor of podiatry, doctor of chiropody, optometrist, optician, psychologist, or clinical social worker is licensed to render in this Commonwealth.

Drafting Note: This section has been amended to clarify the distinction between the subscriber who is entitled to benefits and the contract holder who may be an employer who negotiates the contract with the Blue Cross and Blue Shield corporation.

§ 38.2-4222. Licensing of nonstock corporations.—A. No person shall operate a health services plan without a license issued by the Commission. Each nonstock corporation shall apply for a license and furnish any relevant information the Commission requires. Each license shall expire at midnight on the following June 30. A nonrefundable application fee of $500 shall be paid with each application for a license.

B. The Commission may refuse to issue or renew a license to a nonstock corporation if it is not satisfied that the financial condition, the method of operation, and the manner of doing business of the nonstock corporation enable it to meet its contractual obligations to all subscribers and that the nonstock corporation has otherwise complied with all the requirements of law.

Drafting Note: A $500 nonrefundable fee will be required instead of the $50 license fee. This change is being made in other licensing sections.

§ 38.2-4223 Renewal of license.—A. Each nonstock corporation shall renew its license with the Commission annually by July 1. The renewal license shall not be issued unless the nonstock corporation has paid all fees and charges imposed on it and has complied with all other requirements of law.

B. The Commission shall not fail or refuse to renew the license of any nonstock corporation without first giving the nonstock corporation ten days' notice of its intention not to renew the license and giving the nonstock corporation an opportunity to be heard and introduce evidence in its behalf. Any such hearing may be informal, and the required notice may be waived by the Commission and the nonstock corporation.

Drafting Note: License renewal fees have been eliminated because substantial maintenance fees are paid.

§ 38.2-4224. Licensing of agents.—Subscription contracts may be solicited only through health agents or life and health insurance agents licensed in accordance with Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of subscription contracts shall not be required to be licensed.

Drafting Note: All persons selling health services contracts, even when selling inside the principal office, would have to be licensed as health agents. Salaried officers of the home office are exempt from the licensure requirement.

§ 38.2-4225. Corporate restrictions.

Drafting Note: The last sentence concerning taxation has been moved to a new section, § 38.2-4226.

Except as provided in this chapter and Chapter 43, any nonstock corporation subject to this chapter

shall not engage in any other business. However, a nonstock corporation may administer government health programs.

Drafting Note: No additional restrictions have been placed on the regulation of nonstock corporations.

§ 38.2-4226. Taxation. –Except as provided by Chapter 4 of this title, the application fees paid by a nonstock corporation under this chapter shall be in lieu of all other state and local license fees or license taxes and state income taxes of the nonstock corporation.

Drafting Note: The reference to "license and renewal fees" has been changed to "application fees" because application fees are now being required instead of license and renewal fees. (See §§ 38.2-4222 and 38.2-4223.)

§ 38.2-4227. Misleading applications or contracts.–In the operation of a plan, no person shall use any misleading subscription applications or contracts.

Drafting Note: The reference to advertising matter has been deleted because misleading advertising is covered in the Unfair Trade Practices Chapter (Chapter 5, § 38.2-500 et seq., of this title) to which health services plans are referenced in proposed § 38.2-4214.

Drafting Note: Existing §§ 38.1-830, 38.1-831, and 38.1-832 have been deleted as a result of the decision to have unified sections dealing with rules and regulations hearings, cease and desist orders, penalties, and appeals.

§ 38.2-4228. Controversies involving subscription contracts.–The Commission shall have no jurisdiction to adjudicate controversies growing out of subscription contracts. A breach of contract shall not be deemed a violation of this chapter.

§ 38.2-4229. Reinsurance.–Any nonstock corporation licensed under this chapter may by policy, treaty or other agreement cede to any insurer reinsurance upon the whole or any part of any risk, with or without contingent liability or participation, and if a mutual insurer, with or without membership therein.

Drafting Note: This new section has been added at the request of the Blues to allow them to cede risks.

Title 38.2

CHAPTER 43.

Health Maintenance Organizations.

1. In subsection B of existing § 38.1-865 (proposed § 38.2-4302), the 90-day time limit for issuing a license to an HMO has been deleted.

2. The term "subscribers" has been added in proposed §38.2-4305 to eliminate any ambiguity in the applicability of the section which deals with fiduciary responsibilities.

3. In § 38.2-4306 we are requiring the evidence of coverage to include a list of the HMO's providers and a description of its service area if this information is not given at the time of enrollment.

4. The term "filing" has been defined to mean "actual receipt by the Commission" for forms filing purposes in subsection C of proposed §38.2-4306.

5. The extension of filing time for annual reports that is contained in existing § 38.1-161 (proposed § 38.2-1302) has been added to proposed §38.2-4307.

6. In § 38.2-4308 we have added a provision requiring the complaint record to be maintained for the period prescribed by § 38.2-511.

7. Proposed § 38.2-4309 relating to investments has been changed to conform with revisions made in investment laws.

8. Subsection E of proposed § 38.2-4312 is being amended to include a prohibition of sexual discrimination in the selection of health care providers.

9. Existing § 38.1-877 (proposed § 38.2-4313) is being amended to require those selling HMO contracts to be licensed as health agents, which means they will have to take a limited health agents license study course and examination. This is consistent with the change made in Chapter 42. Salaried officers of the home office are exempt from the licensure requirement.

10. The changes in proposed § 38.2-4315, examinations of HMOs, were made in conjunction with changes in proposed § 38.2-1317 to clarify the Commission's authority to examine the business affairs of non-insurers.

11. The $100 application fee required in existing §38.1-883 (proposed § 38.2-4318) has been increased to a $500 nonrefundable fee (see § 38.2-4302), and the requirement of a renewal fee has been deleted. This is consistent with the changes in Chapters 42, 43 and 45.

12. Existing §§38.1-882, 38.1-884 and 38.1-885 are being deleted and a reference to the title-wide rules and regulations section, appeals section, and injunctions section is being added to proposed §38.2-4319.

13. Existing § 38.1-886 is being deleted and the uniform penalties section will be made applicable to this chapter by a reference in proposed §38.2-4319. All provisions dealing with revocation of an HMO's license are in § 38.2-4316.

14. Proposed § 38.2-4319 is being amended to add references to the Privacy Act, the uniform penalties section, the new rules and regulations section, the Insurance Agents Chapter and the Unfair Trade Practices Act.

15. Existing § 38.1-888 is being deleted and HMOs will be subject to the Privacy Act by a reference in proposed §38.2-4319.

CHAPTER 43.

HEALTH MAINTENANCE ORGANIZATIONS.

§ 38.2-4300. Definitions. —As used in this chapter:

"Basic health care services" means in and out of area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services.

"Copayment" means a nominal payment required of enrollees as a condition of the receipt of specific health services.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate, individual or group agreement or contract, or identification card issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, as distinguished from mere indemnification against the cost of the services, on a prepaid basis.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.

§ 38.2-4301. Establishment of health maintenance organizations.—A. No person shall establish or operate a health maintenance organization in this Commonwealth without obtaining a license from the Commission. Any person, including a foreign corporation, may apply to the Commission for a license to establish and operate a health maintenance organization in compliance with this chapter.

Drafting Note: Subsection B is being deleted because HMO's operating on July 1, 1980, have complied with this requirement and it is no longer necessary.

B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of any basic organizational document of the applicant including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents;

2. A copy of the bylaws, rules and regulations, or any similar document regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions of each member of the governing body, and a full disclosure in the application of (i) any financial interest between any officer or member of the governing body or any provider, organization or corporation owned or controlled by such person and the health maintenance organization, and (ii) the extent and nature of the financial arrangements between such persons and the health maintenance organization;

4. A copy of any contract made or to be made between any providers, sponsors or organizers of the health maintenance organization, or persons listed in paragraph 3 of this subsection and the applicant;

5. A copy of the evidence of coverage form to be issued to subscribers;

6. A copy of any group contract form that is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the health maintenance organization;

7. Financial statements showing the applicant's assets, liabilities, and sources of financial support or, if the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement unless the Commission directs that additional or more recent financial information is required for the proper administration of this chapter;

8. A complete description of the health maintenance organization and its method of operation, including (i) the method of marketing the plan, (ii) a financial plan that includes a three-year projection of the anticipated initial operating results, (iii) a statement regarding the sources of working capital as well as any other sources of funding, and (iv) a description of any insurance, reinsurance or alternative coverage arrangements proposed;

9. A description of the geographic areas to be served;

10. A description of the complaint system required in § 38.2-4308;

11. A description of the procedures and programs established by the health maintenance organization to (i) assure both availability and accessibility of adequate personnel and facilities, and (ii) assess the quality of health care services provided;

12. A description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in subsection B of § 38.2-4304; and

13. Any other information the Commission may require to make the determinations required pursuant to § 38.2-4302.

C. Unless otherwise provided for in this chapter, a health maintenance organization shall file notice with the Commission describing any modification of the operation set out in the information required by subsection B of this section. The notice shall be filed with the Commission within thirty days after the effective date of the modification.

§ 38.2-4302. Issuance of license; fee.– A. The Commission shall issue a license to a health maintenance organization after the receipt of a complete application and payment of a $500 nonrefundable application fee if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and reputable;

2. The health care plan constitutes an appropriate mechanism for the health maintenance organization to provide or arrange for the provision of, as a minimum, basic health care services on a prepaid basis, except to the extent of reasonable requirements for copayments;

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of prepaid charges used for those services;

b. The adequacy of working capital;

c. Any agreement with an insurer, a health services plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health care plan is discontinued;

d. Any contracts with health care providers that set forth the health care services to be performed and the providers' responsibilities for fulfilling the health maintenance organization's obligations to its enrollees; and

e. The deposit of a surety bond or deposit of securities in an amount satisfactory to the Commission, submitted in accordance with § 38.2-4310 as a guarantee that the obligations to the enrollees will be duly performed;

4. The enrollees will be given an opportunity to participate in matters of policy and operation as required by § 38.2-4304; and

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 or by independent investigation.

Drafting Note: The 90-day requirement is being deleted. Other licensing sections do not have time limits.

The initial application fee has been increased to $500 to be consistent with changes in Chapters 42, 44, and 45. This provision was transferred from § 38.1-883 (proposed § 38.2-4318), which previously required a $100 application fee.

§ 38.2-4303. Powers.–A. The powers of a health maintenance organization shall include, but shall not be limited to, the following, provided that the activities comply with all applicable state statutes and regulations:

1. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical or other health care facilities, and their ancillary equipment and other property reasonably required for its principal office or for other purposes necessary in the transaction of the business of the organization;

2. The making of loans to (i) health care providers under contract with it in advancement of its health care plan or (ii) any corporation under its control for the purpose of acquiring or constructing medical or other health care facilities and hospitals or in advancement of its health care plan providing health care services to enrollees;

3. The furnishing of health care services through providers that are under contract with or employed by the health maintenance organization;

4. The contracting with any person for the performance on its behalf of certain functions including, but not limited to, marketing, enrollment and administration;

5. The contracting with an insurer or with a health services plan licensed in this Commonwealth, for the provision of insurance, indemnity, or reimbursement for the cost of health care services provided by the health maintenance organization; and

6. The offering, in addition to basic health care services, of:

a. Additional health care services;

b. Indemnity benefits covering out-of-area services; and

c. Indemnity benefits, in addition to those relating to out-of-area services, provided through insurers or health services plans.

B. 1. A health maintenance organization shall file notice with the Commission within thirty days after the exercise of any power granted in paragraph 1 or 2 of subsection A of this section that exceeds one percent of the admitted assets of the organization or $25,000, whichever is less. A health maintenance organization shall file notice, with adequate supporting information, with the Commission prior to the exercise of any power granted in paragraph 1 or 2 of subsection A of this section that exceeds five percent of the admitted assets of the organization or $150,000, whichever is less. Any series of transactions occurring within a twelve-month period that are sufficiently similar in nature to be reasonably construed as a single transaction shall be subject to the limitations set forth in this section. The Commission shall disapprove the exercise of power if the Commission believes such exercise of power would substantially and adversely affect the financial soundness of the health maintenance organization and endanger the health maintenance organization's ability to meet its obligations. If the Commission does not disapprove the exercise of power within thirty days of the filing, it shall be deemed approved.

2. Upon application by the health maintenance organization, the Commission may exempt from the filing requirement of paragraph 1 of subsection B of this section those activities having a minimal effect.

§ 38.2-4304. Governing body.--A. The governing body of any health maintenance organization may include providers of health care services, other individuals, or both, but in no event shall any class of health care provider be excluded from eligibility for membership on the governing body of any health maintenance organization.

B. The governing body shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (i) the establishment of advisory panels, (ii) the use of advisory referenda on major policy decisions, or (iii) the use of other mechanisms.

Drafting Note: The phrase, "but in no event shall any class of health care provider be excluded from eligibility from membership on the governing body of any health maintenance organization," is a result of 1985 legislative action.

§ 38.2-4305. Fiduciary responsibilities. - Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization shall be responsible for the funds in a fiduciary relationship with the subscribers and enrollees.

Drafting Note: The term "subscribers" has been added to eliminate any possible ambiguity with regard to fiduciary responsibilities.

§ 38.2-4306. Evidence of coverage and charges for health care services.--A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section.

3. No evidence of coverage shall contain

provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee;

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment; and

g. The right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.

B. 1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within thirty days after notice of the disapproval. If the Commission does not disapprove any form within thirty days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional thirty days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

Drafting Note: 1. The "filing" of forms has been defined to mean receipt by the Commission. This will eliminate problems that are sometimes caused by delays in mail service.

2. A list of providers and a description of the service area has been added in subsections A4f and g.

3. A provision requiring the HMO to advise subscribers of their right to convert coverage has been added (subsection A4h). This parallels the language found in proposed § 38.2-4301.

4. Modifications were made in subsection C (30-day extension for waiting period) to make this section consistent with other form filing sections.

§ 38.2-4307. Annual statement. - A. Each health maintenance organization shall file a statement with the Commission annually by March 1. The statement shall be verified by at least two principal officers and shall cover the preceding calendar year. Each health maintenance organization shall also send a copy of the statement to the State Health Commissioner.

B. The statement shall be on forms prescribed by the Commission and shall include:

1. A financial statement of the organization, including its balance sheet and income statement for the preceding year;

2. Any material changes in the information submitted pursuant to subsection C of § 38.2-4301;

3. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year; and

4. Any other information relating to the performance and utilization of the health maintenance organization required by the Commission after consultation with the State Health Commissioner to carry out the Commission's duties under this chapter.

C. If the health maintenance organization is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the Commission by June 30.

D. The Commission may extend the time prescribed for filing annual statements or other reports or exhibits of any health maintenance organization for good cause shown. However, the Commission shall not extend the time for filing annual statements beyond sixty days after the time prescribed by subsection A of this section. Any health maintenance organization which fails to file its annual statement within the time prescribed by this section shall be subject to a fine as specified in § 38.2-218.

Drafting Note: The language in D is contained in § 38.2-1302 and includes extensions for the filing of reports. It is being added here for consistency.

§ 38.2-4308. Complaint system. –A. Each health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints. The complaint system shall be established after consultation with the State Health Commissioner and approval by the Commission.

B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission, after consultation with the State Health Commissioner. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) a compilation of causes underlying the complaints filed, and (iv) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of its health care providers. A record of the complaints shall be maintained for the period set forth in § 38.2-511.

Drafting Note: This last sentence is being added for consistency with the Unfair Trade Practices Act, which is applicable to HMOs. Proposed § 38.2-511 is existing § 38.1-52.10.

C. The Commission or the State Health Commissioner may examine the complaint system.

§ 38.2-4309. Investments.– A health maintenance organization may invest in any type of Category 1 investment as defined in Chapter 14 of this title or any other investment the Commission may permit.

Drafting Note: This change is required because of major revisions to the investment law in 1983.

§ 38.2-4310. –Protection against insolvency. –Each health maintenance organization shall furnish a surety bond in an amount satisfactory to the Commission, or deposit acceptable securities with the State Treasurer in at least the same amount, as a guarantee that the obligations to the enrollees will be performed. The Commission may waive this requirement whenever the Commission is satisfied that the assets of the organization or its contract with insurers, health services plans, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

§ 38.2-4311. Filing of provider contracts. –Any contracts made with health care providers enabling a health maintenance organization to provide health care services shall be filed with the Commission and may be used commencing fifteen days after their filing.

Drafting Note: The change in this section is being made to clarify the time that contracts must be on file before they can be used.

§ 38.2-4312. Prohibited practices.–A. No health maintenance organization or its representative may cause or knowingly permit the (i) use of advertising that is untrue or misleading, (ii) solicitation that is untrue or misleading, or (iii) any form of evidence of coverage that is deceptive. For the purposes of this chapter:

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee or person considering enrollment in a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if the statement or item of information may be understood by a reasonable person who has no special knowledge of health care coverage as indicating (i) a benefit or advantage if that benefit or advantage does not in fact exist or (ii) the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee or person considering enrollment in a health care plan if the absence of that exclusion, limitation, or disadvantage does not in fact exist; consideration shall be given to the total context in which the statement is made or the item of information is communicated; and

3. An evidence of coverage shall be deemed to be deceptive if it causes a reasonable person who has no special knowledge of health care plans to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; consideration shall be given to the evidence of coverage taken as a whole and to the typography, format, and language.

B. The provisions of Chapter 5 of this title shall apply to health maintenance organizations, health care plans, and evidences of coverage except to the extent that the Commission determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render any of the provisions clearly inappropriate.

C. No health maintenance organization may cancel or refuse to renew the coverage of an enrollee on the basis of the status of the enrollee's health.

D. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature (i) any of the words "insurance," "casualty," "surety," "mutual," or (ii) any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer doing business in this Commonwealth.

E. No health maintenance organization shall discriminate on the basis of race, creed, color, sex or religion in the selection of health care providers for participation in the organization.

F. No health maintenance organization shall unreasonably discriminate against physicians as a class or any class of providers listed in § 38.2-4221 when contracting for specialty or referral practitioners, provided the plan covers services which the members of such classes are licensed to render. Nothing contained in this section shall prevent a health maintenance organization for selecting, in the judgment of the health maintenance organization, the numbers of providers necessary to render the services offered by the health maintenance organization.

Drafting Note: The addition in subsection E explicitly prohibits sexual discrimination in the selection of health care providers.

Subsection F is a result of 1985 legislative action.

§ 38.2-4313. Licensing of agents.— Enrollee contracts may be solicited only through licensed health agents or life and health insurance agents as provided for in Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of enrollee contracts shall not be required to be licensed.

Drafting Note: Those selling HMO contracts will be required to be licensed either as health agents or as life and health insurance agents, which means they will have to take the appropriate study course and examination. This change is also being made in Chapter 42. Salaried officers of the home office are exempt from the licensure requirement.

§ 38.2-4314. Powers of insurers and health services plans.—A. An insurer or a health services plan licensed in this Commonwealth may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law that may be inconsistent with this section, any two or more licensed insurers, health services plans, or their subsidiaries or affiliates, may jointly organize and operate a health maintenance organization.

B. An insurer or a health services plan may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group for purposes of laws applicable to insurers and health services plans. Under the contracts the insurer or health services plans may make benefit payments to health maintenance organizations for health care services rendered by providers under the health care plan.

§ 38.2-4315. Examinations.—A. The Commission shall examine the affairs of each health maintenance organization as provided for in § 38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.

B. The State Health Commissioner may examine the quality of health care services of any health maintenance organization or providers with whom the organization has contracts, agreements, or other arrangements according to its health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth.

C. For the purpose of examinations, the State Health Commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

D. The expenses of examinations by or for the State Health Commissioner under this section shall be assessed against the organization being examined and remitted to the State Health Commissioner.

E. Instead of making its own examination, the Commission or State Health Commissioner may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of the state of domicile.

Drafting Note: The changes in proposed § 38.2-4315 have been made as a result of the change proposed for § 38.2-1317 making it applicable to all persons licensed under this title.

§ 38.2-4316. Suspension or revocation of license.—A. The Commission may suspend or revoke any license issued to a health maintenance organization under this chapter if it finds that any of the following conditions exist:

1. The health maintenance organization is operating significantly at variance with its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.2-4301, unless amendments to those submissions have been filed with and approved by the Commission;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that do not comply with the requirements of § 38.2-4306;

3. The health care plan does not provide or arrange for basic health care services;

4. The State Health Commissioner certifies to the Commission that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth in its health care plan consistent with prevailing medical care standards and practices in the Commonwealth;

5. The health maintenance organization is no longer financially responsible and a reasonable

expectation exists that it may be unable to meet its obligations to enrollees or prospective enrollees;

6. The health maintenance organization has failed to implement a mechanism providing the enrollees with an opportunity to participate in matters of policy and operation as provided in § 38.2-4304;

7. The health maintenance organization has failed to implement the complaint system required by § 38.2-4308 to resolve valid complaints reasonably;

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

9. The continued operation of the health maintenance organization would be hazardous to its enrollees; or

10. The health maintenance organization has otherwise failed to substantially comply with the provisions of this chapter.

B. When the license of a health maintenance organization is suspended, the health maintenance organization shall not enroll any additional enrollees during the period of the suspension except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

C. The Commission shall not revoke or suspend the license of a health maintenance organization upon any of the grounds set out in subsection A of this section until it has given the organization ten days' notice of the proposed revocation or suspension and the grounds for it, and has given the organization an opportunity to introduce evidence and be heard. Any hearing authorized by this section may be informal. The required notice may be waived by the Commission and the health maintenance organization.

D. When the license of a health maintenance organization is revoked, the organization shall proceed to wind up its affairs immediately following the effective date of the order of revocation. The health maintenance organization shall conduct no further business except as may be essential to the orderly conclusion of its affairs. It shall engage in no further advertising or solicitation. The Commission may, by written order, permit further operation of the organization that it finds to be in the best interests of enrollees for the purpose of giving them the greatest practical opportunity to obtain continuing health care coverage.

§ 38.2-4317. Rehabilitation, liquidation, or conservation.—Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be conducted under the supervision of the Commission. The Commission may enter an order directing the rehabilitation, liquidation, or conservation of a health maintenance organization upon any one or more grounds set out in §§ 38.2-1500 through 38.2-1521 or when, in the Commission's opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this Commonwealth.

Drafting Note: This section is being deleted, and a reference to the title-wide rules and regulations section (§ 38.2-223) is being added to proposed § 38.2-4319.

§ 38.2-4318. Licensed renewals.—

A. Each health maintenance organization licensed under this chapter shall renew its license with the Commission annually by March 1. The renewal license shall not be issued until the health maintenance organization has paid all fees and charges imposed on it and has complied with all other requirements of law.

B. The Commission shall not fail or refuse to renew the license of any health maintenance organization without first giving the health maintenance organization ten days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence on its behalf. Any such hearing may be informal. The required notice may be waived by the Commission and the health maintenance organization.

Drafting Note: The provision found in existing subsection A pertaining to the application fee has been moved to § 38.2-4302. The renewal license fee has been deleted, which is consistent with the other chapters. Subsection D has been moved to § 38.2-4319.

Drafting Note: This section is being deleted, and a reference to the title-wide injunctions section (proposed § 38.2-220 in Chapter 2) is being added to proposed § 38.2-4319.

Drafting Note: This section is being deleted, and a reference to the title-wide appeals section (proposed § 38.2-222 in Chapter 2) is being added to proposed § 38.2-4319.

Drafting Note: This section is being deleted and a reference to the uniform penalties section (proposed § 38.2-218 in Chapter 2) will be added to proposed § 38.2-4319. All provisions dealing with revocation of an HMO's license are in proposed § 38.2-4316.

§ 38.2-4319. Statutory construction and relationship to other laws.—A. No provisions of this title except this Chapter and, insofar as they are not inconsistent with this Chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316,38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-909, §§ 38.2-1317 through 38.2-1321, 38.2-1800 through 38.2-1836, and § 38.2-3405 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 of this title except with respect to the

activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

Drafting Note: 1. Identification of and cross-reference for the additional sections that are being made applicable to HMO's are as follows:

a) § 38.2-100 (existing § 38.1-1). Definitions.
b) § 38.2-200 (existing § 38.1-29). General powers of Commission relative to insurance.
c) § 38.2-210 (existing § 38.2-22). Loans to officers, directors, etc., prohibited.
d) § 38.2-211 (existing § 38.1-34). Other interests of officers, directors, etc., prohibited.
e) § 38.2-212 (existing § 38.1-35). Certain compensation prohibited.
f) § 38.2-213 (existing § 38.1-36). Violation of §§ 38.2-210 or 38.2-211.
g) § 38.2-218 (existing § 38.1-40). Fines.
h) § 38.2-219 (existing § 38.1-40.1). Cease and desist orders.
i) § 38.2-220 (existing § 38.1-40.2). Injunctions.
j) § 38.2-221 (existing § 38.1-41). Enforcement of penalties.
k) § 38.2-222 (existing § 38.1-41.2). Appeals generally.
l) § 38.2-223 (existing § 38.1-41.3). Rules and regulations; orders.
m) § 38.2-224 (existing § 38.1-41.4). Procedures. to claim.
n) § 38.2-225 (existing § 38.1-42). Fines and penalties to Literary Fund.
o) § 38.2-229 (new section) Immunity from liability.
p) § 38.2-316 (existing § 38.1-342.1). Policy forms to be filed with Commission.
q) § 48.2-400 et seq. (existing §§ 38.1-44 through 38.1-4810). Chapter 4—Assessment for administration of insurance laws and declaration of estimated assessment by insurers.
r) § 38.2-500 et seq. (existing §§ 38.1-49 through 38.2-57.1). Chapter 5—Unfair trade practices.
s) § 38.2-600 et seq. (existing §§ 38.1-57.2 through 38.2-57.28). Chapter 6—Insurance information and privacy protection.
t) § 38.2-900 et seq. (existing §§ 38.1-43.1 through 38.1-43.6). Chapter 9—Transition provisions.
u) §§ 38.2-1317 through 38.2-1321 (existing §§ 38.1-174 through 38.1-178). Article 4 of Chapter 13—Examinations.
v) § 38.2-1800 et seq. (existing §§ 38.1-327.1 through 38.1-327.45.). Chapter 18—Insurance agents.
2. § 38.2-3405 is existing § 38.1-342.2.

Drafting Note: This section is being deleted and HMO's are being made subject to the Privacy Act. (See proposed § 38.2-4319)

§ 38.2-4320. Authority of Commonwealth to contract with health maintenance organizations.— This Commonwealth is authorized to enter into contracts with health maintenance organizations on behalf of its employees and the citizens of the Commonwealth, including contracts to furnish health care services to recipients of medical assistance under Title XIX of the United States Social Security Act, 42 U.S.C. § 1396, et seq.

§ 38.2-4321. Health maintenance organization affected by chapter. —Except as otherwise provided by law, no health maintenance organization shall be operated in this Commonwealth other than in the manner set forth in this chapter.

Title 38.2

CHAPTER 44.

~~Contracts and Plans for Future~~ Legal Services Plans.

The changes proposed for this chapter are:

1. The title has been changed tc be consistent with the other service plans. The word "future" has been deleted because it is not used in the chapter.

2. Section 38.1-790, purposes and interpretation of chapter, has been deleted at the suggestion of the Code Commission.

3. In § 38.1-791 (proposed § 38.2-4400), a) the defined term "legal services plan" has been changed to indicate the prepaid nature of the plans to reduce confusion between products sold under this chapter and "legal services insurance". b) "Legal services organization" has been defined to distinguish between the sponsoring organization and the plan or services provided. The term "organization" has been used instead of "corporation" (which is used in the other service plans chapters) since legal service plans can be and frequently are managed by a single person. The customary legal use of the word "corporation" was thought to preclude a single proprietorship or a partnership from operating a legal services plan. c) "Subscriber" and "subscription contract" have been defined since they are used throughout the chapter.

4. In § 38.1-793.1 (proposed § 38.2-4403), the provision in item 4 that the Commission shall issue regulations for implementing Virginia State Bar sponsored plans has been deleted for consistency with the decision to have a general rules and regulations section. The remainder of item 4, dealing with quarterly certification of compliance, has been retained.

5. In § 38.1-798 (proposed § 38.2-4408), the list of sections within this title that apply to legal services plans has been updated.

6. In § 38.1-802 (proposed § 38.2-4413), a $500 nonrefundable application fee will be required instead of the $50 license fee. (This change accords with other licensing sections.)

7. In § 38.1-803 (proposed § 38.2-4414), license renewal fees have been eliminated. (This change accords with other renewal sections.)

8. The requirement in existing § 38.1-804 (proposed § 38.2-4415) that only those persons soliciting subscription contracts outside the principal office of a plan must be licensed has been changed to require that all persons who solicit subscription contracts must be licensed as legal services agents. Salaried officers of the home office are exempt from the licensure requirement.

9. Existing §§ 38.1-806 (Injunctions), 38.1-807 (Penalties) and 38.1-808 (Appeals) have been deleted because the appropriate general provisions will apply and have been cross-referenced in proposed §38.2-4408.

CHAPTER 44.

LEGAL SERVICES PLANS.

§ 38.2-4400. Definitions. - As used in this chapter:

"Contract holder" means a person entering into a subscription contract with an organization;

"Legal services organization" or "organization" means a person subject to regulation and licensing under this chapter who operates, conducts or administers a legal services plan;

"Legal services plan" or "plan" means a contractual obligation or an arrangement, whereby legal services are provided in consideration of a specified payment consisting in whole or in part of prepaid or periodic charges, regardless of whether the payment is made by the subscribers individually or by a third person for them;

"Licensed attorney" means an attorney licensed by the Virginia Board of Bar Examiners or other state licensing authority;

"Participating attorney" means a licensed attorney who is participating in a legal services plan;

"Subscriber" means any person entitled to benefits under the terms and conditions of a subscription contract;

"Subscription contract" means a written contract which is issued to a subscriber by an organization and which provides legal services or benefits for legal services.

Drafting Note: 1. The definition of "Commission" was deleted because it is defined in Chapter 1. The definition of "Commissioner" was deleted because the Commissioner may only act through the Commission.

2. "Legal services organization" has been defined to distinguish between the sponsoring organization and the plan or services provided. The term "organization" has been used instead of "corporation" (which is used in the other service plans chapters) since legal service plans can be and frequently are managed by a single person. The customary legal use of the word "corporation" was thought to preclude a single proprietorship or a partnership from operating a legal services plan.

3. The "legal services plan" definition has been changed to indicate the prepaid nature of the plans. Without this addition the definition is so general as to indicate almost any contract made for legal services.

4. "Subscriber" and "subscription contract" have been defined since they are used throughout the chapter. "Contract holder" was added to be consistent with the other service plans chapters in distinguishing between the person making the contract with the organization and the person entitled to the benefits of the plan.

§ 38.2-4402. Certain contracts, etc., not deemed plans. - For the purposes of this chapter, the following are not deemed to be legal services plans:

1. Retainer contracts made by attorneys with individual clients where fees are based on estimates of the nature and amount of services that will be provided to the specific client, and similar contracts made with a group of clients involved in the same or closely related legal matters;

2. Plans providing no benefits other than a limited amount of consultation and advice on simple matters either alone or in combination with referral services or on the promise of fee discounts for other matters;

3. Plans providing limited benefits on simple legal matters on an informal basis, not involving a legally binding promise, in the context of an employment, educational or similar relationship;

4. Legal services related to employment or occupation, provided by unions or employee associations to their members;

5. Legal services provided by an agency of federal or state government or a subdivision of federal or state government to its employees;

6. Legal services insurance as provided for in §§ 38.2-127 and 38.2-300 when provided by an insurer licensed pursuant to Chapter 10 of this title; or

7. Legal assistance provided to members or their dependents by an organization of employees that contracts directly with an attorney or law firm for the provision of legal services.

Drafting Notes: 1. Proposed §§ 38.2-127 and 38.2-300 are existing §§ 38.1-22.1 and 38.1-389.4, respectively.

2. To improve the organization of this chapter, this material has been moved from existing § 38.1-802. Minor editorial changes have been made.

Drafting Note: This section is being incorporated into proposed § 38.2-4403.

§ 38.2-4402. Any person or group of persons may operate a plan. - Any person or any group of persons, including a group of attorneys, may operate a legal services plan or plans directly or through an agent.

§ 38.2-4403. The Virginia State Bar may sponsor plans. - The Virginia State Bar may sponsor, and its

member attorneys may, through a nonstock corporation, operate a legal services plan under the following conditions:

1. All members of the Virginia State Bar may participate in the plan.

2. No more than one-fourth of the board of directors of the nonstock corporation operating the plan may be attorneys who shall be appointed to the board by the Virginia State Bar. A majority of the members of the board shall not be providers of legal services to the plan nor employees or officers of the corporation conducting the plan. The nonprovider members of the board may not be elected or appointed by the Virginia State Bar or by attorneys participating in the plan.

3. No part of the dues paid by attorneys to the Virginia State Bar shall be used to financially support the nonstock corporation.

4. The Commission shall require quarterly compliance certification from all plans licensed pursuant to this section.

Drafting Notes: The first part of existing § 38.1-793.1 (4) is being deleted because the authority to issue rules and regulations in proposed § 38.2-223 is incorporated into this chapter by reference in proposed § 38.2-4409.

§ 38.2-4404. Liability of participants.—A. Except for a plan established pursuant to § 38.2-4403, all persons and attorneys participating in a plan shall be jointly and severally liable on all contracts made for the purposes of the plan by them or by their agent. Each contract may be executed and signed by their agent on their behalf. A contract so signed shall be binding on the principals and not on the agent.

B. Actions for breach of these contracts may be brought against the principals by naming the agent as the sole defendant. A judgment in favor of the plaintiff may be satisfied out of the assets of the legal services organization or out of the assets of each of the principals.

C. Each participant shall be liable for his own torts and not for the torts of any other participant or of the agent.

§ 38.2-4405. Change of participants.—A. Any participating person or attorney may resign from a plan at any time but will continue to be liable on each subscription contract while effective. However, this liability shall not extend beyond the end of each subscription contract's current contract year.

B. Persons and attorneys may be admitted to a plan at any time and will then automatically become liable on all its outstanding contracts.

§ 38.2-4406. Board of directors of corporation operating plan.—Notwithstanding the provisions of §§ 13.1-675 and 13.1-855, any corporation that operates any plan pursuant to the terms of this chapter shall have a board of directors consisting of no more than fifteen members of whom a majority shall be subscribers to the plan who are not providers of legal services and not employees or officers of any plan. This section does not apply to a plan operated by a group of attorneys except as provided in § 38.2-4403.

§ 38.2-4407. Board of directors of plan created by attorneys.—Notwithstanding the provisions of §§ 13.1-675, 13.1-677 and 13.1-855 to the contrary, any legal services organization operating a plan created by a group of attorneys shall have a board of directors consisting of no more than fifteen members of whom a majority may be providers of legal services. This section does not apply to a plan operated under § 38.2-4403.

Drafting Note: The cross-references to Title 13.1 have been updated to reflect the recent reorganization of that title.

§ 38.2-4408. Application of certain provisions.—No provision of this title except this chapter and insofar as they are not inconsistent with this chapter §§ 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-704, §§ 38.2-800 through 38.2-806, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1306, 38.2-1317 through 38.2-1321, and 38.2-1800 through 38.2-1836, insofar as they are not inconsistent with this chapter, and § 58.1-2500 et seq. shall apply to the operation of a plan.

Drafting Note: 1. Identification of and cross reference for the additional sections that are being made applicable to legal service plans are as follows:

a) § 38.2-210 (existing § 38.1-33). Loans to officers, directors, etc. prohibited.
b) § 38.2-211 (existing § 38.1-34). Other interests of officers, directors, etc., prohibited.
c) § 38.2-212 (existing § 38.1-35). Certain compensation prohibited.
d) § 38.2-213 (existing § 38.1-36). Violation of § 38.2-210 or § 38.2-211.
e) § 38.2-218 (existing § 38.1-40). Fines.
f) § 38.2-219 (existing § 38.1-40.1). Cease and desist orders.
g) § 38.2-220 (existing § 38.1-40.2). Injunctions.
h) § 38.2-221 (existing § 38.1-41). Enforcement of penalties.
(i) § 38.2-222 (existing § 38.1-41.2). Appeals generally.
j) § 38.2-223 (existing § 38.1-41.3). Rules and regulations: orders.
k) § 38.2-224 (existing § 38.1-41.4). Procedures.
l) § 38.2-225 (existing § 38.1-42). Fines and penalties to Literary Fund.
m) § 38.2-229 (new section) Immunity from liability.
n) § 38.2-1800 et seq. (existing §§ 38.1-327.1 through 38.1-327.45). Insurance agents.

2. The cross-reference for the applicable sections from the existing Code are as follows:

Existing Section Numbers		*Proposed Section Numbers*
38.1-1		38.2-100
38.1-29		38.2-200
38.1-29.1		38.2-203
38.1-44	to	38.2-400 et seq.,
38.1-70		38.2-500 et seq.,
		38.2-600 et seq.,
		38.2-700 et seq.,
		38.2-800 through 38.2-806
38.1-99 to 38.1-103		38.2-1040 through 38.2-1044
(38.1-104 deleted)		
38.1-159 to 38.1-165		38.2-1300 through 38.2-1306
38.1-174 to 38.1-178		38.2-1317 through 38.2-1321
38.1-342.1		38.2-316
58-490 and		58.1-2500 et seq.
58-502.1 et seq.		

3. The last sentence in existing § 38.1-798 has been moved to a separate section for clarity (proposed § 38.2-4410). No substantive changes were made.

§ 38.2-4409. Payments under plan. - No payment shall be made by a legal services organization to a person included in a subscription contract unless the payment is for breach of contract or for contractually included costs incurred by that person for services received by the person and rendered by a nonparticipating attorney.

§ 38.2-4410. Quarterly reports. - In addition to the annual statement required by § 38.2-1300, the Commission shall require each organization to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the organization. The Commission establish deadlines for submitting any additional reports, exhibits or statements. The Commission may require verification by any officers of the organization the Commission designates.

§ 38.2-4411. Subscriber to have free choice of attorneys available. –A plan shall be organized and operated to assure that any subscriber shall have free choice of the attorneys available and participating in the plan.

§ 38.2-4412. Subscriber to be advised in writing as to benefits and limitations thereon.–A legal services organization shall, prior to and during the term of the subscription contract, fully, fairly, and currently advise the subscriber in writing of the benefits available under the contract and all limitations on the benefits available under the contract.

§ 38.2-4413. Licensing of organization.–A. No person shall operate a legal services plan in this Commonwealth without a license issued by the Commission. Each organization shall apply for a license and furnish any relevant information the Commission requires. Each license shall expire at midnight on the following June 30. A nonrefundable application fee of $500 shall be paid with each application for a license.

B. The Commission shall not issue to or renew a license of an organization unless it is satisfied that the financial condition, the method of operation, and the manner of doing business of the organization enable it to meet its contractual obligations to all subscribers and that the organization has otherwise complied with all the requirements of law.

Drafting Notes: 1. The taxation material in the present third paragraph, now designated subsection C, has been moved to a new section, proposed § 38.2-4417. The material appearing in paragraphs 4 through 7 has been moved to a new section, proposed § 38.2-4402.

2. For consistency with other prepaid plans the $500 application fee is included and the annual $50 licensing fee has been deleted.

§ 38.2-4414. Renewal of organization license.– A. Each legal services organization shall renew its license with the Commission annually by July 1. The renewal license shall not be issued unless the organization has paid all fees and charges imposed on it, and has complied with all other requirements of law.

B. The Commission shall not fail or refuse to renew the license of any organization without first giving the organization ten days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence in its behalf. Any nonrenewal hearing may be informal. The required notice may be waived by the Commission and the organization.

Drafting Note: License renewal fees have been eliminated because substantial maintenance fees are paid. This section is now similar to the renewal section for the dental, optometrical and health services plans.

§ 38.2-4415. Licensing of agents. Subscription contracts may be solicited only through licensed legal services agents as provided for in Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of subscription contracts shall not be required to be licensed.

Drafting Note: All persons selling legal services contracts, even when selling inside the principal office, would have to be licensed as legal services agents. Salaried officers of the home office are exempt from the licensure requirement.

§ 38.2-4416. Taxation. - Except as provided by § 58.1-2501 and Chapter 4 of this title, the application fees paid by a legal services organization under this chapter shall be in lieu of all other state and local license fees or license taxes and state income taxes.

Drafting Note: This material was moved from existing § 38.1-802 and editorial changes made for consistency with proposed Chapters 42 and 45.

§ 38.2-4417. Misleading applications or contracts.—In the operation of a plan, no person shall use any misleading subscription applications or contracts.

Drafting Note: The reference to advertising matter has been deleted because misleading advertising is covered in the Unfair Trade Practices Act to which this chapter is referenced in proposed § 38.2-4408.

Drafting Note: In accordance with the decision to have unified injunction, penalties and appeals sections, existing §§ 38.1-806, 38.1-807, and 38.1-808 have been deleted. The appropriate general provisions sections have been cross-referenced in proposed § 38.2-4409.

Drafting Notes: See comments under existing § 38.1-806.

§ 38.2-4418. Controversies involving subscription contracts.—The Commission shall have no jurisdiction to adjudicate controversies growing out of subscription contracts. A breach of contract shall not be deemed a violation of this chapter.

Title 38.2

CHAPTER 45.

~~Plans For Future~~ Dental or Optometric Services Plans.

The changes proposed for this article are:

1. The title has been changed to be consistent with other service plans chapters. The word "future", which is rarely used, has been deleted.

2. A definitions section, proposed § 38.2-4501, has been added identifying the key terms used in the chapter.

3. Presently, the word "plan" is used in this chapter with two meanings, one referring to the sponsoring organization and the other referring to which types of services are covered under a subscriber contract. Where plan has been used to refer to the sponsoring organization, nonstock corporation has been substituted.

4. In § 38.1-899 (proposed § 38.2-4509), the list of sections within this title to which dental or optometric services plans apply has been updated.

5. In § 38.1-906 (proposed § 38.2-4517), a $500 nonrefundable application fee will be required instead of the $50 license fee. (This change accords with other licensing sections.)

6. In § 38.1-907 (proposed § 38.2-4518), license renewal fees have been eliminated. (This change accords with other renewal sections.)

7. In § 38.1-908 (proposed § 38.2-4519), the requirement that only those persons soliciting subscription contracts outside the principal office of a plan must be licensed has been changed to require that all persons soliciting subscription contracts must be licensed. Home office salaried officers of the corporation are exempt from the licensure requirement.

8. Existing §§ 38.1-911 (Injunctions), 38.1-912 (Penalties) and 38.1-913 (Appeals) have been deleted because the appropriate general provisions will apply and have been cross referenced in proposed §38.2-4509.

CHAPTER 45.

DENTAL OR OPTOMETRIC SERVICES PLANS.

§ 38.2-4500. Applicability of chapter.—A. Except as otherwise provided by law, no arrangement for furnishing prepaid dental services or prepaid optometric services shall be organized, conducted or offered in this Commonwealth other than in the manner set forth in this chapter.

B. Nothing contained in this chapter prohibits any dentist or optometrist individually, in partnership with other dentists or optometrists, or as part of a professional corporation of dentists or optometrists from entering into agreements directly with his own patients, or with a parent, guardian, spouse or other family member acting in a patient's behalf, involving payment for professional services to be rendered or made available in the future.

Drafting Note: To improve the organization of this chapter, this material has been moved from existing § 38.1-894. Minor editorial changes have been made.

§ 38.2-4501. Definitions.—As used in this chapter:

"Contract holder" means a person entering into a subscription contract with a nonstock corporation.

"Dental services plans" means any arrangement for offering or administering prepaid dental services by a nonstock corporation licensed under this chapter.

"Nonstock corporation" means a foreign or domestic nonstock corporation which is subject to regulation and licensing under this chapter and which operates a dental services plan or a optometric services plan.

"Nonstock holder" means a person entering into a subscription contract with a nonstock corporation.

"Optometric services plan" means any arrangement for offering or administering prepaid optometric services by a nonstock corporation licensed under this chapter.

"Plan" means any dental services plan or any optometric services plan subject to regulation under this chapter.

"Subscriber" means any person entitled to benefits under the terms and conditions of a subscription contract.

"Subscription contract" means a written contract which is issued to a contract holder by a nonstock corporation and which provides dental or optometric services or benefits for dental or optometric services.

Drafting Note: This section has been added to define some of the key terms used in this chapter.

§ 38.2-4502. Dental services plans.—A group of licensed dentists may conduct through a nonstock corporation as agent for them a dental services plan as defined in § 38.2-4501.

§ 38.2-4503. Optometric services plans.—A group of licensed optometrists may conduct through a nonstock corporation as agent for them an optometric services plan as defined in § 38.2-4501.

Drafting Note: This section has been moved to the beginning of the chapter (proposed § 38.2-4500).

§ 38.2-4504. Nonstock corporation required. —Each plan shall be conducted either by or through (i) a nonstock corporation organized pursuant to the laws of this Commonwealth or (ii) a foreign nonstock corporation that is subject to regulation and licensing under the laws of its domiciliary jurisdiction that are substantially similar to those provided by this chapter.

Drafting Note: This section has been changed to clarify that a plan must be conducted by a domestic nonstock corporation or a foreign nonstock corporation subject to regulation under laws similar to those of this chapter.

§ 38.2-4505. Liability of participants.—A. All dentists or optometrists participating in a plan shall be jointly and severally liable on all contracts made for the purpose of the plan by the nonstock corporation as agent for them. Each contract may be executed and signed by their agent on their behalf. A contract so signed shall be binding on the principals and not on the agent.

B. Actions for breach of these contracts may be brought against the principals by naming the agent as the sole defendant. A judgment in favor of the plaintiff may be satisfied out of the assets of the nonstock corporation or out of the assets of each of the principals.

C. Each participant shall be liable for his own torts and not for the torts of any other participant or of the agent.

§ 38.2-4506. Terms of participation.—A. Each dentist or optometrist participating in any plan shall do so in accordance with the terms and conditions imposed on other participating providers under similar circumstances. Participating providers shall have the right to engage in other practice. A nonstock corporation shall not engage in the practice of dentistry or optometry.

Drafting Note: The rest of existing § 38.1-897 has been moved to proposed § 38.2-4507. The sections were separated for clarity.

§ 38.2-4507. Change of participants.—A. Any participating dentist or optometrist may resign from a plan at any time but will continue to be liable on each subscription contract then in effect. However, this liability shall not extend beyond the end of each such subscription contract's current contract year.

B. Dentists or optometrists may be admitted to a plan at any time and will then automatically become liable on all its outstanding contracts.

§ 38.2-4508. Board of directors of nonstock corporation.—Notwithstinding the provisions of § 13.1-853, a nonstock corporation shall have a board of directors consisting of at least twelve but no more than twenty members. A majority of the members of the board of directors of a nonstock corporation operating a dental services plan shall be participating dentists. A majority of the members of the board of directors of a nonstock corporation operating an optometric services plan shall be participating optometrists.

Drafting Note: The existing section could be read to mean that the majority of the board of directors of a dental plan could be optometrists, so the proposed provision has been made more specific.

§ 38.2-4509. Application of certain laws.—No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, §§ 38.2-1038, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1310, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1321, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, §§ 38.2-3404, 38.2-3405, 38.2-3415, 38.2-3541, and 38.2-3600 through 38.2-3603 shall apply to the operation of a plan.

Drafting Note: 1. Identification of and cross-reference for the additional sections that are being made applicable to dental and optometric services plans are as follows:

a) § 38.2-210 (existing § 38.1-33). Loans to officers, directors, etc., prohibited.
b) § 38.2-211 (existing § 38.1-34). Other interests of officers, directors, etc., prohibited.
c) § 38.2-212 (existing § 38.1-35). Certain compensation prohibited.
d) § 38.2-213 (existing § 38.1-36). Violation of § 38.2-210 or § 38.2-211.

e) § 38.2-218 (existing § 38.1-40). Fines.
f) § 38.2-219 (existing § 38.1-40.1). Cease and desist orders.

g) § 38.2-220 (existing § 38.1-40.2). Injunctions.
h) § 38.2-221 (existing § 38.1-41). Enforcement of penalties.

i) § 38.2-222 (existing § 38.1-41.2). Appeals generally.
j) § 38.2-223 (existing § 38.1-41.3). Rules and regulations; orders.

k) § 38.2-224 (existing § 38.1-41.4). Procedures.
l) § 38.2-225 (existing § 38.1-42). Fines and penalties to Literary Fund.
m) § 38.2-229 (new section) Immunity from liability.
n) § 38.2-600 et seq. (existing 38.1-57.2 through 38.1-57.28). Insurance information and privacy protection.
o) § 38.2-900 et seq. (existing 38.2-43.1 through 38.1-43.6). Transition provisions.
p) § 38.2-1800 et seq. (existing §§ 38.1-327.1 through 38.1-327.45.) Insurance agents. (This would include existing § 38.1-165.1, which is now proposed § 38.2-1810. Reports of acts deemed larceny under § 18.2-111; privileged communications; Commonwealth's attorney to be informed.)

2. The cross-reference for the applicable sections from the existing Code are as follows:

Existing Section Numbers	Proposed Section Numbers
38.1-29	38.2-200
38.2-44 to	38.2-400 et seq., and
38.1-57	38.2-500 et seq.,
38.1-99 to 38.1-103	38.2-1040 through 38.2-1044
(38.1-104 deleted)	
38.1-159 to 38.1-165	38.2-1300 through 38.2-1306
38.1-166 to 38.1-169	38.1-1300 through 38.2-1310
38.1-171	38.2-1312
38.1-173	38.2-1314
38.1-174 to 38.1-178	38.2-1317 through 38.2-1321
38.1-217.1 to 38.1-217.47	38.2-1400 et seq.
38.1-342.1	38.2-316
38.1-342.2	38.2-3405
38.1-348.10	38.2-3415
38.1-348.11	38.2-3537
38.1-354.1	38.2-3404
38.1-362.7 to 38.1-362.8:3	38.2-3600 through 38.2-3603
(38.1-362.9 was deleted)	

§ 38.2-4510. Quarterly reports.— In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports , exhibits or statements the Commission considers necessary to furnish ful l information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting additional reports, exhibits or statements. Th e Commission may require verification by any officers of the nonstock corporation the Commission designates.

§ 38.2-4511. Corporation's contracts with participating dentists or optometrists.— Participating dentists or

optometrists shall agree to (i) perform the dental services or optometric services specified by the plan at the rates of compensation determined by the nonstock corporation and filed with the Commission, and (ii) abide by the bylaws, rules and regulations of the nonstock corporation.

§ 38.2-4512. Contracts between participating dentists or optometrists and subscribers.– Participating dentists or optometrists, acting through their agents, may enter into contracts subscribers. Contracts may vary as to services and rates.

§ 38.2-4513. Subscriber to have free choice of practitioners available.– A plan shall be organized and operated to assure that any subscriber shall have free choice of any participating dentist or optometrist who agrees to accept the subscriber as a patient for services provided by the plan.

Drafting Note: The second paragraph of existing § 38.1-903 has been made into a new section, proposed § 38.2-4514. No substantive changes were made.

§ 38.2-4514. Subscriber to be advised in writing as to benefits and limitations thereon. – A nonstock corporation shall, prior to and during the term of the subscription contract, fully, fairly, and currently advise the subscriber in writing of the benefits available under the contract and all limitations on the benefits available under the contract.

§ 38.2-4515. Geographical area.–A. Each nonstock corporation seeking to be licensed by the Commission shall specify the geographical area it desires to serve and shall satisfy the Commission that it is able to render the services of the plan.

B. The Commission may, after notice and hearing, license more than one nonstock corporation for the same geographical area unless the Commission finds that the (i) nonstock corporation's proposed method of operation or manner of doing business is not satisfactory or (ii) licensing of more than one nonstock corporation for the same geographical area will not promote the public welfare. If more than one nonstock corporation is licensed in a geographical area, the nonstock corporations in that area shall make arrangements among themselves to see that any claim filed with the wrong nonstock corporation in that area be promptly forwarded to the proper nonstock corporation, if it can be determined.

C. Subscription contracts shall not be sold to persons residing outside the area of the nonstock corporation unless they are regularly employed within the area. The subscription contract of a subscriber who neither lives nor is employed within the area shall be cancelled by notice given in accordance with the terms of the subscription contract.

§ 38.2-4516. Interplan arrangements.–A nonstock corporation may enter into contracts with similar nonstock corporations or foreign companies for the interchange of services to those included in subscription contracts and may provide in subscription contracts for the substitution of the services instead of those recited in subscription contracts.

§ 38.2-4517. Licensing of nonstock corporation.–A. No person shall operate a dental or optometric services plan in this Commonwealth without a license issued by the Commission. Each nonstock corporation shall apply for a license and furnish any relevant information the Commission requires. Each license shall expire at midnight on the following June 30. A nonrefundable application fee of $500 shall be paid with each application for a license.

B. The Commission shall not issue to or renew a license of a nonstock corporation unless it is satisfied that the financial condition, the method of operation, and the manner of doing business of the nonstock corporation enable it to meet its contractual obligations to all subscribers and that the nonstock corporation has otherwise complied with all the requirements of law.

Drafting Note: A $500 nonrefunable application fee has been included instead of the $50 license fee. This change is being made in other licensing sections.

§ 38.2-4518. Renewal of nonstock corporation license.–A. Each nonstock corporation licensed under this chapter shall renew its license annually by July 1. The renewal license shall not be issued unless the nonstock corporation has paid all fees and charges imposed on it, and has complied with all other requirements of law.

B. The Commission shall not fail or refuse to renew the license of any nonstock corporation without first giving the nonstock corporation ten days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence in its behalf. Any nonrenewal hearing may be informal, and the required notice may be waived by the Commission and the nonstock corporation.

Drafting Note: License renewal fees have been eliminated because substantial maintenance fees are paid.

§ 38.2-4519. Licensing of agents.–Subscription contracts for dental services plans may be solicited only by licensed dental services agents as provided for in Chapter 18 of this title. Subscription contracts for optometric services plans may be solicited only by licensed optometric services agents as provided for in Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of subscription contracts shall not be required to be licensed.

Drafting Notes: 1. "Salesman" and "salesmen" have been changed to "dental services agent" or "optometric services agent."

2. For clarity, it has been specifically stated that sellers of dental services subscription contracts must be licensed dental services agents and sellers of optometric services subscription contracts must be licensed optometric services agents.

3. Agents must be licensed regardless of whether or not they are soliciting outside the principal office of a plan.

4. Agents will be subject to the relevant parts of Chapter 18 but will be exempt from the education and examination requirements.

5. Salaried officers of the home office are exempt from the licensure requirement.

§ 38.2-4520. Corporate restrictions.–Any Any nonstock corporation subject to this chapter shall not engage in any other business. However, a nonstock corporation may assist in the administration of governmental health care programs in a manner provided for by contract or regulations. A nonstock corporation's charter may provide for ex officio directors and directors elected by persons or associations who are not directors or members of the nonstock corporation.

Drafting Note: The last sentence in existing § 38.1-909 concerning taxation has been moved to a new section, proposed § 38.2-4521; only minor editorial changes have been made.

§ 38.2-4521. Taxation. -Except as provided by Chapter 4 of this title, the application fees paid by a nonstock corporation under this chapter shall be in lieu of all other state and local license fees or license taxes and state income taxes of the nonstock corporation.

Drafting Note: The reference in existing § 38.1-909 to "license and renewal fees" has been changed to "application fees" because application fees are now being required instead of license fees and renewal fees (see proposed §§ 38.2-4517 and 38.2-4518).

§ 38.2-4522. Misleading applications or contracts.– In the operation of a plan, no person shall use any misleading subscription applications or contracts.

Drafting Note: The reference to advertising matter has been deleted because misleading advertising is covered in the Unfair Trade Practices chapter (Chapter 5, § 38.2-500 et seq., of this title) which applies to this chapter (see proposed § 38.2-4509 for this cross-reference).

Drafting Note: In accordance with the decision to have unified injunction, penalties, and appeals sections, existing §§ 38.1-911, 38.1-912 and 38.1-913 have been deleted. The appropriate general provisions sections have been cross-referenced in proposed § 38.2-4509.

§ 38.2-4523. Controversies involving subscription contracts.– The Commission shall have no jurisdiction to adjudicate controversies growing out of subscription contracts. A breach of contract shall not be deemed a violation of this chapter.

Title 38.2

CHAPTER 46.

Title Insurance.

All changes made to this Chapter are purely editorial and no change in meaning is intended.

CHAPTER 46.

TITLE INSURANCE.

§ 38.2-4600. Class of insurance and insurance companies to which chapter applies.—Except as otherwise provided, this chapter applies to title insurance as defined in § 38.2-123, and to title insurance companies as defined in § 38.2-4601.

§ 38.2-4601. Title insurance company defined.—"Title insurance company" means any company licensed to transact, or transacting, title insurance.

§ 38.2-4602. What laws applicable.—Except as otherwise provided, and except where the context otherwise requires, all provisions of this title relating to insurance and insurers generally shall apply to title insurance and title insurance companies.

§ 38.2-4603. What companies may transact title insurance.—No company other than an insurance company organized as a stock company and licensed to transact title insurance shall transact title insurance in this Commonwealth.

§ 38.2-4604. Investment in plant and equipment.—Notwithstanding the provisions of Chapter 14 of this title, any domestic title insurance company may invest in title records and equipment an amount that is not in excess of fifty percent of its assets comprising its minimum capital and surplus, and any of its assets comprising its excess capital and surplus and its reserves other than unearned premium and loss reserves.

§ 38.2-4605. Interim binders.—Binders or other temporary insurance contracts may be made and used pending the issuance of a title insurance policy.

§ 38.2-4606. Forms to be filed with Commission.—All forms of title insurance policies and interim binders that are customarily used by any title insurance company in connection with the insurance of titles to property located in this Commonwealth shall be filed with the Commission.

§ 38.2-4607. Maximum risk.—On and after July 1, 1952, no company transacting title insurance in this Commonwealth shall assume a single risk in an amount in excess of fifty percent of the aggregate amount of its total capital and surplus and its reserves other than its loss or claim reserves. As used in this section, "a single risk" means the risk or hazard attaching to or arising in connection with any one piece or parcel of property, whether or not the policy insures other property. Any risk, or portion of any risk, that has been reinsured as authorized in this title shall be deducted in determining the limitation of risk prescribed in this section.

§ 38.2-4608. Title insurance rates.—A. Title insurance risk rates shall be reasonable and adequate for the class of risks to which they apply. Risk rates shall not be unfairly discriminatory between risks involving essentially the same hazards and expense elements. The rates may be fixed in an amount sufficient to furnish a reasonable margin for profit after provision for (i) probable losses as indicated by experience within and without this Commonwealth, (ii) exposure to loss under policies, (iii) allocations to reserves, (iv) costs of participating insurance, (v) operating costs, and (vi) other items of expense fairly attributable to the operation of a title insurance business.

B. Policies may be grouped into classes for the establishment of rates. A title insurance policy that is unusually hazardous to the title insurance company because of an alleged defect or irregularity in the title insured or because of uncertainty regarding the proper interpretation or application of the law involved, may be classified separately according to the facts of each case.

C. Title insurance risk rates shall not include charges for abstracting, record searching, certificates regarding the record title, escrow services, closing services, and other related services that may be offered or furnished, or the cost and expenses of examinations of titles.

D. Any title insurance company may issue, publish and use price schedules for title insurance and for any separate or related services, or schedules setting forth one price covering the risk rate and the charges for any separate or related services.

§ 38.2-4609. Loss or claim reserves.—Each title insurance company licensed in this Commonwealth shall maintain loss reserves in an amount estimated in the aggregate as being sufficient to provide for the payment of all unpaid losses and claims under title insurance contracts of which the company has received written notice from or on behalf of the insured.

§ 38.2-4610. Unearned premium reserve generally.—Each domestic title insurance company shall, in addition to other reserves, establish and maintain a reserve to be known as the "unearned premium reserve" for title insurance, which shall at all times and for all purposes be considered and constitute unearned portions of the original risk premiums and shall be charged as a reserve liability of that title insurance company in determining its financial condition.

§ 38.2-4611. Amount of unearned premium reserve.—A. The unearned premium reserve of each domestic title insurance company shall be the sum of:

1. The amount of the unearned premium reserve held as of June 28, 1968, and

2. The amount of all additions required to be made to such reserve by subsection B of this section,

3. Less the sum of all reductions in the unearned premium reserve required by subsections C and D of this section.

B. On each title insurance policy issued by a domestic title insurance company on and after June 28, 1968, there shall be reserved initially as an unearned premium reserve an amount equal to ten percent of the original risk premium charged for the contract.

C. The amount of each year's unearned premium reserve established pursuant to subsection B of this section shall be reduced at the end of each subsequent calendar year, starting with the year following the year in which the reserve is established, by five percent of the initial value of the reserve for twenty years.

D. The amount of the unearned premium reserve on any policy that is held on June 28, 1968, shall be reduced at the rate provided for by the laws of this Commonwealth that were in effect when that reserve was established.

§ 38.2-4612. Unearned premium reserve on policies issued by foreign and alien companies.--Each foreign or alien title insurance company licensed in this Commonwealth shall establish and maintain the same reserves that are required of domestic companies under § 38.2-4611, unless the laws of its domiciliary jurisdiction require unearned premium reserves to be maintained in an amount that is at least as great as the requirements of § 38.2-4611.

§ 38.2-4613. Unearned premium reserve to be held and administered for benefit of policyholders.--A. The reserve required under § 38.2-4611 shall be for the security of policyholders of the title insurance company as provided in this section.

B. If an order of rehabilitation or liquidation of any title insurance company is entered by a court of competent jurisdiction, the rehabilitator or receiver, with the approval of the court, or the Commission if it has been directed to rehabilitate or liquidate the title insurance company under the provisions of Chapter 15 of this title, may (i) use assets equal to the unearned premium reserve to pay any claims for losses sustained by policyholders prior to the time reinsurance is effected to the extent that those losses are in excess of the loss or claim reserves available for their payment, (ii) enter into contracts for the reinsurance of the obligations under the outstanding title insurance policies of the company in accordance with their terms and conditions, and (iii) use assets equal to the unearned premium reserve to pay the cost of reinsurance. After the payments authorized by this subsection have been made, assets equal to any balance in the unearned premium reserve shall become general assets of the company.

C. If no such contract of reinsurance is effected, assets equal to the unearned premium reserve may be applied by the rehabilitator or receiver with the approval of the court, or by the Commission, in the following order of preference: (i) all expenses incurred under this section in connection with the receivership or rehabilitation proceedings, (ii) all allowed and unpaid claims for losses sustained by policyholders pending at the time fixed by the court or the Commission for the filing of claims, and (iii) all allowed claims for losses asserted within twenty years from the date of the entry of the order of rehabilitation or liquidation, which claims shall be paid in the order of the date of their allowance by the court or the Commission. Assets equal to any balance in the unearned premium reserve after payment of all allowed claims shall become general assets of the company. All title records that the rehabilitator, or the receiver, or the Commission if appointed to rehabilitate or liquidate the company, deems necessary to carry out the provisions of this section shall be preserved for twenty years.

D. In proceedings for the rehabilitation or liquidation of a title insurance company that has not been declared insolvent, no assets of the company shall be distributed to its stockholders until all claims allowed in the proceedings have been paid in full. If the proposed distribution is within twenty years from the date of the entry of the order of rehabilitation or liquidation, the distribution may be made if general assets of the title insurance company sufficient to fund the unearned premium reserve to the required amount as of the date of the entry of such order are first transferred to the unearned premium reserve. Upon the expiration of twenty years from the date of the order, assets equal to any balance in the unearned premium reserve after payment of all allowed claims asserted within the twenty-year period shall become general assets of the company.

§ 38.2-4614. Prohibition against payment or receipt of title insurance kickbacks, rebates, commissions and other payments.--A. No person selling real property, or performing services as a real estate agent, attorney, or lender, which services are incident to or a part of any real estate settlement or sale, shall pay or receive, directly or indirectly, any kickback, rebate, commission or other payment in connection with the issuance of title insurance for any real property that is a part of such sale or settlement; and no title insurance company, agency or agent shall make any such payment. This section shall not apply to federally insured lenders, holding companies to which they belong, or subsidiaries of such lenders or holding companies.

B. Any person violating this section shall be guilty of a misdemeanor and subject to a fine of not more than $1,000 or imprisonment for not more than six months, or both, in the discretion of the court.

Drafting Note: This subsection was not changed to an enumerated misdemeanor because it falls between a Class 1 and Class 2 misdemeanor. A Class 1 misdemeanor is subject to a $1000 fine and 12 months' imprisonment while a Class 2 misdemeanor is subject to a $500 fine and 6 months' imprisonment.

C. No person shall be in violation of this section solely by reason of ownership of stock in a bona fide title insurance company, agency, or agent. For purposes of this section, and in addition to any other statutory or regulatory requirements, a "bona fide title insurance company, agency or agent" is defined to be a company, agency or agent that passes upon and makes title insurance underwriting decisions on title risks, including the issuance of title insurance policies or binders and endorsements.

§ 38.2-4615. Exchange of information.—A. In order to further more equitable adoption, use and adjustment of risk rates and premiums and forms of temporary insurance policies and contracts, the Commission and title insurance companies may (i) exchange information and experience data with each other, and with the insurance supervisory officers and insurers of other states, and with national organizations and associations, including duly licensed rating organizations, and (ii) may consult and cooperate with them with respect to risk rates, premiums, and forms of policies and contracts.

B. Any two or more licensed title insurance companies may act in concert with each other and with others with respect to any or all matters pertaining to the making of risk rates or premiums, or the preparation of forms of title insurance policies, underwriting rules and practices, surveys and investigations, or the furnishing of loss or expense statistics, or other information or data relating thereto.

Title 38.2

CHAPTER 47.

Insurance Premium Finance Companies.

The major substantive changes proposed for this chapter are:

1. In proposed § 38.2-4701, the $200 application fee has been increased to a $500 nonrefundable application fee. (This is in accordance with other application fees.)

2. In proposed § 38.2-4702, subdivision (iv) has been changed to read "that the applicant has assets equal to or greater than its liabilities and has working capital sufficient for the operation of its business."

3. In proposed § 38.2-4704, failure to comply with an order of the Commission has been added as grounds for suspension, revocation or refusal of an insurance premium finance company's license.

4. Proposed § 38.2-4710, a penalty section has been retained because of its unique nature, and the maximum daily fine has been raised from $50 to $100.

CHAPTER 47.

INSURANCE PREMIUM FINANCE COMPANIES.

§ 38.2-4700. What persons deemed insurance premium finance companies.—A. Any person engaged in whole or in part in financing premiums for insurance on subjects of insurance resident, located or to be performed in this Commonwealth shall be an insurance premium finance company subject to this chapter. Any person who acquires agreements for this financing from an insurance premium finance company shall be deemed an insurance premium finance company subject to this chapter.

B. No person shall be deemed an insurance premium finance company by reason of any transaction lawful under the laws of this Commonwealth without regard to the provisions of this chapter. No bank, trust company, savings and loan association, industrial loan association, credit union, consumer finance company licensed under Chapter 6 (§ 6.1-244 et seq.) of Title 6.1, licensed insurance agent extending credit as authorized in § 38.2-1806, or insurer shall be licensed under the provisions of this chapter, nor be subject to the restrictions and obligations imposed by this chapter.

Drafting Note: 1) Listing only "person" is sufficient as the definition of person includes partnerships and corporations. The parenthetical statement is deleted as the shorthand referral is not used in this chapter.

2) A cross-reference to the provisions found in proposed § 38.2-1806 (existing § 38.1-327.7) has been added to subsection B.

§ 38.2-4701. License required; application; fee.—No person shall act as an insurance premium finance company in this Commonwealth until that person has obtained a license from the Commission as provided in this chapter. Application for a license shall be made in writing in the form prescribed by the Commission and shall be accompanied by a nonrefundable application fee of $500.

Drafting Note: The increase in the amount of the application fee brings insurance premium finance companies in line with the fees paid by other companies. The specification of "nonrefundable" states current Bureau policy.

§ 38.2-4702. Investigation of applicant; issuance of license.—Upon the filing of an application and the payment of the application fee, the Commission shall make an investigation of the applicant. The Commission shall issue a license, expiring on June 30 immediately following the date of issuance, if it finds that (i) the application is in proper form and the required fee has been paid; (ii) the financial responsibility, experience, character, and general fitness of the applicant indicate that the business will be operated lawfully, honestly, fairly and efficiently within the purpose of this chapter, the same criteria being applicable to members of the applicant if the applicant is a partnership or association and to officers and directors of the applicant if the applicant is a corporation; (iii) if the applicant is a corporation, it is a corporation of this Commonwealth or a foreign corporation that has a certificate of authority to transact business in this Commonwealth; and (iv) the applicant has assets equal to or greater than its liabilities and has working capital sufficient for the operation of its business.

Drafting Note: The change from "liquid assets" to "working capital" is intended to make requirement (iv) less ambiguous. Also, as requirement (iv) is amended, our concern is with the operation of the total business, not just the business in Virginia.

§ 38.2-4703. Renewal of license.—Subject to the provisions of § 38.2-4704, a licensed insurance premium finance company may renew its license on July 1 of each year, upon payment of a nonrefundable annual license fee of $200, unless the license has been surrendered, suspended or revoked.

§ 38.2-4704. Suspension, revocation or failure to renew license; imposition of penalty.—The Commission may suspend, revoke or refuse to renew a license of any insurance premium finance company whenever it finds that:

1. The licensee has (i) failed to pay the annual license fee, (ii) violated or failed to comply with any of the provisions of this chapter or with any rule or regulation made by the Commission pursuant to this chapter, or (iii) violated or failed to comply with any order, demand, ruling, provision or requirement of the Commission lawfully made pursuant to or within the authority of this chapter; or

2. The licensee no longer meets the standards required for the initial issuance of a license.

Drafting Note: 1) With the addition of the word "order" in subsection (1), the last sentence of existing § 38.1-472 (proposed § 38.2-4708) may be deleted. 2) The last sentence has been deleted in favor of the comprehensive penalty section.

§ 38.2-4705. Maximum interest rate and maximum service charge on premium finance agreement.—A. The Commission shall periodically investigate the economic conditions and other factors relating to and affecting the business of insurance premium finance companies. The Commission shall ascertain all pertinent facts necessary to determine what maximum interest rate and what maximum service charge shall be permitted. Upon the basis of those facts and subject to this chapter, the Commission shall determine and fix by regulation or order the maximum interest rate and maximum service charge that may be charged in advance upon the amount financed by any insurance premium finance company.

B. The Commission shall initially fix the maximum interest rate at one percent per month charged in advance upon the entire amount financed payable in installments, and shall initially fix the maximum service charge at fifteen dollars. Thereafter, the maximum interest rate and maximum service charge shall be determined by the Commission after giving due consideration to such factors as (i) prevailing market

interest rates, (ii) other relevant cost indices, and (iii) the industry-wide experience of premium finance companies operating in this Commonwealth. Before redetermining the maximum interest rate or maximum service charge, the Commission shall give all licensees notice and opportunity to be heard and to introduce evidence with respect to the maximum interest rate or service charge.

C. Interest at the authorized rate may be charged from the effective date of the premium finance agreement or the inception date of the insurance contract for which the premiums are being financed, whichever is earlier, through the date when the final installment of the premium finance agreement is payable. The service charge received by an insurance premium finance company shall be fully earned upon its receipt and no portion of the service charge need be refunded upon cancellation or prepayment of the loan. Only one service charge shall be made for each premium finance agreement, and no insurance agent or insurance premium finance company shall induce any person to enter into more than one premium finance agreement for the purpose of obtaining more than one service charge. No part of any charges shall be paid to any insurance agent by an insurance premium finance company.

D. Notwithstanding the foregoing, the Commission by rule or order may exempt any premium finance agreement, any class of premium finance agreements or any market segment from any of the provisions of this section, if it finds their application unnecessary to achieve the purposes of this chapter.

§ 38.2-4706. Default charge; bad check charge.–A. If any installment under a premium finance agreement is not paid in full within seven days after it is due, Sundays and holidays included, the insurance premium finance company may charge and collect a default charge not to exceed five percent of the installment. The default charge shall be collected only once on any installment.

B. An insurance premium finance company may charge and collect a fee, not in excess of fifteen dollars, for each check returned to the insurance premium finance company because the drawer had no account or insufficient funds in the payor bank.

Drafting Note: Changing the maximum charge for returned checks from $5.00 to $15.00 brings this provision in line with current banking practices.

§ 38.2-4707. Forms of premium finance agreements and related forms to be approved by Commission; false or misleading statements or omissions prohibited.– No form of premium finance agreement or any related form shall be used until it is approved by the Commission. No such form shall contain any statements that are materially false or misleading or omit statements necessary to prevent the form from being in any material way false or misleading.

§ 38.2-4708. Examination of books and records of company; bond; rules and regulations; order by Commission to remedy concerns.–A.1. The Commission is empowered to examine the books and records of an insurance premium finance company. 2. The Commission is empowered to require an insurance premium finance company to enter into bond with surety approved by the Commission, in the amount determined as reasonable by the Commission, and conditioned to protect its customers and the public in the manner required by law. The aggregate liability of the surety for all breaches of the conditions of the bond shall in no event exceed the penalty of the bond. The surety on the bond shall have the right to cancel the bond upon thirty days' notice in writing to the Commission and shall be relieved of liability for any breach of condition occurring after the effective date of the cancellation. 3. Any rules and regulations issued by the Commission with respect to the operation of insurance premium finance companies may include, without limitation, rules and regulations for the cancellation of policies by insurance premium finance companies, for the notice required to be given to the insured and the insurer, and for the mutual obligations and duties of insurers and insurance premium finance companies with regard to the cancellation of policies and the required notice.

Drafting Note: The comprehensive rules and regulations section will enable the Commission to issue regulations regarding the operations of premium finance companies.

B. If the Commission finds (i) that an insurance premium finance company's financial condition, method of operation or manner of doing business does not satisfy the Commission that the company can meet its obligations to all customers or (ii) that the company's continued operation in this Commonwealth is hazardous to customers and creditors in this Commonwealth and to the public, it may order the company to take appropriate action within a specified time to remedy the concerns of the Commission. The Commission shall give the insurance premium finance company ten days' notice of its finding and shall grant it the opportunity to be heard and to introduce evidence on its behalf. Any hearing with regard to the order may be informal, and the required notice may be waived with the mutual consent of the Commission and the company.

Drafting Note: The last sentence is deleted in light of the change made to proposed § 38.2-4704.

§ 38.2-4709. Disposition of license and other fees.–The Commission shall collect and pay directly into the state treasury licensing fees and all other fees. These fees shall be credited to the fund for the maintenance of the Bureau of Insurance.

§ 38.2-4710. Penalty for engaging in business without license.–Any person engaging in the business of financing insurance premiums in this Commonwealth without obtaining a license as required under this chapter shall be subject to a fine of not more than $100 for each day that person operates without a license. The fine shall be imposed and judgment entered by the Commission after ten days' notice has been given to the defendant by rule to show cause.

Drafting Note: 1) "Partnership" and "corporation" are deleted as they are included in the definition of person.

2) The fine is increased from $50 to $100 to provide a more substantial deterrent to engaging in

the business without a proper license.

§ 38.2-4711. Exemptions.— This chapter shall not apply to the inclusion of a charge for insurance in a sale of property, goods or services payable in installments, or in a loan made for purposes other than the financing of insurance premiums only.

§ 38.2-4712. Validity of secured transactions.— No filing of the premium finance agreement or recording of a premium finance transaction shall be necessary to validate the agreement as a secured transaction.

Drafting Note: This new section replaces existing subsection A of § 38.1-745.

CHAPTER 48.

Surplus Lines Insurance Law.

1. In § 38.2-4805 an amendment is proposed that clarifies Bureau policy that any business referred to a surplus lines broker must come from a licensed P&C agent and that surplus lines brokers may only compensate licensed P&C agents for referral business.

2. In § 38.2-4806 an amendment is proposed that clarifies that the Commission is to prescribe the combined affidavit form. This will allow for the inclusion of information such as declining admitted insurer, underwriter and line of insurance necessary for the Commission to monitor compliance with the law. In addition, a provision is being added which will require the affidavit to show that the insured has been given the notice required under subsection B prior to the placement of insurance.

3. In § 38.2-4806 the concept of a good faith search is defined differently for broker originated business and referral business. For broker originated business, the concept of a good faith search with three unaffiliated authorized insurers is defined as requiring that the three declinations come from insurers authorized to write such business. The term authorized is defined to mean that a company is licensed to write such business and has complied with the applicable filing requirements of Chapter 19. The purpose of these changes is to provide that declining insurers must be able to write the insurance coverage sought. For business that is referred by property and casualty agents the requirements under present law are retained.

4. Under proposed subsection C of § 38.2-4806 commercial insureds, subject to certain conditions, may waive the requirement of diligent search and thus have the surplus lines broker place the business without obtaining declination from three authorized insurers under this new subsection.

5. In § 38.2-4807 a new subsection B is proposed that requires records of each policy to be kept for at least 5 years.

6. A new section numbered 38.2-4808 provides that payment to a surplus lines broker shall be deemed to be payment to the insurer.

7. Amendments to § 38.2-4809 are proposed that will broaden the Bureau's scope of authority with surplus lines brokers who are delinquent in paying the assessment or premium tax. In addition, surplus lines brokers whose annual tax liability is expected to exceed $1,500 will be required to make quarterly tax payments and all surplus lines brokers will be responsible for the taxes and assessments in a fiduciary relationship with the Commonwealth of Virginia. Also, wilful violations of the tax or assessment provisions will be a Class 1 misdemeanor.

8. An amendment to § 38.2-4811 gives the Commission discretionary authority to extend by two months the period within which annual statements must be filed.

9. The severability provision that applied to all of former Chapter 7.1 is being deleted in favor of a title-wide severability provision.

CHAPTER 48.

SURPLUS LINES INSURANCE LAW.

§ 38.2-4800. Property and casualty insurance agents may be licensed as surplus lines brokers for certain insurance from unlicensed insurers.—The Commission may issue a surplus lines broker's license to any person licensed as a property and casualty insurance agent for the procuring of insurance of the classes enumerated in §§ 38.2-109 through 38.2-121 and §§ 38.2-124 through 38.2-134 from insurers not licensed to transact insurance business in this Commonwealth. However, insurance of the rolling stock and operating properties of railroads used in interstate commerce or any liability or other risks incidental to the ownership, maintenance or operation of such railroads shall not be subject to this chapter.

§ 38.2-4801. Applications for surplus lines brokers' licenses.—Every original applicant for a surplus lines broker's license shall apply for such license on a form prescribed by the Commission, signed by the applicant, and containing any information the Commission requires.

§ 38.2-4802. Fees for surplus lines brokers' licenses.—The annual fee for each surplus lines broker's license shall be fifty dollars. The fee shall be paid when the application for license is filed and then prior to March 15 of each subsequent year. However, the fee for any license applied for after September 15 shall be twenty-five dollars. All fees shall be collected by the Commission and paid into the state treasury to the credit of the fund for the maintenance of the Bureau of Insurance.

§ 38.2-4803. Term of licenses; renewal.—Every license issued pursuant to this chapter shall be for a term expiring on March 15 next following the date of its issuance and may be renewed for the ensuing license year, upon the filing of an application in the form prescribed by the Commission and payment of the fee prescribed in § 38.2-4802.

§ 38.2-4804. Applicants to file bond with Commission.—Prior to issuance of a license, the applicant shall file with the Commission, and thereafter for as long as the license remains in effect he shall keep in force, a bond in favor of this Commonwealth in the amount of $25,000 with corporate sureties licensed by the Commission. The bond shall be conditioned that the broker will conduct business under the license in accordance with the provisions of the surplus lines insurance law and that he will promptly remit the taxes provided by such law. The bond shall not be terminated unless at least thirty days' prior written notice of the termination is filed with the Commission.

§ 38.2-4805. Accepting and placing surplus lines business.—No surplus lines broker shall accept surplus lines business from any person other than an applicant for insurance or a duly licensed property and casualty insurance agent nor shall such surplus lines broker compensate any person other than a duly licensed property and casualty insurance agent for such business. No person other than an applicant for insurance or a duly licensed property and casualty insurance agent shall place surplus lines business with a surplus lines broker licensed under this chapter nor shall any person other than a duly licensed property and casualty agent accept compensation for such business.

Drafting Note: The above change is intended to clarify Bureau policy that any business referred to a surplus lines broker must come from a licensed property and casualty agent and that surplus lines brokers may only compensate licensed property and casualty agents for referral business.

§ 38.2-4806. Affidavits that insurance is unprocurable from licensed insurers required; notice to insured. —A. When any policy of insurance is procured under this chapter, the surplus lines broker procuring the policy shall execute an affidavit in form and content as prescribed by the Commission stating that the surplus lines broker was unable, after diligent effort, to procure in a form and at a premium acceptable to the insured the amount of such insurance from an insurer licensed in this Commonwealth to transact insurance business of the class within which such insurance is included. The affidavit shall also affirm that the insured was given the notice required and prescribed under subsection B of this section and shall be filed with the Commission within thirty days after the end of the calendar month in which any such insurance has been procured. If the broker has made more than one such placement of insurance with one or more nonlicensed insurers within the preceding calendar month, the broker, in lieu of such individual affidavits, may execute and file, within thirty days of the end of the calendar month, a joint or combined affidavit in form and content as prescribed by the Commission listing all such policies.

Drafting Notes: (1) A provision is being added which will require the affidavit to show that the insured has been given notice required under subsection B prior to the placement of insurance.

(2) The change in the last sentence clarifies that the Commission is to prescribe the combined affidavit form. This will allow for the inclusion of information such as declining admitted insurer, underwriter and line of insurance necessary for the Commission to monitor compliance with the law.

"Class" of insurance shall mean those classes enumerated in §§ 38.2-109 through 38.2-121 and §§ 38.2-124 through 38.2-134. For business that is referred from a licensed property and casualty insurance agent, a surplus lines broker shall be deemed to have made "diligent effort," as required in the preceding paragraph whenever the risk or portion of risk placed with a nonlicensed insurer has been rejected or declined by three insurers licensed to transact such class of insurance. For business that is originated by a surplus lines broker, "diligent effort" means a good faith search for insurance among admitted insurers resulting in declinations of coverage by three unaffiliated admitted insurers licensed and authorized to write in this Commonwealth the insurance coverage sought.

A company is authorized to write the insurance coverage sought when it is licensed for that class of insurance in this Commonwealth and has complied with the applicable provision of Chapter 19 of this title

concerning rules, rates and policy forms providing the insurance coverage sought, unless such insurance coverage has been exempted from filing by Commission order pursuant to § 38.2-1903.

Drafting Note: For broker originated business, the concept of a good faith search with three unaffiliated authorized insurers is defined as requiring that the three declinations come from insurers authorized to write such business. The term authorized is defined to mean that a company is licensed to write such business and has complied with the applicable filing requirements of Chapter 19. The purpose of these changes is to provide that declining insurers must be able to write the insurance coverage sought. For business that is referred by property and casualty agents the requirements under present law are retained.

B. A notice in a form prescribed by the Commission shall be given to the insured under the provisions of a policy procured pursuant to this chapter by the surplus lines broker procuring the policy or by any duly licensed property and casualty insurance agent placing surplus lines business with the surplus lines broker. The notice shall contain, but not be limited to, statements that the policy is being procured from or has been placed with an insurer approved by the Commission for issuance of surplus lines insurance in this Commonwealth, but not licensed or regulated by the Commission and that there is no protection under the Virginia Property and Casualty Insurance Guaranty Association, established under Chapter 16 of this title, against financial loss to claimants or policyholders because of the insolvency of an unlicensed insurer. The notice shall also set forth the name, license number and mailing address of the broker. The notice shall be given prior to placement of the insurance; provided, in the event coverage must be placed and become effective within twenty-four hours after referral of the business to the surplus lines broker, the notice may be given promptly following such a placement. In addition, a copy of the notice shall be affixed to the policy.

C. The requirement of a diligent search among companies licensed and authorized to write the class of insurance sought may be waived by a commercial insured. For purposes of this section, a "commercial insured" is an insured (i) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer, (ii) whose aggregate annual premiums for insurance on all risks total at least $75,000 or (iii) who has at least twenty-five full-time employees. Such waiver shall be in writing on a form prescribed by the Commission and shall be signed by the commercial insured. One copy of the signed waiver shall be retained by the surplus lines broker for the time period specified in § 38.2-4807 and one copy shall be attached to the affidavit forwarded to the Commission as prescribed in subsection A of this section.

Drafting Note: Under proposed subsection C commercial insureds, subject to certain conditions, may waive the requirement of diligent search and thus have the surplus lines broker place the business without obtaining declination from three authorized insurers under this new subsection.

D. Within thirty days after the end of each calendar month each person licensed under this chapter shall file a report with the Commission summarizing the business transacted during that month. Such report shall be on a form prescribed by the Commission and shall include for each surplus lines policy written the direct gross premium, the policy number, the name of the insured, the policy period and the name of the insurer from which coverage has been procured. However, a surplus lines broker may file the combined affidavit set forth in subsection A of this section in lieu of this report provided such combined affidavit contains all of the information required by this subsection.

Drafting Note: New subsection D codifies the monthly report currently required of all surplus lines brokers.

§ 38.2-4807. Licensees to keep records and file annual statement of policies.—A. Every person licensed pursuant to this chapter shall keep in his office a complete record of, and file in the office of the Commission annually on or before March 1, a statement setting forth (i) each policy of insurance procured by him under this chapter during the previous calendar year; (ii) the name and address of the insurer or insurers; (iii) the inception and expiration dates of each policy; (iv) the perils insured against; (v) the location of each risk so insured and the premium rate and the gross premium charged for each such policy of insurance; (vi) the amount of premium returned; and (vii) any other information the Commission requires. The annual statement shall be on a form furnished by the Commission and shall be verified.

B. The record of each policy of insurance shall be kept open at all reasonable times to examination by the Commission without notice for a period of not less than five years following termination of the policy.

Drafting Note: New subsection B proposes that records of each policy be kept for at least 5 years. This provision is consistent with the record keeping practices required by the Commission of other licensed companies.

§ 38.2-4808. Effect of payment to surplus lines broker.—A. No surplus lines broker may accept a payment of premium for issuance of surplus lines insurance before placing the insurance with an eligible surplus lines insurer.

B. A payment of premium to a surplus lines broker shall be deemed to be payment to the insurer notwithstanding any policy conditions or stipulations to the contrary.

Drafting Note: The new section is similar to the NAIC model providing that payment of premium to a surplus lines broker shall be deemed to be payment to the insurer.

§ 38.2-4809. Licensees to pay assessments and license taxes on insurers.— A. Every person licensed under this chapter shall be subject to the annual assessment, penalties, and other provisions of §§ 38.2-400 and 38.2-403 and shall also be subject to the annual taxes, penalties, and other provisions of Article 1 of Chapter 25 of Title 58.1 on each policy of insurance procured by him during the preceding calendar year with an insurer not licensed to transact insurance business in this Commonwealth.

B. Each person licensed under this chapter whose annual premium tax liability can reasonably be expected to exceed $1,500 shall file a quarterly tax report with the Commission. Such report shall be on a form prescribed by the Commission. This report shall be filed no later than thirty days after the end of each calendar quarter. Notwithstanding any provision to the contrary, each such person shall pay the premium tax owed for the direct gross premiums adjusted for additional and returned premiums shown by each quarterly tax report when such report is filed with the Commission.

C. In addition to other penalties provided by law, any person licensed or required to be licensed under this chapter who willfully fails or refuses to pay the full amount of the tax or assessment required by this chapter, either by himself or through his agents or employees, or who makes a false or fraudulent return with intent to evade the tax or assessment hereby levied, or who makes a false or fraudulent claim for refund shall be guilty of a Class 1 misdemeanor.

D. If any person licensed or required to be licensed under this chapter charges and collects from the insured the taxes and assessments required by this section, such person shall be a fiduciary to this Commonwealth for any taxes and assessments owed to this Commonwealth under this chapter.

Drafting Note: The above change will broaden the Bureau's scope of authority with surplus lines brokers who are delinquent in paying the assessment or license tax. In addition, surplus lines brokers whose annual tax liability is expected to exceed $1,500 will be required to make quarterly tax payments and all surplus lines brokers will be responsible for the taxes and assessments in a fiduciary relationship with the Commonwealth of Virginia. Also, willful violations of the tax or assessment provision will be deemed a Class I misdemeanor.

§ 38.2-4810. Issuance and delivery of surplus lines policies; prior authority or information required.— Each policy or other written evidence of insurance procured pursuant to this chapter shall be delivered promptly to the insured. No surplus lines broker shall issue or deliver any policy or other written evidence of insurance or represent that insurance will be or has been granted by an unlicensed insurer unless (i) he has prior written authority from such insurer for the insurance, (ii) he has received information from the insurer in the regular course of business that the insurance has been granted, or (iii) an insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

§ 38.2-4811. Surplus lines coverage to be placed only with unlicensed insurers approved by Commission. —A. No surplus lines broker shall procure a policy of insurance with any insurer not licensed to transact insurance business in this Commonwealth, unless such unlicensed insurer has prior approval of the Commission to issue surplus lines insurance.

B. Any unlicensed insurer wishing to be approved by the Commission to issue surplus lines coverage may receive such approval upon providing:

1. Satisfactory evidence of good repute and financial integrity; and

2. Proof that it qualifies under (a), (b) or (c) of this paragraph:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equal the greater of (i) the minimum capital and surplus requirements under §§ 38.2-1029, 38.2-1030, 38.2-1031 and 38.2-1033 or (ii) $2.5 million three years after June 30, 1984; $3.5 million five years after June 30, 1984; and $5 million six years after June 30, 1984.

After June 30, 1990, the requirements of paragraph 2a of this subsection may be satisfied by an unlicensed insurer possessing less than $5 million in capital and surplus upon an affirmative finding of acceptability by the Commission. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and company record and reputation within the industry. In no event, however, shall the Commission make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $3.5 million. In addition, an alien insurer may qualify under this paragraph if it maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than $1.5 million for the protection of all of its policyholders in the United States. This trust fund shall consist of cash, securities, letters of credit, or investments of substantially the same character and quality as those which are eligible investments for admitted insurers authorized to write like classes of insurance in this Commonwealth. Such trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; and

b. In the case of any Lloyd's or other similar unincorporated group of alien individual insurers, maintains a trust fund of not less than $50 million as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and such trust shall likewise comply with the terms and conditions established in paragraph 2a of this subsection for alien insurers; and

c. In the case of an "insurance exchange" created by the laws of individual states, maintains capital and surplus, or the substantial equivalent of capital and surplus, of not less than $15 million in the aggregate. For insurance exchanges which maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent of capital and surplus, of not less than $1.5 million. If the insurance exchange does not maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of paragraph 2 a of this subsection.

C. Any such unlicensed insurer shall cause to be provided to the Commission not later than six months after the close of the period reported upon a copy of its current annual statement certified by the insurer. The report shall be:

1. Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

2. Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

3. In the case of an insurance exchange, may be an aggregate combined statement of all underwriting syndicates operating during the period reported upon.

The Commission, at its discretion, may extend the period for filing an annual statement by a maximum of two months.

Drafting Note: Alien insurers frequently find it difficult to file annual statements within six months. The above change gives the Commission discretionary authority to extend the filing period by two months.

D. If at any time the Commission has reason to believe that an eligible surplus lines insurer (i) is in unsound financial condition, (ii) is no longer eligible under paragraph 2 above, (iii) has willfully violated the laws of this Commonwealth, or (iv) does not make reasonably prompt payment of just losses and claims in this Commonwealth or elsewhere, the Commission may declare it ineligible. The Commission shall promptly mail notice of all such declarations to each surplus lines licensee.

§ 38.2-4812. Surplus lines insurers subject to Unlicensed Insurers Process.– Every insurer issuing surplus lines coverage under this chapter shall be subject to the provisions of §§ 38.2-801 through 38.2-804.

§ 38.2-4813. Commission to make rules and regulations. –The Commission may make, approve and adopt reasonable rules and regulations consistent with this chapter to effect the purposes of this chapter.

§ 38.2-4814. Penalties.–Any violation of this chapter shall be punished as provided for in §§ 38.2-218 and 38.2-1831.

§ 38.2-4815. Effect on other provisions of Title 38.2.– Except as is otherwise provided herein, the provisions relating to the licensing and control of surplus lines brokers shall have no effect on or in any way alter any of the other provisions of this title.

Drafting Note: Section 38.1-327.61 is being deleted in favor of a title-wide severability provision.

Title 38.2

CHAPTER 49.

Continuing Care Provider Registration and Disclosure.

As this chapter was enacted during the 1985 session of the General Assembly and the Bureau has no experience in regulating these entities at this time, no substantive changes are proposed for this chapter.

CHAPTER 49.

CONTINUING CARE PROVIDER REGISTRATION AND DISCLOSURE.

§ 38.2-4900. Definitions.—As used in this chapter:

"Continuing care" means providing or committing to provide board, lodging and nursing services to an individual, other than an individual related by blood or marriage, (i) pursuant to an agreement effective for the life of the individual or for a period in excess of one year, including mutually terminable contracts, and (ii) in consideration of the payment of an entrance fee or periodic charges. A contract shall be deemed to be one offering nursing services, irrespective of whether such services are provided under such contract, if nursing services are offered to the resident entering such contract either at the facility in question or pursuant to arrangements specifically offered to residents of the facility.

"Entrance fee" means an initial or deferred transfer to a provider of a sum of money or other property made or promised to be made in advance or at some future time as full or partial consideration for acceptance of a specified individual as a resident in a facility. A fee which is less than the sum of the regular periodic charges for one year of residency shall not be considered to be an entrance fee.

"Facility" means the place or places in which a person undertakes to provide continuing care to an individual.

"Provider" means any person, corporation, partnership or other entity that provides or offers to provide continuing care to any individual in an existing or proposed facility in this Commonwealth. Two or more related individuals, corporations, partnerships or other entities may be treated as a single provider if they cooperate in offering services to the residents of a facility.

"Resident" means an individual entitled to receive continuing care in a facility.

"Solicit" means all actions of a provider or his agent in seeking to have individuals enter into a continuing care agreement by any means such as, but not limited to, personal, telephone or mail communication or any other communication directed to and received by any individual, and any advertisements in any media distributed or communicated by any means to individuals.

§ 38.2-4901. Registration.—A. Except as provided in § 38.2-4912, no provider shall engage in the business of providing or offering to provide continuing care at a facility in this Commonwealth unless the provider has registered with the Commission with respect to such facility.

B. A registration statement shall be filed with the Commission by the provider on forms prescribed by the Commission and shall include:

1. All information required by the Commission pursuant to its enforcement of this chapter; and

2. The initial disclosure statement required by § 38.2-4902.

C. Registration shall be approved or disapproved in writing by the Commission within ninety days of the filing.

§ 38.2-4902. Disclosure statement.—A. The disclosure statement of each facility shall contain all of the following information unless such information is contained in the continuing care contract and a copy of that contract is attached to and made a part of the initial disclosure statement:

1. The name and business address of the provider and a statement of whether the provider is a partnership, foundation, association, corporation or other type of business or legal entity.

2. Full information regarding ownership of the property on which the facility is or will be operated and of the buildings in which it is or will be operated.

3. The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent or greater equity or beneficial interest in the provider, and a description of such person's interest in or occupation with the provider.

4. For (i) the provider, (ii) any person named in response to paragraph 3 of this subsection or (iii) the proposed management, if the facility will be managed on a day-to-day basis by a person other than an individual directly employed by the provider:

a. A description of any business experience in the operation or management of similar facilities.

b. The name and address of any professional service, firm, association, foundation, trust, partnership or corporation or any other business or legal entity in which such person has, or which has in such person, a ten percent or greater interest and which it is presently intended will or may provide goods, leases or services to the provider of a value of $500 or more, within any year, including:

(1) A description of the goods, leases or services and the probable or anticipated cost thereof to the provider;

(2) The process by which the contract was awarded;

(3) Any additional offers that were received; and

(4) Any additional information requested by the Commission detailing how and why a contract was awarded.

c. A description of any matter in which such person:

(1) Has been convicted of a felony or pleaded nolo contendere to a criminal charge, or been held liable or enjoined in a civil action by final judgment, if the crime or civil action involved fraud, embezzlement, fraudulent conversion, misappropriation of property or moral turpitude; or

(2) Is subject to an injunctive or restrictive order of a court of record, or within the past five years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including without limitation actions affecting a license to operate a foster care facility, nursing home, retirement home, home for the aged or facility registered under this chapter or similar laws in another state; or

(3) Is currently the subject of any state or federal prosecution, or administrative investigation involving allegations of fraud, embezzlement, fraudulent conversion, or misappropriation of property.

5. A statement as to:

a. Whether the provider is or ever has been affiliated with a religious, charitable or other nonprofit organization, the nature of any such affiliation, and the extent to which the affiliate organization is or will be responsible for the financial and contractual obligations of the provider.

b. Any provision of the federal Internal Revenue Code under which the provider is exempt from the payment of income tax.

6. The location and description of the real property of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates of improvements, whether or not construction has begun and the contingencies under which construction may be deferred.

7. The services provided or proposed to be provided under continuing care contracts, including the extent to which medical care is furnished or is available pursuant to any arrangement. The disclosure statement shall clearly state which services are included in basic continuing care contracts and which services are made available by the provider at extra charge.

8. A description of all fees required of residents, including any entrance fee and periodic charges. The description shall include (i) a description of all proposed uses of any funds or property required to be transferred to the provider or any other person prior to the resident's occupancy of the facility and of any entrance fee, (ii) whether provisions exist for the escrowing and return of any such funds, property or entrance fee and the manner and any conditions of return, and (iii) the manner by which the provider may adjust periodic charges or other recurring fees and any limitations on such adjustments. If the facility is already in operation, or if the provider operates one or more similar facilities within this Commonwealth, there shall be included tables showing the frequency and average dollar amount of each increase in periodic rates at each facility for the previous five years or such shorter period that the facility has been operated by the provider.

9. Any provisions that have been made or will be made to provide reserve funding or security to enable the provider to fully perform its obligations under continuing care contracts, including the establishment of escrow accounts, trusts or reserve funds, together with the manner in which such funds will be invested and the names and experience of persons who will make the investment decisions. The disclosure statement shall clearly state whether or not reserve funds are maintained.

10. Certified financial statements of the provider, including (i) a balance sheet as of the end of the two most recent fiscal years and (ii) income statements of the provider for the two most recent fiscal years or such shorter period that the provider has been in existence.

11. A pro forma income statement for the current fiscal year.

12. If operation of the facility has not yet commenced, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

a. An estimate of the cost of purchasing or constructing and equipping the facility including such related costs as financing expense, legal expense, land costs, occupancy development costs and all other similar costs that the provider expects to incur or become obligated for prior to the commencement of operations.

b. A description of any mortgage loan or other long-term financing intended to be used for any purpose in the financing of the facility and of the anticipated terms and costs of such financing, including without limitation, all payments of the proceeds of such financing to the provider, management or any related person.

c. An estimate of the percentage of entrance fees that will be used or pledged for the construction or purchase of the facility, as security for long-term financing or for any other use in connection with the commencement of operation of the facility.

d. An estimate of the total entrance fees to be received from or on behalf of residents at or prior to commencement of operation of the facility.

e. An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing care contracts.

f. A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of any government subsidies for health care services to be provided pursuant to the continuing care contracts.

g. A projection of estimated operating expenses of the facility, including (i) a description of the assumptions used in calculating any expenses and separate allowances for the replacement of equipment and furnishings and anticipated major structural repairs or additions and (ii) an estimate of the percentage of occupancy required for continued operation of the facility.

h. Identification of any assets pledged as collateral for any purpose.

i. An estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing.

13. A description of the provider's criteria for admission of new residents.

14. A description of the provider's policies regarding access to the facility and its services for nonresidents.

15. Any other material information concerning the facility or the provider that may be required by the Commission or included by the provider.

B. The disclosure statement shall state on its cover that the filing of the disclosure statement with the Commission does not constitute recommendation or endorsement of the facility by the Commission.

C. A copy of the standard form or forms for continuing care contracts used by the provider shall be attached as an exhibit to each disclosure statement.

D. If the Commission determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.2-4915.

§ 38.2-4903. Availability of disclosure statement to prospective residents.—At least three days prior to the execution of a continuing care contract or the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever first occurs, the provider shall deliver to the person with whom the contract is to be entered into a copy of a disclosure statement with respect to the facility in question meeting all requirements of this chapter as of the date of its delivery.

§ 38.2-4904. Annual disclosure statements.—A. Within four months following the end of the provider's fiscal year, each provider shall file with the Commission and make available by written notice to each resident at no cost an annual disclosure statement which shall contain the information required for the initial disclosure statement set forth in § 38.2-4902.

B. The annual disclosure statement shall also be accompanied by a narrative describing any material differences between:

1. The prior fiscal year's pro forma income statement, and

2. The actual results of operations during that fiscal year.

C. The annual disclosure statement shall describe the disposition of any real property acquired by the provider from residents of the facility.

D. In addition to filing the annual disclosure statement, the provider shall amend its currently filed disclosure statement at any other time if, in the opinion of the provider, an amendment is necessary to prevent the disclosure statement from containing any material misstatement of fact or failing to state any material fact required to be stated therein. Any such amendment or amended disclosure statement shall be filed with the Commission before it is delivered to any resident or prospective resident and is subject to all the requirements of this chapter, and the provider shall notify each resident of the existence of such amendment or amended disclosure statement.

E. If the Commission determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.2-4915.

§ 38.2-4905. Resident's contract.—A. In addition to other provisions considered proper to effect the

purpose of any continuing care contract, each contract executed on or after the effective date of this chapter shall:

1. Provide for the continuing care of only one resident, or for two or more persons occupying space designed for multiple occupancy, under appropriate regulations established by the provider.

2. Show the value of all property transferred, including donations, subscriptions, fees and any other amounts paid or payable by, or on behalf of, the resident or residents.

3. Specify all services which are to be provided by the provider to each resident including, in detail, all items that each resident will receive and whether the items will be provided for a designated time period or for life and the estimated current monthly cost to the provider for providing the care. Such items may include, but are not limited to, food, shelter, nursing care, drugs, burial and incidentals.

4. Describe the physical and mental health and financial conditions upon which the provider may require the resident to relinquish his space in the designated facility.

5. Describe the physical and mental health and financial conditions required for a person to continue as a resident.

6. Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident.

7. State (i) the current fees that would be charged if the resident marries while at the designated facility, (ii) the terms concerning the entry of a spouse to the facility and (iii) the consequences if the spouse does not meet the requirements for entry.

8. Provide that the provider shall not cancel any continuing care contract with any resident without good cause. Good cause shall be limited to: (i) proof that the resident is a danger to himself or others; (ii) nonpayment by the resident of a monthly or periodic fee; (iii) repeated conduct by the resident that interferes with other residents' quiet enjoyment of the facility; or (iv) persistent refusal to comply with reasonable written rules and regulations of the facility. If a provider seeks to cancel a contract and terminate a resident's occupancy, the provider shall give the resident written notice of, and a reasonable opportunity to cure within a reasonable period, whatever conduct is alleged to warrant the cancellation of the agreement. Nothing herein shall operate to relieve the provider from duties under Chapter 13.2 (§ 55-248.2 et seq.) of Title 55 when seeking to terminate a resident's occupancy.

9. Provide in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee and the terms under which such fee can be used by the provider.

10. State the terms under which a contract is cancelled by the death of the resident. The contract may contain a provision to the effect that, upon the death of the resident, the money paid for the continuing care of such resident shall be considered earned and become the property of the provider.

11. Provide for at least thirty days' advance notice to the resident, before any change in fees, charges or the scope of care or services may be effective, except for changes required by state or federal assistance programs.

12. Provide that charges for care paid in one lump sum shall not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

B. A resident shall have the right to rescind a continuing care contract, without penalty or forfeiture, within seven days after making an initial deposit or executing the contract. A resident shall not be required to move into the facility designated in the contract before the expiration of the seven-day period.

C. If a resident dies before occupying the facility, or is precluded through illness, injury or incapacity from becoming a resident under the terms of the continuing care contract, the contract is automatically rescinded and the resident or his legal representative shall receive a full refund of all money paid to the provider, except those costs specifically incurred by the provider at the request of the resident and set forth in writing in a separate addendum, signed by both parties to the contract.

D. No standard continuing care contract form shall be used in this Commonwealth until it has been submitted to the Commission. If the Commission determines that the contract does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.1-970 to prevent its use. The failure of the Commission to object to or disapprove of any contract shall not be evidence that the contract does or does not comply with the provisions of this chapter. However, individualized amendments to any standard form need not be filed with the Commission.

§ 38.2-4906 Sale or transfer of ownership or change in management.—A. No provider and no person or entity owning a provider shall sell or transfer, directly or indirectly, more than fifty percent of the ownership of the provider or of a continuing care facility without giving the Commission written notice of the intended sale or transfer at least thirty days prior to the consummation of the sale or transfer. A series of sales or transfers to one person or entity, or one or more entities controlled by one person or entity, consummated within a six-month period that constitute, in the aggregate, a sale or transfer of more than fifty percent of the ownership of a provider or of a continuing care facility shall be subject to the

foregoing notice provisions.

B. A provider or continuing care facility that shall change its chief executive officer, or its management firm if managed under a contract with a third party, shall promptly notify the Commission and the residents of each such change.

§ 38.2-4907. Financial instability.—A. The Commission may act as authorized by § 38.2-4915 to protect residents or prospective residents when the Commission determines that:

1. A provider has been or will be unable to meet the pro forma income or cash flow projections previously filed by the provider and such failure may endanger the ability of the provider to perform fully its obligation pursuant to its continuing care contracts; or

2. A provider is bankrupt, insolvent, under reorganization pursuant to federal bankruptcy laws or in imminent danger of becoming bankrupt or insolvent.

§ 38.2-4908. Waivers.—No act, agreement or statement of any resident or by an individual purchasing care for a resident under any agreement to furnish care to the resident shall constitute a valid waiver of any provision of this chapter intended for the benefit or protection of the resident or the individual purchasing care for the resident.

§ 38.2-4909. Untrue, deceptive or misleading advertising.—The provisions of § 18.2-216 shall apply to all providers.

§ 38.2-4910. Right of organization.—A. Residents shall have the right of self-organization. No retaliatory conduct shall be permitted against any resident for membership or participation in a residents' organization. The provider shall be required to provide to the organization a copy of all submissions to the Commission.

B. The board of directors, its designated representative or other such governing body of a continuing care facility shall hold meetings at least quarterly with the residents or representatives elected by the residents of the continuing care facility for the purpose of free discussion of issues relating to the facility. These issues may include income, expenditures and financial matters as they apply to the facility and proposed changes in policies, programs, facilities and services. Residents shall be entitled to seven days' notice of each meeting.

§ 38.2-4911. Civil liability.—A. A person contracting with a provider for continuing care may terminate the continuing care contract and such provider shall be liable to the person contracting for continuing care for repayment of all fees paid to the provider, facility or person violating this chapter, together with interest thereon at the legal rate for judgments, court costs and reasonable attorney's fees, less the reasonable value of care and lodging provided to the resident prior to the termination of the contract, and for damages if after the effective date of this chapter such provider or a person acting on his behalf, with or without actual knowledge of the violation, enters into a contract with such person:

1. For continuing care at a facility which has not registered under this chapter; or

2. Without having first provided to such person a disclosure statement not (i) containing any untrue statement of a material fact or (ii) omitting a material fact required to be stated therein or necessary in order to make the statements made therein not misleading, in light of the circumstances under which they are made.

B. A person who willfully or recklessly aids or abets a provider in the commission of any act prohibited by this section shall be liable as set out in subsection A of this section.

C. The Commission shall have no jurisdiction to adjudicate controversies concerning continuing care contracts. A breach of contract shall not be deemed a violation of this chapter. Termination of a contract pursuant to subsection A of this section shall not preclude the resident's seeking any other remedies available under any law.

§ 38.2-4912. Special provisions for existing providers; rights of residents with certain existing providers.—A. Providers existing prior to the effective date of this chapter shall comply with its provisions within six months of its effective date. However, the Commission may extend the period within which an existing facility shall comply with this chapter for an additional six months with good cause shown.

B. Continuing care contracts entered into prior to the effective date of this chapter or prior to registration of the provider shall be valid and binding upon both parties in accordance with their terms.

§ 38.2-4913. Regulations.—A. The Commission shall have the authority to adopt, amend or repeal rules and regulations that are reasonably necessary for the enforcement of the provisions of this chapter. The Commission may issue regulations setting forth those transactions which shall require the payment of fees by a provider and the fees which shall be charged.

B. Any provider may be given a reasonable time, not to exceed 120 days from the date of publication of any applicable rules and regulations or amendments thereto adopted pursuant to this chapter, within which to comply with the rules and standards.

Drafting Note: The deleted sentence will not be needed as this chapter will be effective prior to the adoption of Title 38.2.

§ 38.2-4914. Investigations and subpoenas.—A. The Commission may make public or private investigations within or outside of this Commonwealth it deems necessary to determine whether any person has violated any provision of this chapter or any rule, regulation or order promulgated by the Commission.

B. For the purpose of any investigation or proceeding under this chapter, the Commission or any officer designated by it may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of any books, papers, correspondence, memoranda, agreements or other documents or records which the Commission deems relevant or material to the inquiry.

§ 38.2-4915. Cease and desist orders; injunctions.—Whenever it appears to the Commission that any person has engaged in, or is about to engage in, any act or practice constituting a violation of this chapter or any rule, regulation or order issued under this chapter, the Commission may:

1. Issue an order directed at any such person requiring him to cease and desist from engaging in such act or practice.

2. Upon a proper showing, issue a permanent or temporary injunction, or a restraining order to enforce compliance with this chapter or any rule, regulation or order issued under this chapter.

§ 38.2-4916. Penalties.—A. Any person who willfully and knowingly violates any provision of this chapter, or any rule, regulation or order issued under this chapter, shall be subject to payment of a fine as provided in § 38.2-218.

B. Nothing in this chapter limits the power of the Commonwealth to punish any person for any conduct which constitutes a crime under any other statute.

Comparative Tables

Old Title 38.1	New Title 38.2
Chapter 1	
38.1-1	38.2-100
38.1-1(7)	38.2-4100
38.1-2	38.2-101
38.1-3	38.2-102
38.1-4	38.2-106
38.1-5	38.2-109
38.1-6	38.2-110
38.1-7	38.2-111
38.1-8	38.2-112
38.1-9	38.2-113
38.1-10	38.2-114
38.1-11	38.2-115
38.1-12	38.2-111 4
38.1-13	38.2-116
38.1-14	Repealed
38.1-15	38.2-117
38.1-16	38.2-118
38.1-17	38.2-119
38.1-18	38.2-120
	38.2-121
38.1-19	38.2-122
38.1-20	38.2-123

38.1-21

38.1-22

38.1-22.1

38.1-23

38.1-24

38.1-25

38.1-26

38.1-29

38.1-29.1

38.1-30

38.1-30.1

38.1-31

38.1-31.1

38.1-31.2

38.1-31.3

38.1-32

38.1-32.1

38.1-33

38.1-34

38.1-35

38.1-36

38.1-36.1

38.2-124

38.2-125

38.2-126

38.2-127

38.2-133

38.2-134

38.2-135

38.2-136

38.2-200

38.2-203

38.2-201

38.2-202

38.2-204

38.2-206

38.2-207

38.2-513 A 3

38.2-208

38.2-209

38.2-210

38.2-211

38.2-212

38.2-213

38.2-214

38.1-37	38.2-215
38.1-38	38.2-216
38.1-39	38.2-217
38.1-39.1	38.2-230
38.1-40	38.2-218
38.1-41	38.2-221
38.1-42	38.2-225
38.1-42.1	38.2-226
38.1-42.2	38.2-227
38.1-43	Repealed
38.1-43.1	38.2-900
38.1-43.2	38.2-901
38.1-43.3	38.2-902
38.1-43.4	38.2-903
38.1-43.5	38.2-904
38.1-43.6	Repealed
38.1-43.7	38.2-3420
38.1-43.8	38.2-3421
38.1-43.9	38.2-3422
38.1-43.10	38.2-3423
38.1-43.11	38.2-3424
38.1-44	38.2-400
38.1-44.1	38.2-401

38.1-45	38.2-403
38.1-46	38.2-404
38.1-47	38.2-405
38.1-48	38.2-406
38.1-48.1	38.2-402
38.1-48.2	38.2-407
38.1-48.2 B	38.2-402
38.1-48.3	38.2-408
38.1-48.4	38.2-409
38.1-48.5	38.2-410
38.1-48.6	38.2-411
38.1-48.7	38.2-412
38.1-48.8	Repealed
8.1-48.9	38.2-413
38.1-48.10	Repealed
38.1-49	38.2-500
38.1-50	38.2-501
38.1-51	Repealed
38.1-52	Repealed in 1980
38.1-52.1	38.2-502
38.1-52.2	38.2-503
38.1-52.3	38.2-504
38.1-52.4	38.2-505

38.1-52.5	38.2-506
38.1-52.6	38.2-507
38.1-52.7	38.2-508
38.1-52.8	38.2-509
38.1-52.9	38.2-510
38.1-52.10	38.2-511
38.1-52.11	38.2-512
38.1-52.12	38.2-513
38.1-52.13	38.2-514
38.1-52.14	Repealed in 1982
38.1-53	38.2-515
38.1-54	Repealed
38.1-55	Repealed
38.1-56	Repealed
38.1-56.1	Repealed
38.1-57	Repealed
38.1-57.1	Repealed
38.1-57.2	Repealed
38.1-57.3	38.2-600
38.1-57.4	38.2-601
38.1-57.5	38.2-602
38.1-57.6	38.2-603
38.1-57.7	38.2-604

38.1-57.8	38.2-605
38.1-57.9	38.2-606
38.1-57.10	38.2-607
38.1-57.11	38.2-608
38.1-57.12	38.2-609
38.1-57.13	38.2-610
38.1-57.14	38.2-611
38.1-57.15	38.2-612
38.1-57.16	38.2-613
38.1-57.17	38.2-614
38.1-57.18	38.2-615
38.1-57.19	38.2-616
38.1-57.20	Repealed
38.1-57.21	Repealed
38.1-57.22	Repealed
38.1-57.24	38.2-617
38.1-57.25	38.2-618
38.1-57.26	38.2-619
38.1-57.27	Repealed
38.1-57.28	38.2-620
38.1-58	38.2-700
38.1-59	38.2-701

38.1-60	38.2-702
38.1-61	38.2-703
38.1-62	38.2-704
Article 8	
38.1-63	Repealed
38.1-64	38.2-801
38.1-65	38.2-802
38.1-66	38.2-803
38.1-67	38.2-804
38.1-68	38.2-805
38.1-69	38.2-806
38.1-70	38.2-807
38.1-70.1	Repealed
38.1-70.2	38.2-809
38.1-70.3	38.2-810
38.1-70.4	38.2-811
38.1-70.9 through 38.1-70.12	Repealed in 1970
38.1-70.13	Repealed in 1976

Chapter 2

38.1-71	38.2-1000
38.1-72	Repealed
38.1-73	Repealed in 1977
38.1-74	38.2-1001
38.1-75	38.2-1002
38.1-76	38.2-1003
38.1-77	38.2-1004
38.1-79	38.2-1005
38.1-80	38.2-1017
38.1-81	38.2-1018
38.1-82	Repealed in 1956
38.1-83	38.2-1027
38.1-84	Repealed
38.1-85	38.2-1024
38.1-85.1	Repealed
38.1-86	38.2-1024
38.1-87	38.2-1026
38.1-88	38.2-1028
38.1-89	38.2-1033
38.1-90	38.2-1035
38.1-91	38.2-1032
38.1-92	38.2-1034

38.1-92.1	38.2-1034
38.1-93	38.2-1035
38.1-94	38.2-1029
38.1-95	38.2-1031
38.1-95.1	38.2-1030
38.1-96	38.2-1036
38.1-97	38.2-1037
38.1-97.1	Repealed
38.1-97.2	38.2-1038
38.1-98	38.2-1025
38.1-98.1	38.2-1039
38.1-99	38.2-1040
38.1-100	38.2-1041
38.1-101	38.2-1042
38.1-102	38.2-1043
38.1-103	38.2-1044
38.1-104	Repealed
38.1-105	Repealed
38.1-105.1	Repealed
38.1-106	Repealed
38.1-107	Repealed
38.1-108	38.2-1045
38.1-109	Repealed

38.1-110	38.2-1046
38.1-111	38.2-1047
38.1-112	38.2-1048
38.1-113	38.2-1049
38.1-114	38.2-1050
38.1-115	38.2-1051
38.1-116	38.2-1052
38.1-117	38.2-1053
38.1-118	38.2-1054
38.1-119	38.2-1055
38.1-120	38.2-1056
38.1-121	38.2-1057
38.1-122	38.2-1058
38.1-123	
through	Repealed in 1981
38.1-125	

Chapter 3

38.1-126	38.2-1500
38.1-127	38.2-1501
38.1-128	38.2-1502
38.1-129	38.2-1503
38.1-129(1)	38.2-1501

38.1-130
38.1-131
38.1-131.1
38.1-132
38.1-133
38.1-133.1
38.1-134
38.1-135
38.1-136
38.1-137
38.1-138
38.1-139
38.1-140
38.1-141
38.1-142
38.1-143
38.1-144
38.1-145

38.2-1504
38.2-1505
38.2-1506
38.2-1507
38.2-1508
38.2-1509
38.2-1510
38.2-1511
38.2-1512
38.2-1513
38.2-1514
38.2-1515
38.2-1516
38.2-1517
38.2-1518
38.2-1519
38.2-1520
38.2-1521

Chapter 4

38.1-159
38.1-160
38.1-161

38.2-1300
38.2-1301
38.2-1302

38.1-162
38.1-163
38.1-164
38.1-165
38.1-165.1
38.1-166
38.1-167
38.1-168
38.1-169
38.1-170
38.1-171
38.1-171.1
38.1-172
38.1-173
38.1-173.1
38.1-173.2
38.1-174
38.1-175
38.1-176
38.1-177
38.1-178
38.1-178.1
38.1-178.1:1

38.2-1303
38.2-1304
38.2-1305
38.2-1306
38.2-1810
38.2-1307
38.2-1308
38.2-1309
38.2-1310
38.2-1311
38.2-1312
38.2-1316
38.2-1313
38.2-1314
38.2-1315
38.2-1315
38.2-1317
38.2-1318
38.2-1319
38.2-1320
38.2-1321
38.2-1322
38.2-1323

38.1-178.1:2	38.2-1324
38.1-178.1:2(1)	38.2-1322
38.1-178.1:3	38.2-1325
38.1-178.1:4	38.2-1326
38.1-178.1:5	Repealed
38.1-178.1:6	38.2-1327
38.1-178.1:7	38.2-1328
38.1-178.2	38.2-1329
38.1-178.3	38.2-1330
38.1-178.3:1	38.2-1331
38.1-178.4	38.2-1332
38.1-178.5	38.2-1333
38.1-178.6	Repealed
38.1-178.7	Repealed
38.1-178.8	Repealed
38.1-178.9	38.2-1334
38.1-178.11	38.2-1335
38.1-178.12	38.2-1336
38.1-178.13	38.2-1337
38.1-178.14	38.2-1338
38.1-178.15	38.2-1339
38.1-178.16	Repealed
38.1-178.17	Repealed

38.1-178.18	Repealed
38.1-178.19	38.2-1340
Chapter 5	
38.1-179 through 38.1-217	Repealed in 1983
Chapter 5.1	
38.1-217.1	38.2-1400
38.1-217.2	38.2-1401
38.1-217.3	38.2-1402
38.1-217.4	38.2-1403
38.1-217.5	38.2-1404
38.1-217.6	38.2-1405
38.1-217.7	38.2-1406
38.1-217.8	38.2-1407
38.1-217.9	38.2-1408
38.1-217.10	38.2-1409
38.1-217.11	38.2-1410
38.1-217.12	38.2-1411
38.1-217.13	Repealed
38.1-217.14	Repealed

38.1-217.15	38.2-1412
38.1-217.16	38.2-1413
38.1-217.17	38.2-1414
38.1-217.18	38.2-1415
38.1-217.19	38.2-1416
38.1-217.20	38.2-1417
38.1-217.21	38.2-1418
38.1-217.22	38.2-1419
38.1-217.23	38.2-1420
38.1-217.24	38.2-1421
38.1-217.25	38.2-1422
38.1-217.26	38.2-1423
38.1-217.27	38.2-1424
38.1-217.28	38.2-1425
38.1-217.29	38.2-1426
38.1-217.30	38.2-1427
38.1-217.31	38.2-1428
38.1-217.32	38.2-1429
38.1-217.33	38.2-1430
38.1-217.34	38.2-1431
38.1-217.35	38.2-1432
38.1-217.36	38.2-1433
38.1-217.37	38.2-1434

38.1-217.38	38.2-1435
38.1-217.39	38.2-1436
38.1-217.40	38.2-1437
38.1-217.41	38.2-1438
38.1-217.42	38.2-1439
38.1-217.43	38.2-1440
38.1-217.44	38.2-1441
38.1-217.45	38.2-1443
38.1-217.46	38.2-1444
38.1-217.47	38.2-1445

Chapter 6

38.1-218	38.2-2000
38.1-219	38.2-100
38.1-220	38.2-2001
38.1-221 through 38.1-223	Repealed in 1972, 1973
38.1-224	38.2-2002
38.1-225 through 38.1-240	Repealed in 1972, 1973
38.1-241	38.2-2003

38.1-242	38.2-2004
38.1-243 through 38.1-248	Repealed in 1972, 1973
38.1-249	Repealed in 1976
38.1-250	Repealed in 1972,1973
38.1-251	Repealed
38.1-252	38.2-2005
38.1-253	38.2-2006
38.1-254	38.2-2007
38.1-255	38.2-2008
38.1-255.1	Repealed
38.1-255.2	38.2-2009
38.1-256 through 38.1-258	Repealed in 1972, 1973
38.1-259	38.2-2010
38.1-260	38.2-2011
38.1-261	3 .2-2012
38.1-262	38.2-2013
38.1-262.1	Repealed in 1972,1973
38.1-263	38.2-2014
38.1-264	38.2-2015

38.1-265	38.2-1317
38.1-266	38.2-2016
38.1-267	38.2-2017
38.1-268	38.2-2018
38.1-269	38.2-2019
38.1-270	38.2-2020
38.1-271	38.2-2021
38.1-272	38.2-2022
38.1-273	38.2-2023
38.1-274	38.2-2024
38.1-275	38.2-2025
38.1-276	38.2-2026
38.1-277	38.2-2027
38.1-278	Repealed
38.1-279	Repealed
Chapter 6.1	
38.1-279.1 through 38.1-279.28	Repealed in 1973
Chapter 6.2	
38.1-279.29	38.2-1900

38.1-279.30	38.2-1901
	38.2-100
38.1-279.31	38.2-1902
38.1-279.32	38.2-1903
38.1-279.33	38.2-1904
38.1-279.33.1	38.1-1905
38.1-279.34	38.2-1906
38.1-279.35	38.2-1907
38.1-279.36	38.2-1908
38.1-279.37	38.2-1909
38.1-279.38	38.2-1910
38.1-279.39	38.2-1911
38.1-279.40	38.2-1912
38.1-279.41	38.2-1913
38.1-279.42	38.2-1914
38.1-279.43	38.2-1915
38.1-279.44	Repealed in 1976
38.1-279.44:1	38.2-1916
38.1-279.44:2	Repealed
38.1-279.44:3	38.2-1917
38.1-279.45	38.2-1918
38.1-279.46	38.2-1919
38.1-279.47	38.2-1920

38.1-279.48	Repealed in 1976
38.1-279.48:1	38.2-317
38.1-279.49	38.2-1921
38.1-279.49:1	38.2-2118
38.1-279.50	38.2-1922
38.1-279.51	38.2-1923
38.1-279.52	38.2-1924
38.1-279.53	38.2-1925
38.1-279.54	38.2-1926
38.1-279.55	38.2-1927
38.1-279.56	38.2-1928
38.1-279.57	Repealed
Chapter 7	
38.1-280 through 38.1-285	Repealed in 1979
38.1-286	Repealed in 1960
38.1-287 through 38.1-294	Repealed in 1979
38.1-295	Repealed in 1977

38.1-295.1 through 38.1-301.5	Repealed in 1979
38.1-301.6	Repealed in 1960
38.1-301.7 through 38.1-325	Repealed in 1979
38.1-326	Repealed in 1977
38.1-327	Repealed in 1979

Chapter 7.1

38.1-327.1	38.2-1800
38.1-327.2	38.2-1801
38.1-327.3	38.2-1802
38.1-327.4	38.2-1803
38.1-327.5	38.2-1804
38.1-327.6	38.2-1805
38.1-327.7	38.2-1806
38.1-327.8	38.2-1808
38.1-327.9	38.2-1809
38.1-327.10	38.2-1811 38.2-205
38.1-327.11	38.2-1812

38.1-327.12	38.2-1813
38.1-327.13	Repealed in 1981
38.1-327.14	Repealed
38.1-327.15	38.2-1814
38.1-327.16	38.2-1816
38.1-327.17	38.2-1817
38.1-327.18	Repealed in 1985
38.1-327.19	38.2-1818
38.1-327.20	38.2-1819
38.1-327.21	38.2-1820
38.1-327.22	38.2-1821
38.1-327.23	Repealed in 1985
38.1-327.24(A)	38.2-1815
38.1-327.24(B)	Repealed
38.1-327.25	Repealed
38.1-327.26	Repealed in 1985
38.1-327.27	Repealed in 1985
38.1-327.28	Repealed
38.1-327.29	Repealed
38.1-327.30	Repealed
38.1-327.31	Repealed
38.1-327.32	Repealed in 1985
38.1-327.33	38.2-1822

38.1-327.34	38.2-1823
38.1-327.35	38.2-1824
38.1-327.36	38.2-1825
38.1-327.37	38.2-1826
38.1-327.38	38.2-1827
38.1-327.39	38.2-1828
38.1-327.40	38.2-1829
38.1-327.41	Repealed in 1985
38.1-327.42	38.2-1830
38.1-327.43	38.2-1831
38.1-327.44	38.2-1832
38.1-327.44:1	38.2-1833
38.1-327.44:2	38.2-1834
38.1-327.44:3	38.2-1835
38.1-327.45	38.2-1836
38.1-327.46	38.2-4800
38.1-327.47	38.2-4801
38.1-327.48	38.2-4802
38.1-327.49	38.2-4803
38.1-327.50	38.2-4804
38.1-327.51	38.2-4805
38.1-327.52	38.2-4806
38.1-327.53	38.2-4807

38.1-327.54	38.2-4809
38.1-327.55	38.2-4810
38.1-327.56	38.2-4811
38.1-327.57	38.2-4812
38.1-327.58	38.2-4813
38.1-327.59	38.2-4814
38.1-327.60	38.2-4815
38.1-327.61	Repealed
38.1-327.62	38.2-1837
38.1-327.63	38.2-1838
38.1-327.64	38.2-1839
38.1-327.65	38.2-1840
38.1-327.66	38.2-1841
38.1-327.67	38.2-1842
38.1-327.68	38.2-1843
38.1-327.69	38.2-1844
38.1-327.70	38.2-1845
38.1-327.71	Repealed

Chapter 8

38.1-328	38.2-300
38.1-329	38.2-301
38.1-330	38.2-302

38.1-331
38.1-332
38.1-333
38.1-334
38.1-335
38.1-335.1
38.1-335.2
38.1-336
38.1-337
38.1-338
38.1-339
38.1-340
38.1-341
38.1-342
38.1-342.1
38.1-342.2
38.1-343
38.1-344
38.1-345
38.1-346
38.1-346.1
38.1-347
38.1-347.1

38.2-303
38.2-304
38.2-305
38.2-306
38.2-307
38.2-308
38.2-2120
38.2-309
38.2-310
38.2-311
38.2-312
38.2-313
38.2-314
38.2-315
38.2-316
38.2-3405
38.2-318
38.2-319
38.2-320
38.2-3406
38.2-321
38.2-3400
38.2-3408

38.1-347.2	38.2-3407
38.1-348	38.2-3500
38.1-348.1	38.2-3409
38.1-348.2	38.2-3402
38.1-348.3	38.2-3403
38.1-348.4	38.2-3502
38.1-348.5	38.2-3410
38.1-348.6	38.2-3411
38.1-348.7	38.2-3412
38.1-348.8	38.2-3413
38.1-348.9	38.2-3414
38.1-348.10	38.2-3415
38.1-348.10:1	38.2-3416
38.1-348.11	38.2-3537
	38.2-3541
38.1-348.12	Repealed in 1981
38.1-348.12:1	38.2-3417
38.1-348.13	38.2-3418
38.1-348.14	38.2-3419
38.1-349	38.2-3503
38.1-349 (13)	38.2-3515
38.1-350	38.2-3504
38.1-351	38.2-3505

38.1-352	38.2-3506
38.1-353	38.2-3507
38.1-354	38.2-3508
38.1-354.1	38.2-3404
38.1-355	38.2-3509
38.1-356	38.2-3510
38.1-356.01	38.2-3542
38.1-356.1	38.2-1807
38.1-357	38.2-3511
38.1-358	38.2-3512
38.1-359	38.2-3513
38.1-360	38.2-3400
38.1-361	Repealed
38.1-361.1	38.2-3514
38.1-362	Repealed
38.1-362.1	
through	Repealed in
38.1-362.6	1979
38.1-362.7	38.2-3600
38.1-362.8	38.2-3501
38.1-362.8:1	38.2-3601
38.1-362.8:2	38.2-3602
38.1-362.8:3	38.2-3603

38.1-362.9	Repealed
38.1-362.10	Repealed
38.1-362.11	38.2-3516
38.1-362.12	38.2-3517
38.1-362.13	38.2-3518
38.1-362.13 C	38.2-3604
38.1-362.14	38.2-3519
38.1-362.15	38.2-3520
38.1-362.15 B	38.2-3605
38.1-362.16	38.2-3606
38.1-362.17	38.2-3607
38.1-363	38.2-2101
38.1-363.1	38.2-2102
38.1-364	38.2-2103
38.1-365	38.2-2104
38.1-366	38.2-2105
38.1-367	38.2-2104
	38.2-2106
38.1-367.1	38.2-2107
38.1-367.2	38.2-2108
38.1-368	38.2-2109
38.1-369	38.2-2110
38.1-370	38.2-2111

38.1-371	38.2-2112
38.1-371.1	38.2-2113
38.1-371.2	38.2-2114
38.1-372	38.2-2116
38.1-373	38.2-2117
38.1-374	38.2-2119
38.1-375	38.2-2121
38.1-376	38.2-2122
38.1-377	Repealed
38.1-378	38.2-2123
38.1-379	Repealed
38.1-379.1	38.2-3000
38.1-379.2	38.2-3001
38.1-379.3	Repealed
38.1-380	38.2-2200
38.1-380.1	38.2-2201
38.1-380.2	38.2-2202
38.1-380.3	38.2-2203
38.1-381 (a) - (a2)	38.2-2204
38.1-381 (a3) - (a4)	38.2-2205
38.1-381 (b) - (j)	38.2-2206
38.1-381 (i)	38.2-2207
38.1-381.1	38.2-2208

38.1-381.2

38.1-381.3

38.1-381.4

38.1-381.5

38.1-381.6

38.1-381.7

38.1-381.8

38.1-381.9

38.1-381.10

38.1-382

38.1-382.1

38.1-383

38.1-384

38.1-385

38.1-386

38.1-387

38.1-387.1

38.1-388

38.1-389

38.1-389.1

38.1-389.2

38.1-389.3

38.1-389.3:1

38.2-2209

38.2-2210

38.2-2211

38.2-2212

38.2-2213

38.2-2214

38.2-2215

38.2-2216

38.2-2217

38.2-2218

Repealed in 1981

38.2-2219

38.2-2220

38.2-2221

38.2-2222

38.2-2223

38.2-2224

38.2-2225

Repealed

38.2-2226

38.2-2227

Repealed in 1982

38.2-2228

38.1-389.4	38.2-2300
38.1-390	38.2-3300
38.1-390.1	38.2-3301
38.1-391	38.2-3302
38.1-392	38.2-3303
38.1-393	38.2-3304
38.1-394	38.2-3305
38.1-395	38.2-3306
38.1-396	38.2-3307
38.1-397	Repealed in 1981
38.1-397.1	38.2-3308
38.1-398	38.2-3309
38.1-399	38.2-3310
38.1-400	38.2-3311
38.1-401	38.2-3312
38.1-402	38.2-3313
38.1-403	38.2-3314
38.1-404	38.2-3315
38.1-405	38.2-3300
38.1-406	38.2-3316
	38.2-3338
38.1-407	38.2-3317
38.1-408	38.2-3114

38.1-408.1	38.2-3112
38.1-409	38.2-3340
38.1-410	38.2-3341
38.1-410.1	38.2-3342
38.1-411	38.2-3343
38.1-412	38.2-3344
38.1-413	38.2-3345
38.1-414	38.2-3346
38.1-415	38.2-3347
38.1-416	38.2-3348
38.1-417	38.2-3349
38.1-418	38.2-3350
38.1-419	38.2-3351
38.1-420	38.2-3352
38.1-421	38.2-3353
38.1-422	38.2-3354
38.1-424	38.2-3324
38.1-424.1	38.2-3325
38.1-425	38.2-3326
38.1-426	38.2-3327
38.1-426.1	38.2-3328
38.1-427	38.2-3329
38.1-427.1	38.2-3330

38.1-428	38.2-3331
38.1-428.1	38.2-3332
38.1-428.2	38.2-3333
38.1-428.3	38.2-3334
38.1-428.4	38.2-3331 B
38.1-429	38.2-3335
38.1-430	38.2-3336

Chapter 9

38.1-431	38.2-3100
38.1-432	38.2-3101
38.1-433	38.2-3102
38.1-434	38.2-3103
38.1-435	38.2-3104
38.1-436	38.2-3105
38.1-437	38.2-3106
38.1-438	38.2-3107
38.1-439	38.2-3108
38.1-440	38.2-3109
38.1-441	38.2-3110
38.1-442	38.2-3111
38.1-442.1	38.2-3112
38.1-443	38.2-3113
38.1-443.1	38.2-3115
38.1-444	38.2-3118

38.1-445
38.1-446
38.1-447
38.1-448
38.1-449
38.1-450
38.1-451
38.1-452
38.1-453
38.1-454
38.1-455
38.1-456
38.1-457
38.1-458
38.1-459
38.1-460
38.1-461
38.1-462
38.1-463
38.1-464
38.1-465

38.2-3119
38.2-3120
38.2-3121
38.2-3122
38.2-3123
38.2-3124
38.2-3125
38.2-3126
38.2-3127
38.2-3128
38.2-3129
38.2-3130
through
38.2-3142
38.2-3143
38.2-3144
38.2-3200
38.2-3201
38.2-3202
38.2-3203
38.2-3204
38.2-3205
38.2-3206

38.1-465.1	38.2-3207
38.1-465.2	38.2-3208
38.1-465.3	38.2-3209
38.1-465.4	38.2-3210
38.1-466	38.2-3211
38.1-466.1	38.2-3212
38.1-467	38.2-3213
38.1-468	38.2-3214
38.1-468.1	38.2-3215
38.1-468.2	38.2-3216
38.1-469	38.2-3217
38.1-470	38.2-3218
38.1-470.1	38.2-3219 through 38.2-3229
38.1-471	38.2-3319
38.1-471.1	38.2-3318 38.2-3321
38.1-472	Repealed
38.1-472.1	38.2-3323
38.1-473	Repealed in 1960
38.1-474	Repealed in 1960
38.1-475	Repealed

38.1-476	Repealed
38.1-476.1	Repealed
38.1-477	Repealed
38.1-477.1	Repealed in 1960
38.1-477.2	Repealed in 1960
38.1-478	Repealed in 1960
38.1-479	Repealed
38.1-480	38.2-3320 B
38.1-481	Repealed in 1960
38.1-482	38.2-3339
38.1-482.1	38.2-3700 38.2-3716
38.1-482.2	38.2-3701
38.1-482.2 (a)	38.2-103
38.1-482.2 (b)	38.2-109
38.1-482.2 (g)	38.2-1800
38.1-482.2 (h)	38.2-100
38.1-482.3	Repealed in 1982
38.1-482.3:1	38.2-3702
38.1-482.4	38.2-3703
38.1-482.4 (b)	38.2-3704

38.1-482.4:1	Repealed in 1985
38.1-482.4:2	38.2-3705
38.1-482.5	38.2-3706
38.1-482.6	38.2-3707
38.1-482.6 (d)	38.2-3708
38.1-482.6 (e), (f), (g)	38.2-3709
38.1-482.7	Repealed in 1982
38.1-482.7:1	38.2-3710
38.1-482.8	38.2-3711
38.1-482.9	38.2-3712
38.1-482.10	Repealed
38.1-482.11	38.2-3713
38.1-482.12	38.2-3714
38.1-482.12:1	38.2-3715
38.1-482.13	Repealed
38.1-482.14	Repealed in 1982
38.1-482.14:1	Repealed
38.1-482.15	Repealed
38.1-482.16	Repealed in 1982
38.1-482.16:2	Repealed

38.1-482.17	Repealed
38.1-482.18	38.2-1700
38.1-482.19	38.2-1701
38.1-482.20	38.2-1702
38.1-482.21	38.2-1703
38.1-482.22	38.2-1704
38.1-482.23	38.2-1705
38.1-482.24	38.2-1706
38.1-482.25	38.2-1707
38.1-482.26	38.2-1708
38.1-482.27	38.2-1709
38.1-482.28	38.2-1710
38.1-482.29	38.2-1711
38.1-482.30	38.2-1712
38.1-482.31	38.2-1713
38.1-482.32	38.2-1714
38.1-482.33	38.2-1715
38.1-483	38.2-3544
38.1-484	38.2-3545
38.1-485	38.2-3546
38.1-486	38.2-3547
38.1-487	38.2-3548

38.1-488	38.2-3549
38.1-489	38.2-1006
38.1-490	38.2-1007
38.1-491	38.2-1008
38.1-492	38.2-1009
38.1-493	38.2-1006
38.1-494	38.2-1010
38.1-495	38.2-1011
38.1-495.1	38.2-1012
38.1-495.2	38.2-1013
38.1-495.3	38.2-1014
38.1-495.4	38.2-1015
38.1-495.5	38.2-1016

Chapter 10

38.1-496	38.2-3800
38.1-497	38.2-3801
38.1-498	38.2-3802
38.1-499	38.2-3803
38.1-500	Repealed
38.1-501	Repealed
38.1-502	38.2-3804
38.1-503	38.2-3805

38.1-504	38.2-3806
38.1-505	38.2-3807
38.1-506	38.2-3808
38.1-507	38.2-3809
38.1-508	38.2-3810
38.1-509	Repealed
38.1-510	38.2-3811
38.1-511	38.2-3812
38.1-512	38.2-3813
38.1-513	Repealed
38.1-514	38.2-3814
38.1-515	38.2-3815
38.1-516	38.2-3816
38.1-517	38.2-3817
38.1-518	Repealed
38.1-519	38.2-3818
38.1-520	Repealed
38.1-521	Repealed
Chapter 11	
38.1-522 through 38.1-549	Repealed in 1985

Chapter 11.1

38.1-549.1	38.2-3900
38.1-549.2	38.2-3901
38.1-549.3	38.2-3902
38.1-549.4	38.2-3903
38.1-549.5	38.2-3904
38.1-549.6	38.2-3905
38.1-549.7	38.2-3906
38.1-549.8	38.2-3907
38.1-549.9	38.2-3908
38.1-549.10	38.2-3909
38.1-549.11	38.2-3910
38.1-549.12	38.2-3911
38.1-549.13	38.2-3912
38.1-549.14	38.2-3913
38.1-549.15	38.2-3914
38.1-549.16	38.2-3915
38.1-549.17	38.2-3916
38.1-549.18	38.2-3917
38.1-549.19	38.2-3918
38.1-549.20	38.2-3919
38.1-549.21	38.2-3920
38.1-549.22	38.2-3921

38.1-552	38.2-4002
38.1-549.23	38.2-3922
38.1-549.24	38.2-3923

Chapter 12

38.1-550	38.2-4000
38.1-551	38.2-4001
38.1-552	38.2-4002
38.1-553	38.2-4003
38.1-554	38.2-4004
38.1-555	Repealed
38.1-556	38.2-4005
38.1-556.1	Repealed
38.1-557	Repealed
38.1-558	38.2-4008
38.1-559	Repealed
38.1-560	38.2-4013
38.1-561	38.2-4019
38.1-562	38.2-4020
38.1-563	38.2-4021
38.1-564	Repealed
38.1-565	38.2-4022
38.1-566	Repealed
38.1-567	Repealed

38.1-568	Repealed
38.1-569 through 38.1-638	Repealed in 1968

Chapter 13.1

38.1-638.1	38.2-4100
38.1-638.2	38.2-4101 A
38.1-638.3	38.2-4102
38.1-638.4	38.2-4123
38.1-638.5	38.2-4135
38.1-638.6	38.2-4107
38.1-638.7	38.2-4113
	38.2-4114
38.1-638.8	38.2-4106 A
38.1-638.9	38.2-4124
38.1-638.10	38.2-4134
38.1-638.11	38.2-4110
38.1-638.12	38.2-4136
38.1-638.13	38.2-4102
38.1-638.14	38.2-4109
38.1-638.15	38.2-4109
38.1-638.16	38.2-4109

38.1-638.23	38.2-4129
38.1-638.17	38.2-4109
38.1-638.18	38.2-4109
38.1-638.19	38.2-4109
38.1-638.20	38.2-4127
38.1-638.21	38.2-4129
38.1-638.22	38.2-4129
38.1-638.23:1	Repealed
38.1-638.24	38.2-4130
38.1-638.25	38.2-4111
38.1-638.26	38.2-4108
38.1-638.27	38.2-4111
38.1-638.28	38.2-4105
	38.2-4119
38.1-638.29	38.2-4101 B
	38.2-4116 B
	38.2-4117 A
38.1-638.30	38.2-4119
38.1-638.31	38.2-4116
38.1-638.32	38.2-4117
38.1-638.33	38.2-4118
38.1-638.34	38.2-4120
38.1-638.35	38.2-4119 F

38.1-638.42	38.2-4122
38.1-638.36	38.2-4112
38.1-638.37	38.2-4132
38.1-638.38	38.2-4137
38.1-638.39	Repealed
38.1-638.40	Repealed
38.1-638.41	Repealed
38.1-638.43	38.2-4121
38.1-638.44	38.2-4126
38.1-638.45	38.2-4125
	38.2-4126
38.1-638.46	Repealed
38.1-638.47	38.2-4106
38.1-638.48	38.2-4128
38.1-638.49	38.2-4130
38.1-638.50	38.2-4128
	38.2-4131
38.1-638.51	38.2-4128
38.1-638.52	38.2-4131
38.1-638.53	38.2-4115 A
38.1-638.54	38.2-4115 B
38.1-638.55	38.2-4115 C
38.1-638.56	38.2-4115 D

38.1-638.57	38.2-4115 E
38.1-638.59	38.2-4115 G
38.1-638.60	38.2-4133
38.1-638.61	Repealed

Chapter 14

38.1-639	38.2-2400
38.1-640	38.2-2401
38.1-641	38.2-2403
38.1-642	38.2-2404
38.1-643	38.2-2405
38.1-644	38.2-2406
38.1-644.1	38.2-2407
38.1-644.2	38.2-2408
38.1-645	38.2-2409
38.1-646	38.2-2410
38.1-647	38.2-2411
38.1-648	38.2-2412
38.1-649	38.2-2413
38.1-650	38.2-2414
38.1-651	38.2-2415
38.1-652	Repealed

38.1-653	38.2-2416
38.1-654	38.2-2417
38.1-655	38.2-2418
38.1-656	38.2-2419
38.1-657	38.2-2420

Chapter 15

38.1-658	38.2-2500
38.1-659	38.2-2501
	38.2-2503
38.1-660	38.2-2502
	38.2-2503
38.1-661	38.2-2504
38.1-662	38.2-2506
38.1-663	Repealed
38.1-664	Repealed
38.1-665	Repealed
38.1-666	38.2-2508
38.1-667	38.2-2509
38.1-667.1	38.2-2510
38.1-668	38.2-2511
38.1-669	38.2-2512
38.1-669.1	38.2-2513
38.1-670	38.2-2513

38.1-670	38.2-2518
38.1-671	38.2-2514
38.1-672	38.2-2515
38.1-673	38.2-2516
38.1-674	38.2-2527
38.1-675	38.2-2528
38.1-676	38.2-2519
38.1-677	38.2-2518
38.1-678	38.2-2523
38.1-679	38.2-2518
38.1-680	38.2-2518
38.1-681	38.2-2524
38.1-681.1	38.2-1034
38.1-682	Repealed
38.1-683	38.2-2518
38.1-683.1	38.2-2520
38.1-684	38.2-2521
38.1-685	38.2-2522
38.1-686	Repealed
38.1-687	38.2-2505
38.1-687.1	Repealed
Chapter 16	
38.1-688	38.2-1200

38.1-695	38.2-1206
38.1-689	38.2-1201
38.1-690	38.2-1202
38.1-691	38.2-1203
38.1-692	38.2-1204
38.1-693	38.2-1204
38.1-694	38.2-1205
[illegible]	[illegible]
38.1-695.1	38.2-1207
38.1-696	38.2-1208
38.1-698	38.2-1209
38.1-699	38.2-1210
38.1-700	38.2-1223
38.1-700.1	38.2-1211
38.1-701	38.2-1224
38.1-702	38.2-1212
38.1-703	38.2-1213
38.1-704	38.2-1214
38.1-705	38.2-1215
38.1-706	38.2-1216
38.1-707	38.2-1217
38.1-708	38.2-1218
38.1-709	38.2-1219
38.1-710	38.2-1220

38.1-717	38.2-1220
38.1-711	38.2-1221
38.1-712	38.2-1222
38.1-713	38.2-1225
38.1-714	38.2-1226
38.1-715	38.2-1227
38.1-716	38.2-1212
[illegible]	38.2-1228
38.1-718	38.2-1229
38.1-719	Repealed

Chapter 17

38.1-720	38.2-4600
38.1-721	38.2-4601
38.1-722	38.2-4602
38.1-723	38.2-4603
38.1-724	38.2-4604
38.1-725	38.2-4605
38.1-726	38.2-4606
38.1-727	38.2-4607
38.1-728	38.2-4608
38.1-729	38.2-4609
38.1-730	38.2-4610
38.1-731	38.2-4611

38.1-735	38.2-4700
38.1-732	38.2-4612
38.1-733	38.2-4613
38.1-733.1	38.2-4614
38.1-734	38.2-4615
Chapter 18	
38.1-735	38.2-4700
38.1-736	38.2-4701
38.1-737	38.2-4702
38.1-738	38.2-4703
38.1-739	38.2-4704
38.1-740	Repealed in 1981
38.1-740.1	38.2-4705
38.1-740.2	38.2-4706
38.1-741	38.2-4707
38.1-742	38.2-4708
38.1-743	38.2-4709
38.1-744	38.2-4710
38.1-745	38.2-4711
	38.2-4712
Chapter 19	
38.1-746	38.2-2700

38.1-750	38.2-2708
38.1-747	38.2-2701
38.1-748	38.2-2702
	38.2-2704
	38.2-2705
38.1-748.1	38.2-2702
	38.2-2706
38.1-749	38.2-2707
[illegible]	[illegible]
38.1-751	38.2-2709
38.1-752	38.2-2710
38.1-753	38.2-2711
38.1-754	38.2-2712
38.1-755	Repealed in 1970
38.1-755.1	38.2-2713
Chapter 19.1	
38.1-756	Repealed
Chapter 20	
38.1-756.1	Repealed
38.1-757	38.2-1600
38.1-758	38.2-1601
38.1-759	38.2-1602
38.1-760	38.2-1603

38.1-761	38.2-1604
38.1-762	38.2-1605
38.1-763	38.2-1606
38.1-764	38.2-1607
38.1-765	38.2-1608
	38.2-1606
38.1-766	38.2-1609
38.1-767	38.2-1610
38.1-768	38.2-1611
38.1-769	38.2-1612
38.1-770	38.2-1613
38.1-771	38.2-1614
38.1-772	38.2-1615
38.1-773	38.2-1616
38.1-774	38.2-1617

Chapter 21

38.1-775	38.2-2800
38.1-776	38.2-2801
38.1-776.1	38.2-2802
38.1-776.2	38.2-2801
38.1-777	38.2-2803
38.1-778	38.2-2804

38.1-779	38.2-2805
38.1-780	38.2-2806
38.1-781	38.2-2807
38.1-782	38.2-2808
38.1-783	38.2-2809
38.1-784	38.2-2810
38.1-785	38.2-2811
38.1-786	38.2-2812
38.1-787	38.2-2813
38.1-788	38.2-2814
38.1-789	Repealed

Chapter 22

38.1-790	Repealed
38.1-791	38.2-4400
38.1-792	38.2-4402
38.1-793	38.2-4402
38.1-793.1	38.2-4403
38.1-794	38.2-4404
38.1-795	38.2-4405
38.1-796	38.2-4406
38.1-797	38.2-4407

	38.2-4401
38.1-798	38.2-4408
	38.2-4409
38.1-799	38.2-4410
38.1-800	38.2-4411
38.1-801	38.2-4412
38.1-802	38.2-4413
	38.2-4416
38.1-803	38.2-4414
38.1-804	38.2-4415
38.1-805	38.2-4417
38.1-806	Repealed
38.1-807	Repealed
38.1-808	Repealed
38.1-809	38.2-4418

Chapter 23

38.1-810	38.2-4202
38.1-811	38.2-4203
38.1-812	38.2-4204
38.1-813	Repealed in 1980
38.1-813.1	38.2-4200
38.1-813.2	38.2-4206

38.1-813.3	38.2-4207
38.1-813.4	38.2-4208
	38.2-4209
38.1-814	38.2-4210
38.1-815	38.2-4211
38.1-816	38.2-4208
	38.2-4212
	38.2-4213
38.1-817	38.2-4212
38.1-818	38.2-4214
	38.2-4215
38.1-818.1	Repealed
38.1-818.2	38.2-4216
38.1-819	38.2-4217
38.1-820	38.2-4218
38.1-821	38.2-4219
38.1-822	Repealed in 1980
38.1-822.1	Repealed in 1983
38.1-823	38.2-4220
38.1-824	38.2-4221
38.1-825	38.2-4222
38.1-826	38.2-4223
38.1-827	38.2-4224

38.1-824	Repealed in 1980
38.1-828	38.2-4225
	38.2-4226
38.1-829	38.2-4227
38.1-830	Repealed
38.1-831	Repealed
38.1-832	Repealed
38.1-833	38.2-4228
38.1-834	Repealed in 1980
Chapter 24	
38.1-835 through 38.1-848	Repealed in 1980
Chapter 25	
38.1-849 through 38.1-862	Repealed in 1980
Chapter 26	
38.1-863	38.2-4300
38.1-864	38.2-4301
38.1-865	38.2-4302

38.1-866	38.2-4303
38.1-867	38.2-4304
38.1-868	38.2-4305
38.1-869	38.2-4306
38.1-870	38.2-4307
38.1-871	Repealed in 1981
38.1-872	38.2-4308
38.1-873	38.2-4309
38.1-874	38.2-4310
38.1-875	38.2-4311
38.1-876	38.2-4312
38.1-877	38.2-4313
38.1-878	38.2-4314
38.1-879	38.2-4315
38.1-880	38.2-4316
38.1-881	38.2-4317
38.1-882	Repealed
38.1-883	38.2-4302
	38.2-4318
	38.2-4319
38.1-884	Repealed
38.1-885	Repealed
38.1-886	Repealed

38.1-887	38.2-4319
38.1-888	Repealed
38.1-889	38.2-4320
38.1-890	38.2-4321
38.1-891	Repealed
Chapter 27	
38.1-892	38.2-4502
38.1-894	38.2-4500
38.1-895	38.2-4504
38.1-896	38.2-4505
38.1-897	38.2-4506
	38.2-4507
38.1-898	38.2-4508
38.1-899	38.2-4509
38.1-900	38.2-4510
38.1-901	38.2-4511
38.1-902	38.2-4512
38.1-903	38.2-4513
	38.2-4514
38.1-904	38.2-4515
38.1-905	38.2-4516
38.1-906	38.2-4517

38.1-912	Repealed
38.1-907	38.2-4518
38.1-908	38.2-4519
38.1-909	38.2-4520
	38.2-4521
38.1-910	38.2-4522
38.1-911	Repealed
38.1-913	Repealed
38.1-914	38.2-4523

Chapter 28

38.1-915	Repealed
38.1-916	38.2-1100
38.1-917	38.2-1101
38.1-918	38.2-1102
38.1-919	38.2-1103
38.1-920	38.2-1104
38.1-921	38.2-1105
38.1-922	38.2-1106
38.1-923	Repealed
38.1-924	Repealed
38.1-925	Repealed
38.1-926	38.2-1107

38.1-931	Repealed
38.1-927	38.2-1603
38.1-928	38.2-1108
38.1-929	Repealed
38.1-930	38.2-1109

Chapter 29

38.1-932	38.2-2600
38.1-933	38.2-2603
38.1-933 B	38.2-2602
38.1-933 D	38.2-2601
38.1-934	38.2-2604
38.1-935	38.2-2605
38.1-936	38.2-2606
38.1-937	38.2-2607
38.1-938	38.2-2608
38.1-939	38.2-2609
38.1-940	38.2-2610
38.1-941	38.2-2611
38.1-942	38.2-2612
38.1-943	38.2-2613
38.1-944	38.2-2614
	38.2-2600

38.1-949	38.2-1019
38.1-945	38.2-2615
38.1-945 C	38.2-2602
38.1-946	Repealed
38.1-947	Repealed
38.1-948	Repealed

Chapter 30

38.1-949	38.2-1019
38.1-950	38.2-1020
38.1-951	38.2-1021
38.1-952	38.2-1022
38.1-953	38.2-1023
38.1-954	Repealed

Chapter 31

38.1-955	38.2-4900
38.1-956	38.2-4901
38.1-957	38.2-4902
38.1-958	38.2-4903
38.1-959	38.2-4904
38.1-960	38.2-4905
38.1-961	38.2-4906
38.1-962	38.2-4907

38.1-963	38.2-4908
38.1-964	38.2-4909
38.1-965	38.2-4910
38.1-966	38.2-4911
38.1-967	38.2-4912
38.1-968	38.2-4913
38.1-969	38.2-4914
38.1-970	38.2-4915
38.1-971	38.2-4916

#

Comparative Tables

New 38.2-102.2	Old Title 38.1
Chapter 1	
38.2-100	38.1-1
	38.1-362.12 (4)
	38.1-219
	38.1-279.30
38.2-101	38.1-2
38.2-102	38.1-3
38.2-103	38.1-482.2 (a)
38.2-104	38.1-409
38.2-105	new
38.2-106	38.1-4
38.2-107	new
38.2-108	38.1-482.2 (b)
38.2-109	38.1-5
38.2-110	38.1-6
38.2-111	38.1-7
38.2-111(4)	38.1-12
38.2-112	38.1-8
38.2-113	38.1-9
38.2-114	38.1-10
38.2-115	38.1-11
38.2-116	38.1-13
38.2-117	38.1-15
38.2-118	38.1-16

38.2-123	38.1-21
38.2-119	38.1-17
38.2-120	38.1-18 (3), (4)
38.2-121	38.1-18 (1), (2), (5)
38.2-122	38.1-19
38.2-123	38.1-20
38.2-124	38.1-21
38.2-125	38.1-21
38.2-126	38.1-22
38.2-127	38.1-22.1
38.2-128	new
38.2-129	new
38.2-130	new
38.2-131	new
38.2-132	new
38.2-133	38.1-23
38.2-134	38.1-24
38.2-135	38.1-25
38.2-136	38.1-26
Chapter 2	
38.2-200	38.1-29
38.2-201	38.1-30
38.2-202	38.1-30.1

38.2-204

38.2-205

38.2-206

38.2-207

38.2-208

38.2-209

38.2-210

38.2-211

38.2-212

38.2-213

38.2-214

38.2-215

38.2-216

38.2-217

38.2-218

38.2-219

38.1-31

38.1-327.10

38.1-31.1

38.1-31.2

38.1-32

38.1-32.1

38.1-33

38.1-34

38.1-35

38.1-36

38.1-36.1

38.1-37

38.1-38

38.1-39

38.1-40

38.1-178.7

38.1-60

through

38.1-62

38.1-54

38.1-55

38.1-178.17

38.2-221	38.1-41
	38.1-482.14:1
38.2-220	38.1-806
	38.1-830
	38.1-884
	38.1-911
	38.1-946
38.2-221	38.1-41
38.2-222	new
38.2-223	new
38.2-224	new
38.2-225	38.1-42
38.2-226	38.1-42.1
38.2-227	38.1-42.2
38.2-228	new
38.2-229	new
38.2-230	38.1-39.1

Chapter 3

38.2-300	38.1-328
38.2-301	38.1-329
38.2-302	38.1-330
38.2-303	38.1-331
38.2-304	38.1-332

38.2-305	38.1-333
38.2-306	38.1-334
38.2-307	38.1-335
38.2-308	38.1-335.1
38.2-309	38.1-336
38.2-310	38.1-337
38.2-311	38.1-338
38.2-312	38.1-339
38.2-313	38.1-340
38.2-314	38.1-341
38.2-315	38.1-342
38.2-316	38.1-342.1
38.2-317	38.1-279.48:1
38.2-318	38.1-343
38.2-319	38.1-344
38.2-320	38.1-345
38.2-321	38.1-346.1

Chapter 4

38.2-400	38.1-44
38.2-401	38.1-44.1
38.2-402	38.1-48.1
	38.1-48.2 B

38.2-409	38.1-48.4
38.2-403	38.1-45
38.2-404	38.1-46
38.2-405	38.1-47
38.2-406	38.1-48
38.2-407	38.1-48.2
38.2-408	38.1-48.3
38.2-410	38.1-48.5
38.2-411	38.1-48.6
38.2-412	38.1-48.7
38.2-413	38.1-48.9

Chapter 5

38.2-500	38.1-49
38.2-501	38.1-50
38.2-502	38.1-52.1
38.2-503	38.1-52.2
38.2-504	38.1-52.3
38.2-505	38.1-52.4
38.2-506	38.1-52.5
38.2-507	38.1-52.6
38.2-508	38.1-52.7
38.2-509	38.1-52.8

38.2-510	38.1-52.9
38.2-511	38.1-52.10
38.2-512	38.1-52.11
38.2-513	38.1-52.12
38.2-513 A 3	38.1-31.3
38.2-514	38.1-52.13
38.2-515	38.1-53 A

Chapter 6

38.2-600	38.1-57.3
38.2-601	38.1-57.4
38.2-602	38.1-57.5
38.2-603	38.1-57.6
38.2-604	38.1-57.7
38.2-605	38.1-57.8
38.2-606	38.1-57.9
38.2-607	38.1-57.10
38.2-608	38.1-57.11
38.2-609	38.1-57.12
38.2-610	38.1-57.13
38.2-611	38.1-57.14
38.2-612	38.1-57.15
38.2-613	38.1-57.16

38.2-614	38.1-57.17
38.2-615	38.1-57.18
38.2-616	38.1-57.19
38.2-617	38.1-57.24
38.2-618	38.1-57.25
38.2-619	38.1-57.26
38.2-620	38.1-57.28
Chapter 7	
38.2-700	38.1-58
38.2-701	38.1-59
38.2-702	38.1-60
38.2-703	38.1-61
38.2-704	38.1-62
38.2-705	new
Chapter 8	
38.2-800	new
38.2-801	38.1-64
38.2-802	38.1-65
38.2-803	38.1-66
38.2-804	38.1-67
38.2-805	38.1-68

38.2-806	38.1-69
38.2-807	38.1-70
38.2-808	new
38.2-809	38.1-70.2
38.2-810	38.1-70.3
38.2-811	38.1-70.4
Chapter 9	
38.2-900	38.1-43.1
38.2-901	38.1-43.2
38.2-902	38.1-43.3
38.2-903	38.1-43.4
38.2-904	38.1-43.5
Chapter 10	
38.2-1000	38.1-71
38.2-1001	38.1-74
38.2-1002	38.1-75
38.2-1003	38.1-76
38.2-1004	38.1-77
38.2-1005	38.1-79
38.2-1006	38.1-489
	38.1-493

38.2-1007	38.1-490
38.2-1008	38.1-491
38.2-1009	38.1-492
38.2-1010	38.1-494
38.2-1011	38.1-495
38.2-1012	38.1-495.1
38.2-1013	38.1-495.2
38.2-1014	38.1-495.3
38.2-1015	38.1-495.4
38.2-1016	38.1-495.5
38.2-1017	38.1-80
38.2-1018	38.1-81
38.2-1019	38.1-949
38.2-1020	38.1-950
38.2-1021	38.1-951
38.2-1022	38.1-952
38.2-1023	38.1-953
38.2-1024	38.1-85
	38.1-86
38.2-1025	38.1-98
38.2-1026	38.1-87
38.2-1027	38.1-83
38.2-1028	38.1-88

38.2-1034	38.1-92
	38.1-89
38.2-1029	38.1-94
38.2-1030	38.1-95.1
38.2-1031	38.1-95
38.2-1032	38.1-91
38.2-1033	38.1-89
38.2-1034	38.1-92
	38.1-92.1
38.2-1035	38.1-90
	38.1-93
38.2-1036	38.1-96
38.2-1037	38.1-97
38.2-1038	38.1-97.2
38.2-1039	38.1-98.1
38.2-1040	38.1-99
38.2-1041	38.1-100
38.2-1042	38.1-101
38.2-1043	38.1-102
38.2-1044	38.1-103
38.2-1045	38.1-108
38.2-1046	38.1-110
38.2-1047	38.1-111
38.2-1048	38.1-112

38.2-1055	38.1-119
38.2-1049	38.1-113
38.2-1050	38.1-114
38.2-1051	38.1-115
38.2-1052	38.1-116
38.2-1053	38.1-117
38.2-1054	38.1-118
--	--
38.2-1056	38.1-120
38.2-1057	38.1-121
38.2-1058	38.1-122

Chapter 11

38.2-1100	38.1-916
38.2-1101	38.1-917
38.2-1102	38.1-918
38.2-1103	38.1-919
38.2-1104	38.1-920
38.2-1105	38.1-921
38.2-1106	38.1-922
38.2-1107	38.1-926
38.2-1108	38.1-928
38.2-1109	38.1-930

Chapter 12

38.2-1200	38.1-688
38.2-1201	38.1-689
38.2-1202	38.1-690
38.2-1203	38.1-691
38.2-1204	38.1-692
	38.1-693
38.2-1205	38.1-694
38.2-1206	38.1-695
38.2-1207	38.1-695.1
38.2-1208	38.1-696
38.2-1209	38.1-698
38.2-1210	38.1-699
38.2-1211	38.1-700.1
38.2-1212	38.1-702
	38.1-716
38.2-1213	38.1-703
38.2-1214	38.1-704
38.2-1215	38.1-705
38.2-1216	38.1-706
38.2-1217	38.1-707
38.2-1218	38.1-708
38.2-1219	38.1-709

38.2-1220	38.1-710
38.2-1221	38.1-711
38.2-1222	38.1-712
38.2-1223	38.1-700
38.2-1224	38.1-701
38.2-1225	38.1-713
38.2-1226	38.1-714
38.2-1228	38.1-717
38.2-1229	38.1-718

Chapter 13

38.2-1300	38.1-159
38.2-1301	38.1-160
38.2-1302	38.1-161
38.2-1303	38.1-162
38.2-1304	38.1-163
38.2-1305	38.1-164
38.2-1306	38.1-165
38.2-1307	38.1-166
38.2-1308	38.1-167
38.2-1309	38.1-168
38.2-1310	38.1-169

38.2-1311

38.2-1312

38.2-1313

38.2-1314

38.2-1315

38.2-1316

38.2-1317

38.2-1318

38.2-1319

38.2-1320

38.2-1321

38.2-1322

38.2-1323

38.2-1324

38.2-1325

38.2-1326

38.2-1327

38.2-1328

38.2-1329

38.2-1330

38.2-1331

38.1-170

38.1-171

38.1-172

38.1-173

38.1-173.1

38.1-173.2

38.1-171.1

38.1-174

38.1-175

38.1-176

38.1-177

38.1-178

38.1-178.1

38.1-178.1:2 (1)

38.1-178.1:1

38.1-178.1:2

38.1-178.1:3

38.1-178.1:4

38.1-178.1:6

38.1-178.1:7

38.1-178.2

38.1-178.3

38.1-178.3:1

38.2-1332	38.1-178.4
38.2-1333	38.1-178.5
38.2-1334	38.1-178.9
38.2-1335	38.1-178.11
38.2-1336	38.1-178.12
38.2-1337	38.1-178.13
38.2-1338	38.1-178.14
38.2-1339	38.1-178.15
38.2-1340	38.1-178.19

Chapter 14

38.2-1400	38.1-217.1
38.2-1401	38.1-217.2
38.2-1402	38.1-217.3
38.2-1403	38.1-217.4
38.2-1404	38.1-217.5
38.2-1405	38.1-217.6
38.2-1406	38.1-217.7
38.2-1407	38.1-217.8
38.2-1408	38.1-217.9
38.2-1409	38.1-217.10
38.2-1410	38.1-217.11
38.2-1411	38.1-217.12

38.2-1412	38.1-217.15
38.2-1413	38.1-217.16
38.2-1414	38.1-217.17
38.2-1415	38.1-217.18
38.2-1416	38.1-217.19
38.2-1417	38.1-217.20
38.2-1418	38.1-217.21
38.2-1419	38.1-217.22
38.2-1420	38.1-217.23
38.2-1421	38.1-217.24
38.2-1422	38.1-217.25
38.2-1423	38.1-217.26
38.2-1424	38.1-217.27
38.2-1425	38.1-217.28
38.2-1426	38.1-217.29
38.2-1427	38.1-217.30
38.2-1428	38.1-217.31
38.2-1429	38.1-217.32
38.2-1430	38.1-217.33
38.2-1431	38.1-217.34
38.2-1432	38.1-217.35
38.2-1433	38.1-217.36
38.2-1434	38.1-217.37

38.2-1435	38.1-217.38
38.2-1436	38.1-217.39
38.2-1437	38.1-217.40
38.2-1438	38.1-217.41
38.2-1439	38.1-217.42
38.2-1440	38.1-217.43
38.2-1441	38.1-217.44
38.2-1442	new
38.2-1443	38.1-217.45
38.2-1444	38.1-217.46
38.2-1445	38.1-217.47

Chapter 15

38.2-1500	38.1-126
38.2-1501	38.1-127
38.2-1502	38.1-128
38.2-1503	38.1-129
38.2-1504	38.1-130
38.2-1505	38.1-131
38.2-1506	38.1-131.1
38.2-1507	38.1-132
38.2-1508	38.1-133
38.2-1509	38.1-133.1

38.2-1510	38.1-134
38.2-1511	38.1-135
38.2-1512	38.1-136
38.2-1513	38.1-137
38.2-1514	38.1-138
38.2-1515	38.1-139
38.2-1516	38.1-140
38.2-1517	38.1-141
38.2-1518	38.1-142
38.2-1519	38.1-143
38.2-1520	38.1-144
38.2-1521	38.1-145

Chapter 16

38.2-1600	38.1-757
38.2-1601	38.1-758
38.2-1602	38.1-759
38.2-1603	38.1-760
38.2-1604	38.1-761
38.2-1605	38.1-762
38.2-1606	38.1-763
	38.1-765
38.2-1607	38.1-764

38.2-1608	38.1-765
38.2-1609	38.1-766
38.2-1610	38.1-767
38.2-1611	38.1-768
38.2-1612	38.1-769
38.2-1613	38.1-770
38.2-1614	38.1-771
38.2-1615	38.1-772
38.2-1616	38.1-773
38.2-1617	38.1-774

Chapter 17

38.2-1700	38.1-482.18
38.2-1701	38.1-482.19
38.2-1702	38.1-482.20
38.2-1703	38.1-482.21
38.2-1704	38.1-482.22
38.2-1705	38.1-482.23
38.2-1706	38.1-482.24
38.2-1707	38.1-482.25
38.2-1708	38.1-482.26
38.2-1709	38.1-482.27
38.2-1710	38.1-482.28

38.2-1711	38.1-482.29
38.2-1712	38.1-482.30
38.2-1713	38.1-482.31
38.2-1714	38.1-482.32
38.2-1715	38.1-482.33

Chapter 18

38.2-1800	38.1-327.1
38.2-1801	38.1-327.2
38.2-1802	38.1-327.3
38.2-1803	38.1-327.4
38.2-1804	38.1-327.5
38.2-1805	38.1-327.6
38.2-1806	38.1-327.7
38.2-1807	38.1-356.1 A
38.2-1808	38.1-327.8
38.2-1809	38.1-327.9
38.2-1810	38.1-165.1
38.2-1811	38.1-327.10
38.2-1812	38.1-327.11
38.2-1813	38.1-327.12
38.2-1814	38.1-327.15
38.2-1815	38.1-327.24 A

38.2-1816	38.1-327.16
38.2-1817	38.1-327.17
38.2-1818	38.1-327.19
38.2-1819	38.1-327.20
38.2-1820	38.1-327.21
38.2-1821	38.1-327.22
38.2-1822	38.1-327.33
38.2-1823	38.1-327.34
38.2-1824	38.1-327.35
38.2-1825	38.1-327.36
38.2-1826	38.1-327.37
38.2-1827	38.1-327.38
38.2-1828	38.1-327.39
38.2-1829	38.1-327.40
38.2-1830	38.1-327.42
38.2-1831	38.1-327.43
38.2-1832	38.1-327.44
38.2-1833	38.1-327.44:1
38.2-1834	38.1-327.44:2
38.2-1835	38.1-327.44:3
38.2-1836	38.1-327.45
38.2-1837	38.1-327.62
38.2-1838	38.1-327.63

38.2-1839	38.1-327.64
38.2-1840	38.1-327.65
38.2-1841	38.1-327.66
38.2-1842	38.1-327.67
38.2-1843	38.1-327.68
38.2-1844	38.1-327.69
38.2-1845	38.1-327.70

Chapter 19

38.2-1900	38.1-279.29
38.2-1901	38.1-279.30
	38.1-279.40 (a)
38.2-1902	38.1-279.31
38.2-1903	38.1-279.32
38.2-1904	38.1-279.33
38.2-1905	38.1-279.33:1
38.2-1906	38.1-279.34
38.2-1907	38.1-279.35
38.2-1908	38.1-279.36
38.2-1909	38.1-279.37
38.2-1910	38.1-279.38
38.2-1911	38.1-279.39
38.2-1912	38.1-279.40

38.2-1913	38.1-279.41
38.2-1914	38.1-279.42
38.2-1915	38.1-279.43
38.2-1916	38.1-279.44:1
38.2-1917	38.1-279.44:3
38.2-1918	38.1-279.45
38.2-1919	38.1-279.46
38.2-1920	38.1-279.47
38.2-1921	38.1-279.49
38.2-1922	38.1-279.50
38.2-1923	38.1-279.51
38.2-1924	38.1-279.52
38.2-1925	38.1-279.53
38.2-1926	38.1-279.54
38.2-1927	38.1-279.55
38.2-1928	38.1-279.56

Chapter 20

38.2-2000	38.1-218
38.2-2001	38.1-220
38.2-2002	38.1-224
38.2-2002 A	38.1-279.43
38.2-2003	38.1-241

38.2-2004	38.1-242
38.2-2005	38.1-252
38.2-2006	38.1-253
38.2-2007	38.1-254
38.2-2008	38.1-255
38.2-2009	38.1-255.2
38.2-2010	38.1-259
38.2-2011	38.1-260
38.2-2012	38.1-261
38.2-2013	38.1-262
38.2-2014	38.1-263
38.2-2015	38.1-264
38.2-2016	38.1-266
38.2-2017	38.1-267
38.2-2018	38.1-268
38.2-2019	38.1-269
38.2-2020	38.1-270
38.2-2021	38.1-271
38.2-2022	38.1-272
38.2-2023	38.1-273
38.2-2024	38.1-274
38.2-2025	38.1-275
38.2-2026	38.1-276
38.2-2027	38.1-277

Chapter 21

38.2-2100	new
38.2-2101	38.1-363
38.2-2102	38.1-363.1
38.2-2103	38.1-364
38.2-2104	38.1-365
	38.1-367
38.2-2105	38.1-366
38.2-2106	38.1-367
38.2-2107	38.1-367.1
38.2-2108	38.1-367.2
38.2-2109	38.1-368
38.2-2110	38.1-369
38.2-2111	38.1-370
38.2-2112	38.1-371
38.2-2113	38.1-371.1
38.2-2114	38.1-371.2
38.2-2115	new
38.2-2116	38.1-372
38.2-2117	38.1-373
38.2-2118	38.1-279.49:1
38.2-2119	38.1-374
38.2-2120	38.1-335.2

38.2-2121	38.1-375
38.2-2122	38.1-376
38.2-2123	38.1-378

Chapter 22

38.2-2200	38.1-380
38.2-2201	38.1-380.1
38.2-2202	38.1-380.2
38.2-2203	38.1-380.3
38.2-2204	38.1-381 (a)-(a2)
38.2-2205	38.1-381 (a3)-(a4)
38.2-2206	38.1-381 (b)-(j)
38.2-2207	38.1-381 (i)
38.2-2208	38.1-381.1
38.2-2209	38.1-381.2
38.2-2210	38.1-381.3
38.2-2211	38.1-381.4
38.2-2212	38.1-381.5
38.2-2213	38.1-381.6
38.2-2214	38.1-381.7
38.2-2215	38.1-381.8
38.2-2216	38.1-381.9
38.2-2217	38.1-381.10

38.2-2218	38.1-382
38.2-2219	38.1-383
38.2-2220	38.1-384
38.2-2221	38.1-385
38.2-2222	38.1-386
38.2-2223	38.1-387
38.2-2224	38.1-387.1
38.2-2225	38.1-388
38.2-2226	38.1-389.1
38.2-2227	38.1-389.2
38.2-2228	38.1-389.3:1
Chapter 23	
38.2-2300	38.1-389.4
Chapter 24	
38.2-2400	38.1-639
38.2-2401	38.1-640
38.2-2402	new
38.2-2403	38.1-641
38.2-2404	38.1-642
38.2-2405	38.1-643
38.2-2406	38.1-644

38.2-2407	38.1-644.1
38.2-2408	38.1-644.2
38.2-2409	38.1-645
38.2-2410	38.1-646
38.2-2411	38.1-647
38.2-2412	38.1-648
38.2-2413	38.1-649
38.2-2414	38.1-650
38.2-2415	38.1-651
38.2-2416	38.1-653
38.2-2417	38.1-654
38.2-2418	38.1-655
38.2-2419	38.1-656
38.2-2420	38.1-657

Chapter 25

38.2-2500	38.1-658
38.2-2501	38.1-659
38.2-2502	38.1-660
38.2-2503	38.1-659
38.2-2504	38.1-661
38.2-2505	38.1-687
38.2-2506	38.1-662

	38.1-91
38.2-2507	new
38.2-2508	38.1-666
38.2-2509	38.1-667
38.2-2510	38.1-667.1
38.2-2511	38.1-668
38.2-2512	38.1-669
38.2-2513	38.1-669.1
	38.1-670
38.2-2514	38.1-671
38.2-2515	38.1-672
38.2-2516	38.1-673
38.2-2517	new
38.2-2518	38.1-677
38.2-2519	38.1-676
38.2-2520	38.1-683.1
38.2-2521	38.1-684
38.2-2522	38.1-685
38.2-2323	38.1-678
38.2-2524	38.1-681
38.2-2525	new
38.2-2526	new
38.2-2527	new

38.2-2528	38.1-675
38.2-2529	new

Chapter 26

38.2-2600	38.1-932
	38.1-944
38.2-2601	38.1-933 D
38.2-2602	38.1-933 B
	38.1-945 C
38.2-2603	38.1-933 A
38.2-2604	38.1-934
38.2-2605	38.1-935
38.2-2606	38.1-936
38.2-2607	38.1-937
38.2-2608	38.1-938
38.2-2609	38.1-939
38.2-2610	38.1-940
38.2-2611	38.1-941
38.2-2612	38.1-942
38.2-2613	38.1-943
38.2-2614	38.1-944
38.2-2615	38.1-945

Chapter 27

38.2-2700	38.1-746
38.2-2701	38.1-747
38.2-2702	38.1-748
	38.1-748.1
38.2-2703	new
38.2-2704	38.1-748
38.2-2705	38.1-748
38.2-2706	38.1-748.1
38.2-2707	38.1-749
38.2-2708	38.1-750
38.2-2709	38.1-751
38.2-2710	38.1-752
38.2-2711	38.1-753
38.2-2712	38.1-754
38.2-2713	38.1-755.1

Chapter 28

38.2-2800	38.1-775
38.2-2801	38.1-776
	38.1-776.2
38.2-2802	38.1-776.1
38.2-2803	38.1-777

38.2-2804	38.1-778
38.2-2805	38.1-779
38.2-2806	38.1-780
38.2-2807	38.1-781
38.2-2808	38.1-782
38.2-2809	38.1-783
38.2-2810	38.1-784
38.2-2811	38.1-785
38.2-2812	38.1-786
38.2-2813	38.1-787
38.2-2814	38.1-788

Chapter 29

38.2-2900 et seq.	Reserved

Chapter 30

38.2-3000	38.1-379.1
38.2-3001	38.1-379.2

Chapter 31

38.2-3100	38.1-431
38.2-3101	38.1-432
38.2-3102	38.1-433
38.2-3103	38.1-434

38.2-3104	38.1-435
38.2-3105	38.1-436
38.2-3106	38.1-437
38.2-3107	38.1-438
38.2-3108	38.1-439
38.2-3109	38.1-440
38.2-3110	38.1-441
38.2-3111	38.1-442
38.2-3112	38.1-408.1
	38.1-442.1
38.2-3113	38.1-443
38.2-3114	38.1-408
38.2-3115	38.1-443.1
38.2-3116	new
38.2-3117	new
38.2-3118	38.1-444
38.2-3119	38.1-445
38.2-3120	38.1-446
38.2-3121	38.1-447
38.2-3122	38.1-448
38.2-3123	38.1-449
38.2-3124	38.1-450
38.2-3125	38.1-451

38.2-3126	38.1-452
38.2-3127	38.1-453
38.2-3128	38.1-454
38.2-3129	38.1-455
38.2-3130	
through	38.1-456
38.2-3142	
38.2-3143	38.1-457
38.2-3144	38.1-458
Chapter 32	
38.2-3200	38.1-459
38.2-3201	38.1-460
38.2-3202	38.1-461
38.2-3203	38.1-462
38.2-3204	38.1-463
38.2-3205	38.1-464
38.2-3206	38.1-465
38.2-3207	38.1-465.1
38.2-3208	38.1-465.2
38.2-3209	38.1-465.3
38.2-3210	38.1-465.4
38.2-3211	38.1-466

38.2-3212	38.1-466.1
38.2-3213	38.1-467
38.2-3214	38.1-468
38.2-3215	38.1-468.1
38.2-3216	38.1-468.2
38.2-3217	38.1-469
38.2-3218	38.1-470
38.2-3219	
through	38.1-470.1
38.2-3229	

Chapter 33

38.2-3300	38.1-390
	38.1-405
38.2-3301	38.1-390.1
38.2-3302	38.1-391
38.2-3303	38.1-392
38.2-3304	38.1-393
38.2-3305	38.1-394
38.2-3306	38.1-395
38.2-3307	38.1-396
38.2-3308	38.1-397.1
38.2-3309	38.1-398

38.2-3310	38.1-399
38.2-3311	38.1-400
38.2-3312	38.1-401
38.2-3313	38.1-402
38.2-3314	38.1-403
38.2-3315	38.1-404
38.2-3316	38.1-406
38.2-3317	38.1-407
38.2-3318	38.1-471.1
	38.1-480
38.2-3319	38.1-471
38.2-3320	38.1-480
38.2-3321	38.1-471.1 (4)
38.2-3322	new
38.2-3323	38.1-472.1
38.2-3324	38.1-424
38.2-3325	38.1-424.1
38.2-3326	38.1-425
38.2-3327	38.1-426
38.2-3328	38.1-426.1
38.2-3329	38.1-427
38.2-3330	38.1-427.1
38.2-3331	38.1-428

	38.1-428.4
38.2-3332	38.1-428.1
38.2-3333	38.1-428.2
38.2-3334	38.1-428.3
38.2-3335	38.1-429
38.2-3336	38.1-430
38.2-3337	38.1-424
38.2-3338	38.1-406
38.2-3339	38.1-482
38.2-3340	38.1-409
38.2-3341	38.1-410
38.2-3342	38.1-410.1
38.2-3343	38.1-411
38.2-3344	38.1-412
38.2-3345	38.1-413
38.2-3346	38.1-414
38.2-3347	38.1-415
38.2-3348	38.1-416
38.2-3349	38.1-417
38.2-3350	38.1-418
38.2-3351	38.1-419
38.2-3352	38.1-420
38.2-3353	38.1-421

38.2-3354	38.1-422
Chapter 34	
38.2-3400	38.1-347
	38.1-360
38.2-3401	new
38.2-3402	38.1-348.2
38.2-3403	38.1-348.3
38.2-3404	38.1-354.1
38.2-3405	38.1-342.2
38.2-3406	38.1-346
38.2-3407	38.1-347.2
38.2-3408	38.1-347.1
38.2-3409	38.1-348.1
38.2-3410	38.1-348.5
38.2-3411	38.1-348.6
38.2-3412	38.1-348.7
38.2-3413	38.1-348.8
38.2-3414	38.1-348.9
38.2-3415	38.1-348.10
38.2-3416	38.1-348.10:1
38.2-3417	38.1-348.12:1
38.2-3418	38.1-348.13

38.2-3419	38.1-348.14
38.2-3420	38.1-43.7
38.2-3421	38.1-43.8
38.2-3422	38.1-43.9
38.2-3423	38.1-43.10
38.2-3424	38.1-43.11

Chapter 35

38.2-3500	38.1-348
38.2-3501	38.1-362.8
38.2-3502	38.1-348.4
38.2-3503	38.1-349
38.2-3504	38.1-350
38.2-3505	38.1-351
38.2-3506	38.1-352
38.2-3507	38.1-353
38.2-3508	38.1-354
38.2-3509	38.1-355
38.2-3510	38.1-356
38.2-3511	38.1-357
38.2-3512	38.1-358
38.2-3513	38.1-359
38.2-3514	38.1-361.1

38.2-3515	38.1-349 (13)
38.2-3516	38.1-362.11
38.2-3517	38.1-362.12
38.2-3518	38.1-362.13
38.2-3519	38.1-362.14
38.2-3520	38.1-362.15 A
38.2-3521	new
38.2-3522	new
38.2-3523	new
38.2-3524	new
38.2-3525	new
38.2-3526	new
38.2-3527	new
38.2-3528	new
38.2-3529	new
38.2-3530	new
38.2-3531	new
38.2-3532	new
38.2-3533	new
38.2-3534	new
38.2-3535	new
38.2-3536	new
38.2-3537	new

38.2-3538	new
38.2-3539	new
38.2-3540	new
38.2-3541	38.1-348.11
38.2-3542	38.1-356.01
38.2-3543	new
38.2-3544	38.1-483
38.2-3545	38.1-484
38.2-3546	38.1-485
38.2-3547	38.1-486
38.2-3548	38.1-487
38.2-3549	38.1-488
38.2-3550	new

Chapter 36

38.2-3600	38.1-362.7 B
38.2-3601	38.1-362.8:1
38.2-3602	38.1-362.8:2
38.2-3603	38.1-362.8:3
38.2-3604	38.1-362.13 C
38.2-3605	38.1-362.15 B
38.2-3606	38.1-362.16
38.2-3607	38.1-362.17 A

Chapter 37

38.2-3700	38.1-482.1
38.2-3701	38.1-482.2
38.2-3702 A	38.1-482.3:1
38.2-3702 B	38.1-480
38.2-3703	38.1-482.4
38.2-3704	38.1-482.4 (b)
38.2-3705	38.1-482.4:2
38.2-3706	38.1-482.5
38.2-3707	38.1-482.6
38.2-3708	38.1-482.6 (d)
38.2-3709	38.1-482.6 (e) (f) (g)
38.2-3710	38.1-482.7:1
38.2-3711	38.1-482.8
38.2-3712	38.1-482.9
38.2-3713	38.1-482.11
38.2-3714	38.1-482.12
38.2-3715	38.1-482.12:1
38.2-3716	38.1-482.1

Chapter 38

38.2-3800	38.1-496
38.2-3801	38.1-497

38.2-3802	38.1-498
38.2-3803	38.1-499
38.2-3804	38.1-502
38.2-3805	38.1-503
38.2-3806	38.1-504
38.2-3807	38.1-505
38.2-3808	38.1-506
38.2-3809	38.1-507
38.2-3810	38.1-508
38.2-3811	38.1-510
38.2-3812	38.1-511
38.2-3813	38.1-512
38.2-3814	38.1-514
38.2-3815	38.1-515
38.2-3816	38.1-516
38.2-3817	38.1-517
38.2-3818	38.1-519

Chapter 39

38.2-3900	38.1-549.1
38.2-3901	38.1-549.2
38.2-3902	38.1-549.3
38.2-3903	38.1-549.4

38.2-3904	38.1-549.5
38.2-3905	38.1-549.6
38.2-3906	38.1-549.7
38.2-3907	38.1-549.8
38.2-3908	38.1-549.9
38.2-3909	38.1-549.10
38.2-3910	38.1-549.11
38.2-3911	38.1-549.12
38.2-3912	38.1-549.13
38.2-3913	38.1-549.14
38.2-3914	38.1-549.15
38.2-3915	38.1-549.16
38.2-3916	38.1-549.17
38.2-3917	38.1-549.18
38.2-3918	38.1-549.19
38.2-3919	38.1-549.20
38.2-3920	38.1-549.21
38.2-3921	38.1-549.22
38.2-3922	38.1-549.23
38.2-3923	38.1-549.24

Chapter 40

38.2-4000	38.1-550

38.2-4001	38.1-551
38.2-4002	38.1-552
38.2-4003	38.1-553
38.2-4004	38.1-554
38.2-4005	38.1-556
38.2-4006	ref. in 38.1-555 as 38.1-531
38.2-4007	ref. in 38.1-555 as 38.1-532
38.2-4008	38.1-558
38.2-4009	ref. in 38.1-555 as 38.1-533
38.2-4010	38.1-534
	38.1-559
38.2-4011	38.1-535
38.2-4012	38.1-537
38.2-4013	38.1-560
38.2-4014	ref. in 38.1-555 as 38.1-543
38.2-4015	ref. in 38.1-555 as 38.1-544
38.2-4016	ref. in 38.1-555 as 38.1-545

38.2-4017	ref. in 38.1-555 as 38.1-547
38.2-4018	ref. in 38.1-555 as 38.1-549
38.2-4019	38.1-561
38.2-4020	38.1-562
38.2-4021	38.1-563
38.2-4022	38.1-565

Chapter 41

38.2-4100	38.1-638.1
38.2-4101	38.1-638.2
38.2-4102	38.1-638.3
38.2-4103	new
38.2-4104 A	38.1-638.36
38.2-4104 B	38.1-638.25
38.2-4105	38.1-638.29
38.2-4106	38.1-638.8
	38.1-638.47
38.2-4107	38.1-638.6
38.2-4108	38.1-638.26
38.2-4109	38.1-638.14 through 38.1-638.19

38.2-4110	38.1-638.11
38.2-4111	38.1-638.25
	38.1-638.27
38.2-4112	38.1-638.36
38.2-4113	38.1-638.7
38.2-4114	38.1-638.7
38.2-4115	38.1-638.53
	through
	38.1-638.59
38.2-4116	38.1-638.31
38.2-4117	38.1-638.32
38.2-4118	38.1-638.33
38.2-4119	38.1-638.28
	38.1-638.29
	38.1-638.30
	38.1-638.35
38.2-4120	38.1-638.34
38.2-4121	38.1-638.43
38.2-4122	38.1-638.42
38.2-4123	new
38.2-4124	38.1-638.9
38.2-4125	38.1-638.45
38.2-4126	38.1-638.44

	38.1-638.45
38.2-4127	38.1-638.20
38.2-4128	38.1-638.48
	38.1-638.50
	38.1-638.51
38.2-4129	38.1-638.21
	38.1-638.22
	38.1-638.23
38.2-4130	38.1-638.49
	38.1-638.24
38.2-4131	38.1-638.52
38.2-4132	38.1-638.37
38.2-4133	38.1-638.60
38.2-4134	38.1-638.10
38.2-4135	38.1-638.5
38.2-4136	38.1-638.12
38.2-4137	38.1-638.38

Chapter 42

38.2-4200	38.1-813.1
38.2-4201	new
38.2-4202	38.1-810
38.2-4203	38.1-811

38.2-4204	38.1-812
38.2-4205	new
38.2-4206	38.1-813.2
38.2-4207	38.1-813.3
38.2-4208	38.1-813.4
	38.1-816
38.2-4209	38.1-813.4
38.2-4210	38.1-814
38.2-4211	38.1-815
38.2-4212	38.1-816
	38.1-817
38.2-4213	38.1-816
38.2-4214	38.1-818
38.2-4215	38.1-818
38.2-4216	38.1-818.2
38.2-4217	38.1-819
38.2-4218	38.1-820
38.2-4219	38.1-821
38.2-4220	38.1-823
38.2-4221	38.1-824
38.2-4222	38.1-825
38.2-4223	38.1-826
38.2-4224	38.1-827

38.2-4225	38.1-828
38.2-4226	38.1-828
38.2-4227	38.1-829
38.2-4228	38.1-833
38.2-4229	new

Chapter 43

38.2-4300	38.1-863
38.2-4301	38.1-864
38.2-4302	38.1-865
38.2-4303	38.1-866
38.2-4304	38.1-867
38.2-4305	38.1-868
38.2-4306	38.1-869
38.2-4307	38.1-870
38.2-4308	38.1-872
38.2-4309	38.1-873
38.2-4310	38.1-874
38.2-4311	38.1-875
38.2-4312	38.1-876
38.2-4313	38.1-877
38.2-4314	38.1-878
38.2-4315	38.1-879

38.2-4316	38.1-880
38.2-4317	38.1-881
38.2-4318	38.1-883
38.2-4319	38.1-887
38.2-4320	38.1-889
38.2-4321	38.1-890

Chapter 44

38.2-4400	38.1-791
38.2-4401	38.1-802
38.2-4402	38.1-793
38.2-4403	38.1-793.1
38.2-4404	38.1-794
38.2-4405	38.1-795
38.2-4406	38.1-796
38.2-4407	38.1-797
38.2-4408	38.1-798
38.2-4409	38.1-798
38.2-4410	38.1-799
38.2-4411	38.1-800
38.2-4412	38.1-801
38.2-4413	38.1-802
38.2-4414	38.1-803

38.2-4415	38.1-804
38.2-4416	38.1-802
38.2-4417	38.1-805
38.2-4418	38.1-809

Chapter 45

38.2-4500	38.1-894
38.2-4501	new
38.2-4502	38.1-892
38.2-4503	38.1-893
38.2-4504	38.1-895
38.2-4505	38.1-896
38.2-4506	38.1-897
38.2-4507	38.1-897
38.2-4508	38.1-898
38.2-4509	38.1-899
38.2-4510	38.1-900
38.2-4511	38.1-901
38.2-4512	38.1-902
38.2-4513	38.1-903
38.2-4514	38.1-903
38.2-4515	38.1-904
38.2-4516	38.1-905

38.2-4517	38.1-906
38.2-4518	38.1-907
38.2-4519	38.1-908
38.2-4520	38.1-909
38.2-4521	38.1-909
38.2-4522	38.1-910
38.2-4523	38.1-914

Chapter 46

38.2-4600	38.1-720
38.2-4601	38.1-721
38.2-4602	38.1-722
38.2-4603	38.1-723
38.2-4604	38.1-724
38.2-4605	38.1-725
38.2-4606	38.1-726
38.2-4607	38.1-727
38.2-4608	38.1-728
38.2-4609	38.1-729
38.2-4610	38.1-730
38.2-4611	38.1-731
38.2-4612	38.1-732
38.2-4613	38.1-733

38.2-4614	38.1-733.1
38.2-4615	38.1-734
Chapter 47	
38.2-4700	38.1-735
38.2-4701	38.1-736
38.2-4702	38.1-737
38.2-4703	38.1-738
38.2-4704	38.1-739
38.2-4705	38.1-740.1
38.2-4706	38.1-740.2
38.2-4707	38.1-741
38.2-4708	38.1-742
38.2-4709	38.1-743
38.2-4710	38.1-744
38.2-4711	38.1-745
38.2-4712	38.1-745
Chapter 48	
38.2-4800	38.1-327.46
38.2-4801	38.1-327.47
38.2-4802	38.1-327.48
38.2-4803	38.1-327.49

38.2-4804	38.1-327.50
38.2-4805	38.1-327.51
38.2-4806	38.1-327.52
38.2-4807	38.1-327.53
38.2-4808	new
38.2-4809	38.1-327.54
38.2-4810	38.1-327.55
38.2-4811	38.1-327.56
38.2-4812	38.1-327.57
38.2-4813	38.1-327.58
38.2-4814	38.1-327.59
38.2-4815	38.1-327.60

Chapter 49

38.2-4900	38.1-955
38.2-4901	38.1-956
38.2-4902	38.1-957
38.2-4903	38.1-958
38.2-4904	38.1-959
38.2-4905	38.1-960
38.2-4906	38.1-961
38.2-4907	38.1-962
38.2-4908	38.1-963

38.2-4909	38.1-964
38.2-4910	38.1-965
38.2-4911	38.1-966
38.2-4912	38.1-967
38.2-4913	38.1-968
38.2-4914	38.1-969
38.2-4915	38.1-970
38.2-4916	38.1-971

#