UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

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Section 1. Authority

This regulation is adopted under the authority of the Unfair Claims Settlement Practices Act.

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards for the investigation and disposition of property and casualty claims arising under contracts or certificates issued to residents of the State. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. Nothing herein shall be construed to create nor imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate any change of position.

Drafting Note: Any jurisdiction which may choose to provide for a private cause of action should consider a different statutory scheme. This regulation is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has separately promulgated an Unfair Life, Accident and Health Claims Settlement Practices Model Regulation.

Section 3. Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

A. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

B. "Claim file" means any retrievable electronic file, paper file or combination of both;

C. "Claimant" means either a first party claimant, a third party claimant, or both and includes the claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

D. "Days" means calendar days;

E. "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

F. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

G. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

H. "Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or insurance broker's license.

I. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

J. "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and

K. "Written communications" includes all correspondence, regardless of source or type that is materially related to the handling of the claim.

Section 4. File and Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by the Commissioner's duly appointed designees. To aid in such examination:

A. The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the two preceding years.

B. Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

C. Each relevant document within the claim file shall be noted as to date received, date processed or date mailed.

D. For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

Drafting Note: States are encouraged to recognize the efficiencies of electronic or other type "paperless" file systems and are encouraged to accommodate all reasonable application of such systems.

Section 5. Misrepresentation of Policy Provisions

A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

C. A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions in the claim file.

D. No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition, or claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

E. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

F. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

Section 6. Failure to Acknowledge Pertinent Communications

A. Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

B. Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within twenty-one (21) days of receipt of such inquiry, furnish the department with an adequate response to the inquiry in duplicate.

C. An appropriate reply shall be made within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

D. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within fifteen (15) days of notification of a claim shall constitute compliance with Subsection A of this section.

Section 7. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

A. Within twenty-one (21) days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain documentation of the denial as required by Section 4.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

B. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within twenty-one (21) days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

C. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

D. No insurer shall continue negotiations for settlement of a claim directly with a claimant who is not legally represented, if the claimant's rights may be affected by a statute of limitations, unless the insurer has given the claimant written notice of such limitation. Notice shall be given to first party claimants at least thirty (30) days and to third party claimants at least sixty (60) days before the date on which such time limit may expire.

E. No insurer shall make statements indicating that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

F. The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute and where the payee is known should be tendered within thirty (30) days if such payment would terminate the insurer's known liability under that individual coverage.

G. No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

H. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the [insert state] Department of Insurance, [insert department address and telephone number].

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

A. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

(a) The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last ninety (90) days to consumers in the local market area; or

(b) The cost of two (2) or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last ninety (90) days to consumers when comparable automobiles are not available in the local market area pursuant to Subparagraph (a); or

(c) One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles are not available pursuant to (a) and (b) above; or

(d) Any source for determining statistically valid fair market values that meet all of the following criteria:

(i) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

(ii) The source's database shall produce values for at least eighty-five percent (85%) of all makes and models for the last fifteen (15) model years taking into account the values of all major options for such vehicles; and

(iii) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to assure statistical validity.

(e) Right of Recourse—If the insurer is notified within thirty-five (35) days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for the market value, the company shall reopen its claim file and the following procedures shall apply:

(i) The company may locate a comparable vehicle by the same manufacturer, same year, similar body style and similar options and price range for the insured for the market value determined by the company at the time of settlement. Any such vehicle must be available through licensed dealers;

(ii) The company shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured;

(iii) The company may elect to offer a replacement in accordance with the provisions set forth in Section 8A(1); or

(iv) The company may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The company is not required to take action under this subsection if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same year, similar body style and similar options in as good or better condition as the total loss vehicle which could have been purchased for the market value determined by the company before applicable deductions. The documentation shall include the vehicle identification number.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in Subsection A(1) and A(2) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for the settlement shall be fully explained to the first party claimant.

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

C. Insurers shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

D. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

E. Vehicle Repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which he obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repairers, the insurer shall assure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications.

F. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. The deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

G. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

H. Storage and Towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges and documentation of the denial as required by Section 4. Such insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used by the insured.

I. Betterment deductions are allowable only if the deductions:

(1) (a) Reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle;

(b) Reflect the general overall condition of the vehicle, considering its age, for either or both:

(i) The wear and tear or rust, limited to no more than a deduction of $1,000;

(ii) Missing parts, limited to no more of a deduction than the replacement costs of the part or parts.

(2) Any deductions set forth in (1)(a) or (b) above must be measurable, itemized, specified as to dollar amount and documented in the claim file.

(3) No insurer shall require the insured or claimant to supply parts for replacement.

J. Replacement Crash Parts

(1) Purpose

The purpose of this subsection is to set forth standards for the prompt, fair and equitable settlements applicable to automobile insurance with regard to the use of replacement crash parts. It is intended to regulate the use of replacement crash parts in automobile damage repairs which insurers pay for on their insured's vehicle. It also requires that all replacement crash parts, as defined in this section, be identified and be of the same quality as the original part.

(2) "Replacement crash part," for purposes of this regulation, means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.

(3) Identification

All replacement crash parts, which are subject to this section and manufactured after the effective date of this section, shall carry sufficient permanent non-removable identification so as to identify its manufacturer. Such identification shall be accessible to the extent possible after installation.

(4) Like Kind and Quality

No insurer shall require the use of replacement crash parts in the repair of an automobile unless the replacement crash part is at least equal in kind and quality to the original part in terms of fit, quality and performance. Insurers specifying the use of replacement crash parts shall consider the cost of any modifications which may become necessary when making the repair.

Drafting Note: Subsection J incorporates the fundamental provisions of the NAIC 1987 "After Market Parts Model Regulation" and makes requirements applicable to all replacement crash parts. Adoption of this subsection is the recommended approach.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

A. When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss. The insured shall not have to pay for betterment nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the area so as to conform to a reasonably uniform appearance. This applies to interior and exterior losses. The insured shall not bear any cost over the applicable deductible, if any.

B. Actual Cash Value:

(1) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at time of loss less depreciation, if any. Upon the insured's request, the insurer shall provide a copy of the claim file worksheets detailing any and all deductions for depreciation.

(2) In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1990 Proc. II 7, 13-14, 160, 179-184 (adopted).
1991 Proc. I 9, 16, 192-193, 206-211 (amended and reprinted).

This document replaces a model named "Unfair Claims Settlement Practices Model Regulation."

1976 Proc. II 15, 17 342, 365, 367-370 (adopted).
1980 Proc. II 22, 26, 906, 930, 936 (amended).
1981 Proc. I 47, 51, 255, 258, 263 (amended).