Accident and Health or Sickness (Disability/Health Producer)

(75 scored questions. 120-minute time limit)

GENERAL KNOWLEDGE

(50 scored plus 5 pretest questions)

I. TYPES OF POLICIES

A. Disability income
1. Individual disability income policy
2. Business overhead expense policy
3. Business disability buyout policy
4. Group disability income policy
5. Key employee policy

B. Accidental death and dismemberment

C. Medical expense insurance
1. Basic hospital, medical, and surgical policies
2. Health Maintenance Organizations (HMOs)
3. Preferred Provider Organizations (PPOs)
4. Health Reimbursement Accounts (HRAs)
5. Major medical policies
6. Flexible Spending Accounts (FSAs)
7. High Deductible Health Plans (HDHPs)
8. Health Savings Accounts (HSAs)
9. Point of Service (POS) plans

D. Medicare supplement policies

E. Group insurance
1. Differences between individual and group contracts
2. General characteristics
3. COBRA

F. Individual/Group Long Term Care (LTC)
1. Eligibility
2. Levels of care

G. Other policies
1. Dental
2. Vision
3. Cancer
4. Critical illness or specified disease
5. Worksite (employer-sponsored)
6. Hospital indemnity
7. Short-term medical
8. Accident

II. POLICY PROVISIONS, CLAUSES, AND RIDERS

A. Mandatory and optional provisions
1. Entire contract
2. Grace period
3. Reinstatement
4. Notice of claim
5. Claim forms
6. Proof of loss
7. Legal actions
8. Illegal occupation
9. Payment of claims
10. Change of beneficiary
11. Change of occupation
12. Time of payment of claims
13. Misstatement of age or gender
14. Relation of earnings to insurance
15. Physical examination and autopsy
16. Time limit on certain defenses

B. Other provisions and clauses
1. Free look
2. Deductibles
3. Coinsurance
4. Pre-authorizations and prior approval requirements
5. Lifetime, annual, or per cause maximum benefit limits
6. Copayments
7. Insuring clause
8. Eligible expenses
9. Probationary period
10. Elimination period
11. Waiver of premium
12. Consideration clause
13. Preexisting conditions
14. Exclusions and limitations
15. Usual, reasonable, and customary charges

C. Riders
1. Impairment/exclusions
2. Guaranteed insurability
3. Future increase option

D. Rights of renewability
1. Noncancelable
2. Cancelable
3. Guaranteed renewable

III. SOCIAL INSURANCE

A. Medicare (Parts A, B, C, D)
B. Medicaid
C. Social Security benefits

IV. OTHER INSURANCE CONCEPTS

A. Total, partial, recurrent and residual disability
B. Owner's rights
C. Dependent children benefits
D. Primary and contingent beneficiaries
E. Modes of premium payments
F. Nonduplication and coordination of benefits (e.g.,primary vs. excess)
G. Occupational vs. non-occupational
H. Tax treatment of premiums and proceeds of insurance contracts
I. Managed care
J. Workers Compensation Impact on health insurance benefits
K. Subrogation
L. Cost containment

V. FIELD UNDERWRITING PROCEDURES

A. Completing the application
B. Explaining sources of insurability and HIPAA privacy information (e.g., MIB Report, Fair Credit Reporting Act, etc.)
C. Initial premium payment and receipt and consequences of the receipt (e.g., medical examination, etc.)
D. Submitting application (and initial premium if collected) to company for underwriting
E. Policy delivery
F. Explaining policy and its provisions, riders, exclusions, and ratings to clients
G. Replacement
H. Contract law
    1. Unique aspects of the insurance contract
    2. Elements of a contract
        a. Conditional
        b. Unilateral
        c. Adhesion
        d. Aleatory
    3. Insurable interest
    4. Warranties and representations

IDAHO SPECIFIC KNOWLEDGE

(25 scored plus 6 pretest questions)

Ref: All references are to Idaho Insurance Laws Title 41 unless otherwise noted

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I. IDAHO STATUTES, RULES, AND REGULATIONS COMMON TO ALL LICENSES

A. Responsibilities of the Director of the Department of Insurance … *Ref: 41-202, 41-203, 41-210 to 41-213, 41-117, 41-117A, 41-219, 41-220, 41-232, 41-235, 41-247, 41-1016, 41-1321*

1. Appointment
2. General duties and powers
3. Examinations
4. Penalties
5. Hearings/notice of hearings/orders

B. Definitions … *Ref: 41-106, 41-110 to 41-112, 41-301, 41-302, 41-305, 41-306, 41-1003, 41-2902, 41-3201, 41-3210*

1. Domestic, Foreign or Alien companies
2. Fraternal company
3. Authorized and unauthorized companies
4. Stock, mutual, reciprocals, companies
5. Certificate of authority
6. Transacting insurance
7. Negotiate

C. Licensing … *Ref: 41-1003 to 41-1013, 41-1016, 41-1018, 41-1019, 41-1026, 41-1036, 41-1103, 41-1104, IDAPA 18.01.02, IDAPA 18.06.04*

1. Persons required to be licensed
   a. Producer
   b. Resident/nonresident
2. Producer appointment/termination of appointment
3. Obtaining a license
   a. Qualifications
   b. License application
   c. Written examinations
   d. Exemptions/exceptions
   e. License denial/refusal
4. Maintaining a license
   a. Record keeping
   b. Continuing education
   c. License expiration
   d. Fees/renewal e. felony convictions
   f. Suspension or revocation of licenses
   g. Change of address/place of business

D. Producer responsibilities … *Ref: 41-1017, 41-1021, 41-1024, 41-1030, 41-1323, 41-1325, 41-1803, IDAPA 18.06.02, IDAPA 18.06.03*

1. Fiduciary capacity
2. Reporting of actions
3. Commissions and compensation
4. Charging of fees and disclosure requirements

E. Insurance contracts
Ref: 41-1328, 41-1807, 41-1812, 41-1828)

1. Filing and approval of policy forms
2. Payment of claims
3. Power to contract

F. Marketing practices … *Ref: 41-117, 41-258, 41-290, 41-293, 41-1016, 41-1303 to 41-1306, 41-1308 to 41-1315, 41-1327 to 41-1329A, 41-1839, 41-3611, Bulletin 03-08*

1. Unfair claims practices
2. Unfair methods of competition
   a. Rebating
   b. Fraud
   c. Twisting
   d. Coercion of borrower
   e. Unfair discrimination
   f. Misrepresentation
   g. Defamation
   h. False advertising
   i. False financial statements
   j. Boycott, coercion, intimidation
3. Penalties

II. IDAHO STATUTES, RULES, AND REGULATIONS COMMON TO LIFE AND HEALTH/ DISABILITY INSURANCE ONLY

A. Credit life and disability insurance … *Ref: 41-2303, 41-2304, 41-2305, 41-2307, 41-2311, IDAPA 18.03.05*

B. Life and Health Insurance Guaranty Association Act … *Ref: 41-4301 to 41-4310*

C. Assignment … *Ref:41-1826,41-1828,41-2025*

III. IDAHO STATUTES, RULES, AND REGULATIONS PERTINENT TO HEALTH/DISABILITY INSURANCE ONLY

A. Policy clauses and provisions … *Ref: 41-520, 41-2103, 41-2106, 41-2107, 41-2138 to 41-2140, 41-2144, 41-2212, 41-4201, 41-4202, 41-2210, 41-2218, 41-2221, 41-3438, 41-3926, 41-3932, 41-4023, 41-4206, 41-4703, 41-5208, 41-5501IDAPA 18.04.03, IDAPA 18.04.08, PPACA*

1. Minimum standards
    a. Purpose
    b. Definition
2. Required and optional coverages
    a. Free look
    b. Mammograms
    c. Grace period
    d. Maternity benefits
    e. Skilled nursing facility
    f. Pre-existing conditions
    g. Handicapped dependents
    h. Newborns and adopted children
    i. Reconstructive surgery/prosthetic devices
    j. Right of insurer to contest (time limit on certain defenses)
3. Benefit standards

B. Accidental death and dismemberment *Ref: 41-501, 41-502; IDAPA 18.04.08*

C. Disclosure … *Ref: 41-2107, 41-2108, 41-4203, 41-4204, 41-4205, 41-4707, 41-5207; IDAPA 18.04.08*
1. Outline of coverage
2. Renewal agreements/nonrenewal and cancellation

D. Medicare supplement insurance … *Ref: 41-4402, 41-4403, 4406-4408, IDAPA 18.04.10*

E. Long term care … *Ref: 41-4603, 41-4605, IDAPA 18.04.11*
1. Definitions
2. Suitability
3. Disclosure Statements
4. Activities of Daily Living
5. Producer Training Requirement

F. Small employer health insurance availability act … *Ref: Title 41-Chapter 47*
1. Special provisions
2. Disclosure requirements
3. Termination/nonrenewal
4. Fair marketing standards
5. Definitions
    a. Small employer
    b. Eligible employee

G. Individual health insurance availability act … *Ref: 41-1008, 41-4204; IDAPA 18.04.08*

H. Disability income protection … *Ref: Title41-Chapter 52*

I. Idaho Health Carrier External Review Act … *Ref: 41-5901 to 41-5917; IDAPA 18.01.05*

Statutes, Bulletins and IDAPAs for the Idaho Knowledge Portion of the Exam

41-106. "Domestic," "foreign," "alien" insurer defined.

(1) A "domestic" insurer is one formed under the laws of this state or an insurer which has transferred its domicile pursuant to section41-342, Idaho Code, to this state.

(2) A "foreign" insurer is one formed under the laws of a jurisdiction other than this state.

(3) An "alien" insurer is one formed under the laws of any country other than the United States of America, its states, districts, territories, and commonwealths.

(4) Except where distinguished by context, "foreign" insurers includes also "alien" insurers.

41-110. "AUTHORIZED," "UNAUTHORIZED" INSURER DEFINED.

(1) An "authorized" insurer is one duly authorized by a subsisting certificate of authority issued by the director to transact insurance in this state.

(2) An "unauthorized" insurer is one not so authorized.

41-111. "CERTIFICATE OF AUTHORITY," "LICENSE" DEFINED.

(1) A "certificate of authority" is one issued by the director evidencing the authority of an insurer to transact insurance in this state.

(2) A "license" is authority granted by the director pursuant to this code authorizing the licensee to engage in a business or operation of insurance in this state other than as an insurer, and the certificate by which such authority is evidenced.

41-112. "TRANSACTING INSURANCE" DEFINED.

"Transacting insurance" includes any of the following:

(1) Solicitation and inducement.

(2) Preliminary negotiations.

(3) Effectuation of a contract of insurance.

(4) Transaction of matters subsequent to effectuation of a contract of insurance and arising out of it.

(5) Mailing or otherwise delivering any written solicitation to any person in this state by an insurer or any person acting on behalf of the insurer for fee or compensation.

41-117. GENERAL PENALTY.

Each violation of this code for which a greater penalty is not provided by another provision of this code or by other applicable laws of this state, shall in addition to any applicable prescribed denial, suspension, or revocation of certificate of authority or license be punishable by an administrative penalty of not more than one thousand dollars ($1,000) for any individual or natural person and not more than five thousand dollars ($5,000) for any other person, imposed by the director, and upon conviction by a fine of not more than one thousand dollars ($1,000) or by imprisonment in the county jail for a period not to exceed six (6) months, or by both such fine and imprisonment in the discretion of the court. Each instance of violation may be considered a separate offense.

41-117A. PENALTY FOR TRANSACTING INSURANCE WITHOUT PROPER LICENSING.

The director may impose an administrative penalty not to exceed fifteen thousand dollars ($15,000), for deposit in the general account of the state of Idaho, upon any person who transacts insurance of any kind or character or transmits for a person, other than himself, an application for a policy of insurance without proper licensing, or after such licensing shall have been suspended or revoked.

41-202. DIRECTOR -APPOINTMENT -TERM -QUALIFICATIONS.

(1) The director of the department of insurance shall be the chief executive officer of the department of insurance.

(2) The director shall be appointed by the governor and shall hold office for a term of four (4) years, subject to earlier removal by the governor. A vacancy in the office of director shall be filled for the balance of the unexpired term only.

(3) The governor shall not appoint as director any individual, and no individual shall hold the office of director, who is not qualified therefor as follows:

(a) Must be a qualified elector of the state of Idaho; and

(b) Must have had at least five (5) years' practical experience in one or more of the types of insurance business subject to regulation by the director, or have had other professional or business experience reasonably adequate in character and scope to equip him to discharge the duties and fulfill the responsibilities of the office of director.

41-203. TERMS CONSTRUED.

Wherever the words "commissioner of insurance" or "insurance commissioner" appear in title 41, Idaho Code, or elsewhere in the Idaho Code, they shall be understood and construed to mean the director of the department of insurance.

41-210. GENERAL POWERS, DUTIES.

(1) The director shall enforce the provisions of this code, and shall execute the duties imposed upon him by this code.

(2) The director shall have the powers and authority expressly conferred upon him by or reasonably implied from the provisions of this code. (3) The director may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he may deem proper to determine whether any person has violated any provision

of this code or to secure information useful in the lawful administration of any such provision. The cost of such additional examinations and investigations shall be borne by the state.

(4) For any document required to be filed with the director or the department of insurance under the laws of this state, the director may specify the place and manner of filing of the document, including whether an electronic or paper filing is required or acceptable.

(5) The director shall have such additional powers and duties as may be provided by other laws of this state.

41-211. RULES.

(1) The director may make reasonable rules necessary for or as an aid to the effectuation of any provision of this code. No such rule shall extend, modify, or conflict with any law of this state or the reasonable implications thereof.

(2) Any such rule affecting persons or matters other than the personnel or the internal affairs of the department shall be made or amended in accordance with the provisions of chapter 52, title 67, Idaho Code.

(3) In addition to any other penalty provided, wilful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

41-212. ORDERS, NOTICES.

(1) Orders and notices of the director shall be effective only when in writing signed by him or by his authority.

(2) Every such order shall state its effective date, and shall concisely state:

(a) Its intent or purpose.

(b) The grounds on which based.

(c) The provisions of this code pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the director of the right to rely thereon.

(3) Except as may be provided in this code respecting particular procedures, an order or notice may be given by:

(a) Personal service upon the person to be ordered or notified;

(b) Mailing it, postage prepaid, by regular United States mail, or by certified mail, return receipt requested, addressed to the person at his residence or principal place of business as last of record in the department; or

(c) Where a party has appeared in a contested case or has not yet appeared but has consented or agreed in writing to service by facsimile transmission (FAX) or e-mail as an alternative to personal service or service by mail, such orders or notices may be served by FAX or by e-mail in lieu of service by mail or personal service.

(4) Service of orders and notices is complete when a copy is personally served upon the person to be served, or when a copy properly addressed and postage prepaid is deposited in the United States mail or the statehouse mail, if the person is a state employee or state agency, or when there is an electronic verification that a FAX or an e-mail has been sent.

41-213. ENFORCEMENT.

(1) The director may institute such suits or other lawful proceedings as he may deem necessary for the enforcement of any provision of title 41, Idaho Code. If the director believes that any person has engaged in or is about to engage in any act or practice constituting a violation of any provision of title 41, Idaho Code, any other law the director has authority to enforce, or any rule or order of the director, the director may, in accordance with the procedures set forth in title 41, Idaho Code, and chapter 52, title 67, Idaho Code:

(a) Issue an order requiring the person to cease and desist from any prohibited act or practice;

(b) Issue an order affecting a person's license for such reasons as set forth in title 41, Idaho Code;

(c) Issue an order imposing an administrative penalty as provided in title 41, Idaho Code; and

(d) Initiate any action in district court for the same relief or any relief authorized by title 41, Idaho Code.

(2) If the director believes that any person is violating or about to violate any provision of title 41, Idaho Code, or any order or requirement of the director issued or promulgated pursuant to authority expressly granted the director by any provision of title 41, Idaho Code, or by other law, the director may bring an action against such person in the name of the people of the state of Idaho in a district court of this state to enjoin such person from continuing such violation or doing any act in furtherance thereof. In the action the court may enter such order or judgment granting such preliminary or final injunction as the court determines to be proper.

(3) If the director has reason to believe that any person has violated any provision of title 41, Idaho Code, or any provision of other law as applicable to insurance operations, for which criminal prosecution is provided and would be in order, he shall give the information relative thereto to the attorney general or county attorney having jurisdiction of any such violation. The attorney general or county attorney shall promptly institute such action or proceedings against such person as the information may require or justify.

(4) Whenever the director may deem it necessary, he shall employ counsel, or call upon the attorney general of this state for legal counsel and such assistance as may be necessary.

41-219. EXAMINATION OF INSURERS.

(1) For the purpose of determining its financial condition, ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, and compliance with the law, the director shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer, including the attorney in fact of a reciprocal insurer in so far as insurer transactions are concerned, as often as he deems advisable. The director or any of the director's examiners may conduct an examination, in accordance with the provisions of this section, of any company as often as the director in his sole discretion deems appropriate but shall, at a minimum, conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the director shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the examiners' handbook adopted by the national association of insurance commissioners and in effect when the director exercises discretion under the provisions of this section.

(2) Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the director.

(3) The director shall in like manner examine each insurer applying for an initial certificate of authority to transact insurance in this state.

(4) In lieu of an examination under the provisions of this section, of any foreign or alien insurer licensed in this state, the director may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port of entry until January 1, 1994.

Thereafter, such reports may only be accepted if the insurance department was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program or, the examination is performed under the supervision of an accredited insurance department or with participation of one (1) or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(5) The term "company" as used in this section shall mean any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the director.

41-220. EXAMINATION OF AGENTS, BROKERS, CONSULTANTS, MANAGERS, ADJUSTERS, PROMOTERS.

For the purpose of ascertaining compliance with law, and in addition to any right of examination otherwise provided, the director may as often as he deems advisable examine the accounts, records, documents, and transactions, pertaining to or affecting its insurance affairs or proposed insurance affairs, of:

(1) any insurance agent, broker, solicitor, consultant, surplus line broker, general agent, or adjuster.

(2) Any person(s) having a contract under which he enjoys in fact the exclusive or dominant right to manage or control an insurer.

(3) Any person holding the shares of voting stock or policyholder proxies of a domestic insurer, for the purpose of controlling the management thereof, as voting trustee or otherwise.

(4) Any person engaged in this state in, or proposing to be engaged in this state in, or holding himself out in this state as so engaging or proposing, or in this state assisting in, the promotion or formation of an insurer or insurance holding corporation, or corporation to finance an insurer or the production of its business.

41-232. HEARINGS IN GENERAL.

(1) The director may hold a hearing which he deems necessary for any purpose within the scope of this code.

(2) The director shall hold a hearing:

(a) If required by any provision of this code; or

(b) Upon written demand for a hearing by a person aggrieved by any act, threatened act or failure of the director to act, or by any report, rule, regulation or order of the director (other than an order for the holding of a hearing, or an order on a hearing of which hearing such person had actual notice or pursuant to such order).

(3) Any such demand for a hearing shall summarize the information and grounds to be relied upon as a basis for the relief to be sought at the hearing.

(4) The director shall hold such demanded hearing within thirty (30) days after his receipt of the demand, unless postponed by mutual consent. Failure to hold the hearing shall constitute a denial of the relief sought, and shall be the equivalent of an order on hearing for the purpose of an appeal.

(5) In any administrative proceeding of the director where a hearing is otherwise authorized or required by law, if a party with respect to whom the hearing is to be held waives the hearing in writing, or fails to plead, or to defend or prosecute, as the case may be, and that fact is made known to the director by affidavit or otherwise, the right of hearing shall be deemed to have been waived, and, any other provision of this code to the contrary notwithstanding, without holding or concluding a hearing the director may, upon satisfactory proof of service of the petition or complaint upon such a party, enter an order which shall be as lawful as to such party as if all allegations in the petition or complaint relative to or concerning such party were proved

or admitted at a hearing. For good cause shown, the director may, in his discretion, set aside any order so entered, and the proceedings may continue as if no waiver or default had existed.

41-235. NOTICE OF HEARING.

(1) Except where a longer period of notice is provided by other provisions of this code relative to particular matters, not less than fourteen (14) days in advance the director shall give notice of the time and place of the hearing, stating the matters to be considered thereat. If the persons to be given notice are not specified in the provision pursuant to which hearing is held, the director shall give such notice to all persons whose pecuniary interests are to be directly and immediately affected by such hearing.

(2) If any such hearing would otherwise require separate notices to more than one hundred (100) persons, in lieu of the notice required under such subsection the director may give notice of the hearing by publishing the notice in at least three (3), but not to exceed five (5), daily newspapers, at least once each week during the four (4) weeks immediately preceding the week in which the hearing is to be held. The director shall select such newspapers, as to location and circulation, as he deems necessary to give adequate opportunity of notice to such persons as should receive notice of the hearing. The published notice shall state the time and place of the hearing and shall specify the matters to be considered thereat. At the time of first publication the director shall mail to every advisory organization which has filed with him pursuant to section41-1425, Idaho Code, a copy of the published notice if the proposed hearing would affect any interest of the members of such advisory organization.

(3) All such notices, other than published notices, shall be given as provided in section41-212, Idaho Code.

41-247. INQUIRY POWERS OF DIRECTOR.

The director shall have power to direct an inquiry in writing to any person subject to his jurisdiction with respect to any insurance transaction or matter relative to a subject of insurance resident, located, or to be performed in this state. The person to whom such an inquiry is addressed shall upon receipt thereof promptly furnish to the director all requested information which is in his possession or subject to his control.

41-258. REPORT OF LOSSES BY FIRE INSURANCE COMPANIES TO STATE FIRE MARSHAL.

Every fire insurance company must report to the fire marshal, within 7 days of a settlement of $1,000 or more or death or personal injury. The report needs state the date of fire, the amount of property loss/personal injury, type of stuff destroyed/ damaged, and cause of the fire. The report is in addition to any other report they have to file.

41-290. FRAUDULENT CLAIMS.

Any insurer which has facts to support a belief that a fraudulent claim is being or has been made shall, within sixty (60) days of the receipt of such notice, send to the director of insurance, on a form prescribed by the director, the information requested and such additional information relative to the claim and the parties claiming loss or damages as the director may require. The director of the department of insurance shall review such reports and select such claims as, in his judgment, may require further investigation. He shall then cause an independent examination of the facts surrounding such claim to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim. The director of the department of insurance shall report any alleged violations of law which his investigations disclose to the appropriate licensing agency and prosecuting authority having jurisdiction with respect to any such violation.

If, upon examination, the director of the department of insurance determines that an insurer has intentionally not reported a claim when the insurer had facts to support a belief that the claim was fraudulent in accordance with the provisions of this chapter, the director may impose fines and penalties pursuant to section41-327, Idaho Code, for each unreported suspected fraudulent claim.

41-293. INSURANCE FRAUD.

Insurance fraud includes:

(1) (a) Any person who, with the intent to defraud or deceive an insurer for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, producer, practitioner or other person, any statement as part of, or in support of, a claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim; or

(b) Any person who, with intent to defraud or deceive an insurer assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to any insurer, producer, practitioner or other person, in connection with, or in support of, any claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim;

(c) Any person who, with intent to defraud or deceive, presents or causes to be presented to or by an insurer, a producer, practitioner or other person, a false or altered statement material to an insurance transaction;

(d) Any insurance producer or other person who, with intent to defraud or deceive, willfully takes premium money knowing that insurance coverage will not be effected;

(e) Any practitioner or other person who willfully submits a false or altered statement, with the intent of deceiving an insurer or other person in connection with an insurance transaction or claim;

(f) Anyone willfully making a false statement or material misrepresentation to an insurer, employer, practitioner or other person, with the intent to defraud or deceive an insurer or other person, to obtain or extend worker's compensation benefits;

(g) Anyone who offers or accepts a direct or indirect inducement to file or solicits another person to file a false statement, with intent to defraud or deceive an insurer;

(h) Any person who, with intent to defraud or deceive, transacts insurance of any kind or character, or transmits for a person other than himself an application for a policy of insurance, without proper licensing or after such license has been suspended or revoked;

(i) Any practitioner or any other person who, with intent to defraud or deceive, employs, uses or acts as a runner for the purpose of submitting a claim containing false, incomplete, or misleading information concerning any fact or thing material to such claim;

(j) Any employer or other person who, with intent to defraud or deceive, presents or causes to be presented to an insurer, producer or any other person or governmental agency any statement containing the number of employees, amount of payroll, job description or job title or any other statement material to worker's compensation insurance which contains false, misleading or incomplete information; or

(k) Any person who, with intent to defraud or deceive, obstructs the director in the conduct of any authorized examination.

(2) A fact, statement or representation is "material" if it includes any of the following:

(a) Any fact which, if communicated to the producer, insurer, adjuster or representative thereof, would induce him to either decline insurance altogether or not accept it unless a higher premium is paid by the insured;

(b) Any fact relating to a claim for insurance benefits which, if disclosed, would be a fair reason for rejecting a claim for insurance benefits;

(c) Any fact, the knowledge or ignorance of which would naturally influence the insurer in making or refusing the contract, in estimating the degree or character of the risk, or in fixing the rate of premium;

(d) Any fact, the knowledge or ignorance of which would naturally influence the insurer in accepting or rejecting a claim for insurance benefits or compensation, or in determining the amount of compensation or insurance benefits to be paid to the insured; or

(e) Any fact that necessarily has some bearing on the subject matter of the insurance coverage or claim for benefits under an insurance contract.

(3) Any offense committed by use of a telephone, any means of electronic communication or mail as provided by this chapter may be deemed to have been committed at the place from which the telephone call or electronic communication was made, or mail was sent, or the offense may be deemed to have been committed at the place at which the telephone call, electronic communication or mail was received.

(4) Any violator of this section is guilty of a felony and shall be subject to a term of imprisonment not to exceed fifteen (15) years, or a fine not to exceed fifteen thousand dollars ($15,000), or both and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section. Each instance of violation may be considered a separate offense.

41-301. "STOCK" INSURER DEFINED.

For the purposes of this code a "stock" insurer is an incorporated insurer with its capital divided into shares and owned by its stockholders.

41-302. "MUTUAL" INSURER DEFINED.

A "mutual" insurer is an incorporated insurer without capital stock and the governing body of which is elected by its policy holders. This definition shall not be deemed to exclude as "mutual" insurers certain foreign insurers found by the director to be organized on the mutual plan under the laws of their states of domicile but having temporary share capital or providing for election of the insurer's governing body on a reasonable basis by policy holders and others.

41-305. CERTIFICATE OF AUTHORITY REQUIRED.

(1) No person shall act as an insurer and no insurer or its agents, attorneys, subscribers, or representatives shall directly or indirectly transact insurance in this state except as authorized by a subsisting certificate of authority issued to the insurer by the director, except as to such transactions as are expressly otherwise provided for in this code.

(2) No insurer shall from offices or by personnel or facilities located in this state solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority issued to it by the director authorizing it to transact the same kind or kinds of insurance in this state.

41-306. EXCEPTIONS TO CERTIFICATE OF AUTHORITY REQUIREMENT.

A certificate of authority and application therefor pursuant to section41-319, Idaho Code, shall not be required of an insurer with respect to the following:

(1) Investigation, settlement, or litigation of claims under its policies lawfully written in this state, or liquidation of assets and liabilities of the insurer (other than collection of new premiums), all as resulting from its former authorized operations in this state.
(2) Transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this state at time of issuance, and lawfully solicited, written and delivered outside this state.
(3) Transactions pursuant to surplus lines coverages lawfully written under chapter 12, title 41, Idaho Code.
(4) Reinsurance, when transacted by an insurer duly authorized by its state of domicile to transact the kind of insurance involved.
(5) The continuation and servicing of life insurance or disability insurance policies or annuity contracts remaining in force as to residents of this state if the insurer has withdrawn from the state and is not transacting new insurance therein.
(6) A foreign insurer licensed and authorized to sell individual or group accident and sickness insurance in another state as defined pursuant to section41-306A, Idaho Code, and the insurer obtains a certificate of authority pursuant to that section.

41-1003. Definitions.

(1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.
(2) "Home state" means the District of Columbia and any state or territory of the United States or any province of Canada in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.
(3) "License" means a document issued by the director authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.
(4) "Limited lines insurance" is insurance which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section41-1008(1)(a) through (g), Idaho Code, and shall include, but not be limited to: credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (GAP) insurance, transportation baggage insurance, transportation ticket policies covering personal accident insurance, pet insurance, portable electronics insurance, travel insurance or any other line of insurance that the director deems necessary to recognize for the purposes of complying with section41-1009(5), Idaho Code.
(5) "Limited lines producer" means a producer authorized by the director to sell, solicit or negotiate limited lines insurance. "Limited lines producer" includes a "limited lines travel insurance producer" as used in sections41-1090 through41-1096, Idaho Code.
(6) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in the act either sells insurance or obtains insurance from insurers for purchasers.
(7) "Person" means an individual or a business entity.
(8) "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.
(9) "Resident" means a person whose home state is Idaho or any other particular state identified in conjunction with the use of the term.
(10) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.
(11) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company or companies.
(12) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer’s authority to transact insurance for or on behalf of an insurer.
(13) "Uniform application" means the current version of the national association of insurance commissioners (NAIC) uniform application for resident and nonresident producer licensing.
(14) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

41-1004. LICENSE REQUIRED.

(1) A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed as a producer for that line of authority in accordance with this chapter.
(2) A person shall not, for a fee, engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages under any policy of insurance that could be issued in Idaho unless that person is:
    (a) A licensed insurance producer offering advice concerning a class of insurance as to which the producer is licensed to transact business in this state;
    (b) An attorney rendering services in the performance of the duties of an attorney;
    (c) A certified public accountant rendering services in the performance of the duties of a certified public accountant, as authorized by law;

(d) An actuary rendering actuarial services if such actuary is a member of an organization determined by the director as establishing standards for the actuarial profession;
(e) A person providing services to producers or authorized insurers only;
(f) A person rendering services as an expert pursuant to the Idaho rules of evidence;
(g) An investment adviser, investment adviser representative or federally covered investment adviser as defined in section 30-14-102, Idaho Code; or
(h) A person rendering such services pursuant to a license issued in accordance with sections41-1081 through41-1089 of this chapter [, Idaho Code].

41-1005. EXCEPTIONS TO LICENSING.

(1) Nothing in this chapter shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.
(2) A license as an insurance producer shall not be required of the following:
(a) An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:
(i) The activities of the officer, director or employee are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or
(ii) The function of the officer, director or employee relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or
(iii) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;
(b) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance, or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans, or performs administrative services relating to mass-marketed property and casualty insurance, and who does not receive a commission;
(c) An employer or association or its officers, directors, employees or the trustees of an employee trust plan, to the extent that the employer, association, officer, employee, director or trustee is engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which involves the use of insurance issued by an insurer, as long as the employer, association, officer, director, employee or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contracts;
(d) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers, and who are not individually engaged in the sale, solicitation or negotiation of insurance, and who do not receive a commission;
(e) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;
(f) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one (1) state insured under that contract, provided that the person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;
(g) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; or
(h) A person who, concurrent with the rental of a motor vehicle, provides contract options to the standard rental agreement which provides auto and travel related coverages through authorized insurers during a rental period not to exceed ninety (90) days.

41-1006. APPLICATION FOR EXAMINATION.

(1) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to section41-1008(4) or41-1012, Idaho Code. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and rules of this state. Examinations required by this section shall be developed and conducted under rules prescribed by the director of the department of insurance.
(2) Each individual applying for an examination shall remit a nonrefundable fee as promulgated by the director pursuant to section41-401, Idaho Code.

(3) An individual who fails to appear for the examination as scheduled or who fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.
(4) Applications for licensure not received by the department within one hundred eighty (180) days of the successful completion of the examination shall be denied

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41-1007. APPLICATION FOR PRODUCER LICENSE.

(1) A person applying for a resident insurance producer license shall make application to the director on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the applicant's knowledge and belief. Before approving the application, the director shall find that the applicant:
  (a) Is at least eighteen (18) years of age;
  (b) Has submitted the applicant's fingerprints as may be required by the director;
  (c) Has not committed any act that is a ground for denial, suspension or revocation of the license as set forth in title 41, Idaho Code;
  (d) Has paid the fees prescribed by the director pursuant to section41-401, Idaho Code; and
  (e) Has successfully passed the examinations for the lines of authority for which the applicant has applied.
(2) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the director shall find that:
  (a) The business entity has paid the fees prescribed by the director pursuant to section41-401, Idaho Code; and
  (b) The business entity has designated a licensed producer, who is an individual responsible for the business entity's compliance with the insurance laws and rules of this state.
(3) The director may require any documents which are reasonably necessary to verify the information contained in an application.
(4) Each insurer that sells, solicits or negotiates any form of limited line insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited lines insurance a program of instruction that may be required to be approved by the director. If acceptable to the director, and as stated by rule, the program of instruction may be administered in place of the examination as required in section41-1006, Idaho Code. In addition, such course of instruction may be administered in place of any continuing education requirements pursuant to section41-1013, Idaho Code.

41-1008. PRODUCER LICENSE.

(1) Unless denied licensure pursuant to section41-1016, Idaho Code, persons who have met the requirements of sections41-1006 and41-1007, Idaho Code, shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:
  (a) Life insurance coverage on human lives, including benefits of endowment and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income;
  (b) Disability, including accident and health or sickness insurance coverage for sickness, bodily injury or accidental death and benefits for disability income;
  (c) Property insurance coverage for the direct or consequential loss or damage to property of every kind;
  (d) Casualty insurance coverage against legal liability, including liability for death, injury or disability or damage to real or personal property;
  (e) Variable life and variable annuity products, meaning insurance coverage provided under variable life insurance contracts and variable annuities;
  (f) Personal lines, meaning property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;
  (g) Any other line of insurance permitted under state laws or rules.
(2) An insurance producer license shall remain in effect unless revoked or suspended as long as the renewal fee promulgated by the director pursuant to section41-401, Idaho Code, is paid and the continuing education requirements for resident insurance producers are met in accordance with section41-1013, Idaho Code.
(3) An individual insurance producer who allows his or her license to lapse may, within twelve (12) months from the due date of the renewal fee, reinstate the same license without passing a written examination unless the licensee would otherwise be required to retest under section41-1013(7), Idaho Code. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.
(4) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, such as a long-term medical disability, may request that the director waive those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.
(5) The license shall contain the licensee's name, address, personal identification number, the date of issuance, the lines of authority, the expiration date and any other information the director deems necessary.
(6) Licensees shall inform the director by any means acceptable to the director of a change of address within thirty (30) days of the change. A business entity licensed as a producer shall inform the director by any means acceptable to the director of any

change in ownership, officers, directors or the designated licensed producer responsible for compliance pursuant to section41-1007(2)(b), Idaho Code.

(7) In order to assist in the performance of the director's duties, the director may contract with nongovernmental entities, including the national association of insurance commissioners or its affiliates or subsidiaries, to perform any ministerial functions related to producer licensing, including the collection of fees, that the director and the nongovernmental entity may deem appropriate.

41-1009. NONRESIDENT PRODUCER LICENSE.

(1) Unless denied licensure pursuant to section41-1016, Idaho Code, a nonresident applicant shall receive a nonresident producer license if:

(a) The applicant is currently licensed as a resident and in good standing in his or her home state;

(b) The applicant has submitted the proper request for licensure and has paid the fees set forth by rule pursuant to section41-401, Idaho Code;

(c) The applicant has submitted or transmitted to the director the application for licensure that the applicant submitted to his or her home state or, in lieu of such application, a completed uniform application;

(d) The applicant has submitted the applicant's fingerprints, if required by the director, on a form as prescribed by the director; and

(e) The applicant's home state awards nonresident producer licenses to residents of this state on the same basis.

(2) The director may verify the producer's licensing status through the producer database maintained by the national association of insurance commissioners, its affiliates or subsidiaries, or by any other acceptable means.

(3) A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application shall be required for filing the change of address.

(4) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines broker in his or her home state shall receive a nonresident surplus lines broker license pursuant to subsection (1) of this section. Except as to subsection (1) of this section, nothing in this section otherwise amends or supersedes any provision of section41-1223, Idaho Code.

(5) Notwithstanding any other provision of this chapter, a person licensed as a limited lines producer in his or her home state shall receive a nonresident limited lines producer license, pursuant to subsection (1) of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section41-1008(1)(a) through (g), Idaho Code.

41-1010. NONRESIDENTPRODUCERS-SERVICEOFPROCESS.

(1)Eachperson applyingtobeanonresidentproducershall,onaformprescribedbythedirector,appointthedirectorashisagentforpurposesof receivingserviceoflegalprocessissuedagainsttheproducerinthisstateuponcausesofactionarisingwithinthisstateoutoftransactions underthelicense.Serviceuponthedirectorasanagentshallconstituteeffectivelegalserviceupon the producer.

(2) The appointment shall be irrevocable for as long as there could be any cause of action against the licensee arising out of his insurance transactionsinorwithrespecttothisstate.
Duplicate copies of such legal process against the licensee shall be served upon the director by a person competent to serve a summons. At the time of service the plaintiff shall pay the director an appropriate fee to be determined by rule and not exceeding thirty dollars ($30.00).

(3) Upon receiving such service, the director shall send one (1) copy of the process by registered or certified mail with return receipt requested to the defendantlicenseeathislastaddressofrecordwiththedirector.

(4) The director shall keep a record of the day and hour of such service upon him. No proceedings shall be brought against the producer, and the producer shall not be required to appear, plead or answer until the expiration of thirty (30) days after the date of service upon the director.

41-1011. ISSUANCE -REFUSAL OF LICENSE.

If after completion of application for a license, the taking and passing of any examination required under this chapter and, if required by the director, receipt of a report from the federal bureau of investigation based on the fingerprints of the applicant, the director finds that the applicant has fully met the requirements for a license, the director shall issue the license to the applicant; otherwise, the director shall refuse to issue the license and shall promptly notify the applicant and any appointing insurer or insurers of such refusal and state the grounds for the refusal. Pending the receipt of the report from the federal bureau of investigation, the director may, in his discretion, issue a temporary license if all other qualifications have been met.

41-1012. EXEMPTION FROM EXAMINATION.

(1) An individual who applies for an insurance producer license in this state and who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing examination if:

(a) The person is currently licensed in another state; or

(b) The application is received within ninety (90) days of the cancellation of the applicant's previous license and the prior state issues a certification that:

(i) At the time of cancellation, the applicant was in good standing in that state; or

(ii) The state's producer database records, as maintained by the national association of insurance commissioners or its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the lines of authority requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to section41-1006, Idaho Code. No examination shall be required of that person to obtain any line of authority previously held in the prior state unless the director provides otherwise by rule.

41-1013. CONTINUATION -EXPIRATION OF LICENSES -CONTINUING EDUCATION STATEMENT.

(1) All producer, adjuster, and surplus line broker licenses issued under this code shall continue in force until expired, suspended, revoked or otherwise terminated, subject to payment of the applicable continuation fee on or before the expiration date referred to in subsection (2) of this section, accompanied by a written request for such continuation and a continuing education statement verifying that the licensee has completed any continuing education requirements imposed by the director. An application for renewal is not complete unless it is submitted with both the applicable fee and the completed continuing education statement. Requests for continuation shall be made in writing on forms to be prescribed by the director.

(2) The director may fix the dates of expiration for licenses in such manner as is deemed by him to be advisable for an efficient distribution of the workload of his office. If the expiration date for a particular license or appointment would shorten the period for which the license or appointment continuation fee has been paid, no refund of an unearned fee shall be made. If the expiration date for a particular license or appointment would lengthen the period for which a license or appointment continuation fee has been paid, the director shall charge no additional fee for such lengthened period.

(3) Any license referred to in subsection (1) of this section for which no request for continuation, fee and completed continuing education statement are timely received by the director shall be deemed to have expired at midnight on the applicable expiration date.

(4) All sums tendered as fees for continuations of licenses as producer, limited lines producer, adjuster or surplus line broker shall be deemed earned when paid and shall not be subject to refund, except that the director shall refund any duplicate payment of fees.

(5) For the protection of the people of this state the director shall establish, by rule, additional educational requirements designed to maintain and improve the insurance skills and knowledge of resident producers after licensure by the department of insurance. The director shall also establish, by rule, an advisory committee comprised of representatives from each segment of the insurance industry to assist the director in prescribing additional educational requirements. Such rules promulgated by the director shall include limits on the terms of service for members of the committee.

(6) Subject to subsection (3) of this section, the director shall not permit to be continued the license of any producer who is licensed pursuant to section41-1007, Idaho Code, who is a resident of this state, unless such person has demonstrated to the satisfaction of the director that in addition to meeting the standards contained in sections41-1007, (qualifications for producer license), Idaho Code, as may be applicable, all the additional educational requirements as the director may prescribe by rule have been met.

(7) Failure of the licensee to comply with any applicable additional education requirements prescribed by the director by rule by the expiration date of the license shall be grounds for the director to refuse to continue any such license. The licensee may reinstate his or her license by submitting proof of all education requirements within ninety (90) days from the date of expiration of the license and by submitting an additional administrative penalty of one hundred dollars (sections41-1007, (qualifications for producer license), Idaho Code, as may be applicable, all the additional educational requirements as the director may prescribe by rule have been met.

(8) Failure of the licensee to comply with any applicable additional education requirements prescribed by the director by rule by the expiration date of the license shall be grounds for the director to refuse to continue any such license. The licensee may reinstate his or her license by submitting proof of all education requirements within ninety (90) days from the date of expiration of the license and by submitting an additional administrative penalty of one hundred dollars ($100) for a delinquency of one (1) day to thirty (30) days, two hundred dollars ($200) for a delinquency of00) for a delinquency of one (1) day to thirty (30) days, two hundred dollars (00) for a delinquency of thirty-one (31) days to sixty (60) days, and three hundred dollars ($300) for a delinquency of sixty-one (61) days to ninety (90) days. Following the ninetieth day from the date of nonrenewal of the license and up to one (1) year from the nonrenewal date, the licensee must complete all requirements for licensure including retesting, submission of a new application and payment of all new licensing fees. In addition, the individual must submit proof of completion of the required education requirements for the licensing period in which the license was terminated. After the license has been expired for one (1) year or more, the individual must reapply and retest as a new applicant.

41-1016. ADMINISTRATIVE PENALTY -SUSPENSION, REVOCATION, REFUSAL OF LICENSE.

(1) The director may impose an administrative penalty not to exceed one thousand dollars ($1,000), for deposit in the general fund of the state of Idaho, and may suspend for not more than twelve (12) months or may revoke or refuse to issue or continue any license issued under this chapter, chapter 27, title 41, Idaho Code (title insurance), chapter 11, title 41, Idaho Code (adjusters),

or chapter 12, title 41, Idaho Code (surplus lines brokers), if the director finds that as to the licensee or applicant any one (1) or more of the following causes or violations exist:

(a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(b) Violating any provision of title 41, Idaho Code, department rule, subpoena or order of the director or of another state's insurance director;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;

(e) Misrepresenting the terms of an actual or proposed insurance contract or application for insurance or misrepresenting any fact material to any insurance transaction or proposed transaction;

(f) Being convicted of or pleading guilty to a crime that is deemed relevant in accordance with section 67-9411(1), Idaho Code, or that evidences dishonesty, a lack of integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public;

(g) Admitting or being found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility, or being a source of injury and loss to the public or others, in the conduct of business in this state or elsewhere;

(i) Having an insurance license denied, suspended or revoked in any other state, province, district or territory;

(j) Forging another's name on an application for insurance or on any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(l) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation, provided however, that nothing in this provision shall be deemed to abrogate or modify chapter 14, title 7, Idaho Code;

(n) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax; or

(o) In the case of a bail agent, compensating or agreeing to compensate any incarcerated person to influence or encourage another incarcerated person or other incarcerated persons to engage the bail agent's services or the services of the bail agent's company or of other bail agents employed by such bail company. For purposes of this subsection, compensating any incarcerated person shall include providing payment in any form to any person, organization or entity designated by the incarcerated person to receive such payment.

(2) The director shall, without hearing, suspend for not more than twelve (12) months, or shall revoke or refuse to continue any license issued under this chapter to a nonresident where:

(a) The director has received a final order of suspension, revocation or refusal to continue from the insurance regulatory official or court of jurisdiction of the licensee's home state; or

(b) A nonresident no longer has a license in the licensee's home state because the home state license was:

(i) Voluntarily surrendered for any reason except relicensing as a resident in another state; or

(ii) Otherwise nonrenewed by the nonresident and remains nonrenewed for a period greater than ninety (90) days beyond its expiration date, and without notice to the director of relicensing as a resident in another state.

If cause under this provision exists after the expiration of the twelve (12) months, successive suspensions may be imposed by the director without hearing.

(3) The license of a business entity may be suspended, revoked or refused if the director finds that the violation of an individual licensee, who is registered to or acting on behalf of the business entity, was known or should have been known by one (1) or more of the owners, officers or managers acting on behalf of the business entity and that the violation was not reported to the director and no corrective action was taken.

(4) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine or administrative penalty pursuant to subsection (1) of this section or any other applicable section.

(5) The director shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by title 41, Idaho Code, against any person who is under investigation for or charged with a violation of title 41, Idaho Code, or department rule, even if the person's license or registration has been surrendered or has lapsed by operation of law, or if the person has never been licensed.

41-1017. COMMISSIONS.

(1) An insurance company or insurance producer shall not pay a commission, service fee or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is not duly licensed as required under this chapter.

(2) A person shall not accept a commission, service fee or other valu- able consideration for selling, soliciting or negotiating insurance in this state if that person is not duly licensed as required under this chapter.

(3) Renewals or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if that person was duly licensed as required under this chapter at the time of the sale, solicitation or negotiation.

(4)An insurer or insurance producer may pay or assign commissions, service fees or other valuable consideration to any person, regardless of whether that person is licensed as a producer, unless the payment or assignment would violate a specific section of title 41, Idaho Code, including, but not limited to, sections41-1314 and41-2708, Idaho Code, or department rule.

41-1018. APPOINTMENTS.

(1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(2)To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the director, a notice of appointment within

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41-1019. NOTIFICATION TO DIRECTOR OF TERMINATION.

(1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the director within thirty (30) days following the effective date of the termination, using a format prescribed by the director, if the reason for termination is one of the reasons set forth in section41-1016, Idaho Code, or the insurer has knowledge that the producer was found by a court, governmental body or self-regulatory organization authorized by law to have engaged in any of the activities set forth in section41-1016, Idaho Code. Upon the written request of the director, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer for any reason not set forth in section41-1016, Idaho Code, shall notify the director within thirty (30) days following the effective date of the termination, using a format prescribed by the director. Upon written request of the director, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

(3) The insurer or authorized representative of the insurer shall promptly notify the director in a format acceptable to the director if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the director in accordance with subsection (1) of this section.

(4) A copy of any notification shall be provided to the producer as follows:

(a) Within fifteen (15) days after making the notification required by subsections (1), (2) and (3) of this section, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any other reasons listed in section41-1016, Idaho Code, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(b) Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the director. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the director's file and shall accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (6) of this section.

(5) Immunities.

(a) In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the director, or an organization of which the director is a member and that compiles information and makes it available to other insurance directors or regulatory or law enforcement agencies, shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the director from an insurer or producer or as a result of any statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection (1) of this section was reported to the director, provided that the propriety of any termination for cause under subsection (1) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(b) In any action brought against a person that may have immunity under paragraph (a) of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the director, the party bringing the action shall plead specifically in any allegation that paragraph (a) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(c) Paragraph (a) or (b) of this subsection shall not abrogate or modify any existing statutory or common law privileges or immunities.

(6) Confidentiality.

(a) Any documents, materials or other information obtained by the director in an investigation pursuant to this section shall be exempt from public disclosure under chapter 1, title 74, Idaho Code.

(b) In order to assist in the performance of the director's duties under this chapter, the director:

(i) May share documents, materials or other information, including confidential and privileged documents and materials or information subject to paragraph (a) of this subsection, with other state, federal and international regulatory agencies and law enforcement authorities, and with the national association of insurance commissioners, its affiliates or subsidiaries, provided that the recipient agrees to maintain the confidentiality and privileged status of the documents, materials or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners, its affiliates or subsidiaries and from regulatory agencies and law enforcement authorities of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials or information received with notice or with the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(c) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in paragraph (b) of this subsection.

(d) Nothing in this chapter shall prohibit the director from releasing final adjudicated actions, including for cause terminations that are open to public inspection pursuant to chapter 1, title 74 and title 41, Idaho Code, to a database or other clearinghouse service maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

(7) Penalties for failing to report. An insurer, the authorized representative of the insurer, or a producer who fails to report as required under the provisions of this section or who is found by a court of competent jurisdiction to have reported with actual malice may, after notice and hearing, have his license or certificate of authority suspended or revoked and may be fined in accordance with section41-1016 or41-327, Idaho Code.

41-1021. REPORTING OF ACTIONS.

(1) A producer shall report to the director any administrative action taken against the producer in another jurisdiction or by another governmental agency within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent order or other relevant legal documents.

(2) Within thirty (30) days of the initial pretrial hearing date, a producer shall report to the director any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

41-1024. REPORTING AND ACCOUNTING FOR PREMIUMS.

(1) All fiduciary funds received or collected by a producer shall be trust funds received by the producer in a fiduciary capacity, and the producer shall, in the applicable regular course of business, account for and pay the same to the person entitled to the funds. The producer shall establish a separate account for funds belonging to others in order to avoid a commingling of such fiduciary funds with his own funds. The producer may deposit and commingle in such separate account all fiduciary funds so long as the amount of such deposit so held for all other persons is reasonably ascertainable from the records and accounts of the producer. A producer who duly collects and deposits funds into a sweep account maintained by or for the benefit of an applicable insurer shall not be deemed to be in violation of the fiduciary fund account requirement. The director may promulgate rules relating to accounting for and handling of fiduciary funds and the fiduciary fund account.

(2) Fiduciary funds shall include all funds collected by an insurance producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or the producer's employer, and all funds collected by an insurance producer from an insurance company or its agents that are to be paid to a policyholder or claimant under any contract of insurance.

(3) Any producer who, not being lawfully entitled thereto, diverts or appropriates to his own use such trust or fiduciary funds or any portion thereof, whether or not such funds have been separately deposited, shall upon conviction be guilty of a felony.

41-1026. PROCEDURE FOLLOWING SUSPENSION, REVOCATION, DENIAL -REINSTATEMENT.

(1) Upon suspension, revocation, or refusal to continue any license, the director shall notify the licensee as provided in section41-212(3), Idaho Code, and, in the case of a producer who holds appointments from insurers, shall give like notice to the insurers represented.

(2) Suspension, revocation, or refusal of any one (1) license held by the licensee under title 41, Idaho Code, shall automatically suspend, revoke or refuse continuation of all other licenses held by the licensee under title 41, Idaho Code.

(3) The director shall not issue a license under title 41, Idaho Code, to or as to any person whose license has been revoked or continuance refused until after the expiration of not less than one (1) year, to a maximum of five

(5) years, from the date of such revocation or refusal, which time period shall be set forth in the final order, or, if judicial review of such revocation or refusal is sought, not less than one (1) year, to a maximum of five

(5) years, from the date of a final court order or decree affirming the revocation or refusal. If no time period is specified in the final order or final court order or decree, the time period shall be one (1) year. In the event the former licensee again files an

application for a license under title 41, Idaho Code, the director may require the applicant to show good cause why the prior revocation or refusal to continue his license shall not be deemed a bar to the issuance of a new license.

(4) The director shall not issue a license under title 41, Idaho Code, to any person whose application for a license was previously denied until after the expiration of one (1) year from the date of such license denial or, if judicial review of such license denial is sought, one (1) year from the date of a final court order or decree affirming the license denial.

41-1030. PRODUCER COMPENSATION.

(1) For purposes of this section:

(a) "Consumer" means an insured, a prospective insured or an employer group.

(b) "Retail producer" means a producer who solicits, negotiates with or sells an insurance contract directly to a consumer.

(c) "Wholesale producer" means a producer who solicits, negotiates or sells an insurance contract directly with a retail producer, but not with a consumer.

(2) Notwithstanding any other provision of title 41, Idaho Code, and as provided in this subsection, retail producers and wholesale producers may charge a fee or be compensated by a combination of fees and commissions.

(a) Before charging a fee to a consumer, a retail producer shall provide to the consumer a written statement that describes the services the retail producer will perform and the fees the retail producer will receive. Acceptance by the consumer of a fee arrangement shall be evidenced by the consumer signing and dating the fee statement.

(b) Before charging a fee to a retail producer, a wholesale producer shall provide to the retail producer a written statement that describes the services the wholesale producer will perform and the fees the wholesale producer will receive. Information regarding the amount of the fees charged by the wholesale producer shall be disclosed in writing on the face of the policy as a separately itemized charge.

41-1036. RECORDS.

(1) A producer holding a license under this chapter shall make available through his principal place of business complete records of transactions placed through or countersigned by the producer.

(2) Records as provided in subsection (1) of this section shall include, but not be limited to:

(a) The names and addresses of insurer and insured;

(b) The number and expiration date of the policy or contract;

(c) The premium payable as to the policy or contract;

(d) The date, time, insurer, insured and coverage of every binder made by the producer;

(e) All disclosures made by a producer to an insured or to a prospective insured; and

(f) Such other information as the director may reasonably require.

(3) The records shall be kept available for inspection by the director for at least five (5) years after the creation or the completion, whichever is later, of the respective transactions. The records may be maintained offsite and in electronic form if the records can be made available for inspection through the producer's principal place of business upon reasonable notice by the director.

41-1103. LICENSE REQUIRED.

No person shall in this state be, act as, or advertise or hold himself out to be, an adjuster unless then licensed as an adjuster under this chapter. No resident of Canada may be licensed as a resident adjuster or may designate Idaho as his home state, unless such person has successfully passed the adjuster examination and has complied with the other applicable provisions of this chapter. No resident of Canada may be licensed as a nonresident adjuster unless such person has obtained a resident or home state adjuster license in another state.

41-1104. QUALIFICATIONS FOR ADJUSTER'S LICENSE.

(1) Except as provided in subsection (2) of this section, the director shall not issue, continue, or permit to exist any license as an adjuster as to any person not qualified therefor as follows:

(a) Must be a natural person not less than twenty-one (21) years of age.

(b) Must be trustworthy, and be of good character and reputation as to morals, integrity, and financial responsibility, and must not have been convicted of any crime that is deemed relevant in accordance with section 67-9411(1), Idaho Code.

(c) Must be a salaried employee of a licensed adjuster, or must have had experience or special education or training as to the investigation and settlement of loss of claims under insurance contracts of sufficient duration and extent reasonably to satisfy the director as to his competence to fulfill the responsibilities of an adjuster.

(d) If required by the director, must pass a written examination to test his knowledge of the duties and responsibilities of an adjuster and of matters involved in transactions under an adjuster's license. The examination shall be subject to the same applicable provisions as apply pursuant to title 41, Idaho Code, to examinations for license as insurance agent.

(2) A firm or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers in this state is separately licensed, or is named in the firm or corporation license, and is qualified as for an individual license as adjuster under subsection (1) of this section. An additional full license fee shall be paid as to each individual in excess of one (1) so named in the firm or corporation license to exercise its powers.

41-1303. MISREPRESENTATION OR FALSE ADVERTISING OF POLICIES.

(1) No person shall make, issue, circulate, or cause to be made, issued, or circulated, any estimate, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

(2) No person shall misrepresent a policy for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.

(3) No person shall misrepresent any insurance policy as being shares of stock.

(4) For reasonable cause the director may in his discretion require any insurer or agent using or proposing to use in this state a prospectus, offering sheet, or other sales literature or printed sales aids in the solicitation of life or disability insurance to file the same with him for review. The director shall forthwith by order disapprove any such prospectus, sheet, literature, or aid found by him to be in violation of this section. The order shall become effective on the effective date specified therein, which date shall not be less than ten (10) days after the date the order was issued and mailed to the insurer or agent affected thereby; except, that if the insurer or agent prior to such effective date makes written request to the director for a hearing relative to the matter the director's order shall thereby be stayed pending the hearing and the director's further order on hearing. No insurer, agent, or other representative shall use in this state any prospectus, offering sheet, literature or sales aid after the date an order of disapproval thereof has become effective and has been communicated to the insurer. This provision shall not relieve any person of liability for penalties provided for violation of subsection (1) above.

41-1304. FALSE INFORMATION AND ADVERTISING WITH RESPECT TO INSURANCE BUSINESS.

No person 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 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, any advertisement, announcement, or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

41-1305. "TWISTING" PROHIBITED.

No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, surrender, lease, retain, exchange, or convert, or otherwise use or dispose of any insurance policy, or any right or option thereunder, or in connection with any such statement and for like purpose fail to disclose all reasonably material facts, or a material fact necessary to make the statements made, in the light of the circumstances under which they are made, not misleading.

41-1306. FALSE FINANCIAL STATEMENTS.

(1) No person shall file with any supervisory or other public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.

(2) No person shall make any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

41-1308. 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 which is false, or maliciously critical of or derogatory to the financial condition of an insurer, or of an organization proposing to become an insurer, and which is circulated to injure any person engaged or proposing to engage in the business of insurance.

41-1309. BOYCOTT, COERCION AND INTIMIDATION.

No person or persons 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.

41-1310. PERSON FINANCING PURCHASE OF PROPERTY NOT TO FAVOR INSURER OR AGENT.

No person engaged in the business of financing the purchase of real or personal property and no trustee, director, officer, agent or other employee of any such person shall require, as a condition to financing the purchase of such property or to loaning money upon the security of a mortgage thereon, or, as a condition for the renewal or extension of any such loan or mortgage or for the performance of any other act in connection therewith, that the person for whom such purchase is to be financed or to whom the

money is to be loaned or for whom such extension, renewal or other act is to be granted or performed, purchase or place fire, property damage, theft, collision or personal injury insurance which is required to be maintained by him on the mortgaged property, from or through any particular insurance agent or agents, broker or brokers, or insurer or insurers.

41-1311. SELLER OF PROPERTY NOT TO FAVOR INSURER OR AGENT.

No seller of real or personal property, and no person engaged in the business of selling real or personal property, and no trustee, director, officer, agent or other employee of any such seller or such other person shall require, as a condition to the selling of such property, or for the performance of any other act in connection therewith, that the person to whom such property is to be sold, purchase or place any fire, property damage, theft, collision or personal injury insurance covering such property, from any particular insurance agent or agents, broker or brokers, or insurer or insurers.

41-1312. RIGHTS WITH RESPECT TO INSURANCE ON PROPERTY SOLD OR PURCHASED.

Sections41-1310 or41-1311 shall not prevent:

(1) The reasonable exercise by any person engaged in any such business of his right to approve or disapprove the insurance or the insurer selected to write the insurance, on reasonable grounds related to the risk selection or underwriting practices of the insurer, the adequacy and terms of the coverage with respect to the interest of such person to be insured thereunder, the quality of service rendered by the insurer or its representative in connection with the insurance, and the financial standards to be met by the insurer; nor of his right to furnish such insurance or to renew any insurance required by the contract of sale or mortgage, trust deed or other loan agreement if the borrower or purchaser has failed to furnish the insurance or renewal thereof within such reasonable time or form as may be specified in the sale or loan agreement. The lender or vendor shall not refuse to accept insurance provided by an acceptable insurer on the ground that such insurance provides more coverage than is required in the sale or loan agreement, unless the additional coverage consists of life or disability insurance.

(2) The free choice of insurance agent or broker by any borrower or purchaser at any time, and he may revoke any designation of insurance agent or broker at any time irrespective of the provisions of any loan or purchase agreement, mortgage, or trust deed.

(3) The exercise by any person engaged in such business of his right to furnish such insurance or to renew such insurance, and to charge the account of the borrower or purchaser with the costs thereof, if the borrower or purchaser fails to deliver to the lender or vendor such insurance at least thirty (30) days prior to expiration of the existing policy. If an insurance policy procured by the borrower or purchaser is subsequently substituted for that then in force, the lender or vendor may impose a reasonable service charge as determined by the director for the transaction, and payment of such charge by the agent or broker shall not be a violation of any other provision of this code. No service charge shall be imposed for normal insurance changes made during the term of the policy.

(4) The director may adopt a uniform statewide schedule of permissive maximum charges for the substitution of policies authorized in subdivision (3) above.

41-1313. UNFAIR DISCRIMINATION -LIFE INSURANCE, ANNUITIES, AND DISABILITY INSURANCE.

(1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(3) No person shall discriminate on the basis of a genetic test or private genetic information, as those terms are defined in section 39-8302, Idaho Code, in the issuance of coverage, or the fixing of rates, terms or conditions, for any policy or contract of disability insurance or any health benefit plan.

41-1314. REBATES -ILLEGAL INDUCEMENTS.

(1) Except as otherwise expressly provided by law, no person shall knowingly make, permit to be made, or offer to make any contract of insurance, or of annuity, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity or in connection therewith, any rebate of premiums payable on the contract, or of any producer's commission related thereto, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract; or directly or indirectly give, or sell, or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith, and whether or not specified or to be specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds, or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other person, or any dividends or profits accrued or to accrue thereon; or offer, promise or give anything of value whatsoever not specified in the contract. Nor shall any insured, annuitant, or policyholder or employee thereof, or prospective insured, annuitant or policyholder, or employee thereof, knowingly accept or receive, directly or indirectly, any such prohibited contract, agreement, rebate, advantage, employment, or other inducement.

(2) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed producers, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, the usual and ordinary dividends, savings, or unabsorbed premium deposits.

(3) Nothing in this section shall be construed as prohibiting a life insurer, disability insurer, property insurer or casualty insurer, or producers who are marketing life insurance, disability insurance, property insurance or casualty insurance, from providing to a policyholder or prospective policyholder of life, disability, property or casualty insurance, any prizes, goods, wares, merchandise, articles or property of an aggregate value not to exceed two hundred dollars ($200) in a calendar year.

(4) Extension of credit for the payment of premium beyond the customary premium payment period without charging and collecting interest at a reasonable rate per annum on the amount of credit so extended and for the duration of such credit is prohibited under this section.

41-1315. EXCEPTIONS TO DISCRIMINATION OR REBATE PROVISION -LIFE OR DISABILITY POLICIES, AND ANNUITY CONTRACTS.

Nothing in sections41-1313 and41-1314[, Idaho Code,] shall be construed as including within the definition of discrimination or rebates or illegal inducements any of the following practices:

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policy holders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policy holders.

(2) In the case of life insurance policies issued on the debit plan, making allowance to policy holders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(4) Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check or payroll deduction plan or other similar plan at a reduced rate reasonably related to the savings made by use of such plan.

(5) Issuance of life or disability insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, or modification of premium or rate based on amount of insurance; but any such issuance or modification shall not result in reduction in premium or rate in excess of savings in administration and issuance expenses reasonably attributable to such policies or contracts.

41-1321. PROCEDURES AS TO UNDEFINED PRACTICES.

[(1)] Whenever the director has reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not expressly prohibited or defined in this chapter, that such method of competition is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon as provided for in chapter 2, title 41, Idaho Code, or seek any other relief authorized by title 41, Idaho Code.

41-1323. Illegal dealing in premiums — Excess charges for insurance.

(1) No person shall wilfully collect any sum as premium or charge for insurance, which insurance is not then provided or is not in due course to be provided (subject to acceptance of the risk by the insurer) by an insurance policy issued by an insurer as authorized by this code.

(2) No person shall wilfully collect as premium or charge for insurance any sum in excess of the premium or charge applicable to such insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the director; or, in cases where classifications, premiums, or rates are not required by this code to be so filed and approved, such premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus line brokers licensed under chapter 12 of this code, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. Nor shall it be deemed to prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) Each violation of this section shall be punishable under section 41-117 (general penalty).

41-1325. BORROWING MONEY FROM CLIENTS.

(1) An insurance producer who borrows money, securities or anything of value from a client or customer, unless the client or customer is a person engaged in the business of loaning funds or is an immediate family member of the insurance producer, shall complete a written loan agreement that sets forth the parties to the loan, the purpose of the loan, the amount of the loan and the terms of the loan. All parties to the loan must sign the loan agreement acknowledging the transaction and must receive a copy of the loan agreement. The insurance producer shall keep a record of the loan transaction until the loan is paid back in full. Any release of the debt shall be in writing and signed by all parties to the release.

(2) As used in this section, the term "immediate family member" means a parent, mother-in-law, father-in-law, husband, wife,

sister, brother, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or a son or daughter.

41-1327. VIOLATIONS -PENALTY.

Any person who violates any provision of this chapter as to which a penalty is not expressly provided, or who violates a cease and desist order issued by the director under section41-213, Idaho Code, after such order has become final, shall be subject to penalties as prescribed by or referred to in section41-117, Idaho Code (general penalty).

41-1328. PAYMENT OF CLAIMS BY INSURERS.

Every insurer issuing a motor vehicle insurance policy, as defined in chapter 5, title 41, Idaho Code, shall, in the event of damage to a covered motor vehicle by collision and the election by the insurer to have such motor vehicle repaired, make payment by check or draft, payable to the repairer or to the named insured and the repairer, jointly, no later than twenty (20) days subsequent to receipt of an itemized bill or invoice covering repairs authorized by the insurer which have been satisfactorily completed.

41-1329. UNFAIR CLAIM SETTLEMENT PRACTICES.

Pursuant to section41-1302, Idaho Code, committing or performing any of the following acts or omissions intentionally, or with such frequency as to indicate a general business practice shall be deemed to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance:

(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 to pay claims without conducting a reasonable investigation based upon all available information;
(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 effectuate 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 a claim 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 which 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 the 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, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions 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.

41-1329A. UNFAIR CLAIMS SETTLEMENT PRACTICES -PENALTY.

The director, if he finds after a hearing, that an insurer has violated the provisions of section41-1329, Idaho Code, may, in his discretion, impose an administrative penalty not to exceed ten thousand dollars ($10,000) to be deposited by the director as provided in section41-406, Idaho Code, and may, in addition to the fine, or in the alternative to the fine, refuse to continue or suspend or revoke an insurer's certificate of authority.

41-1803. "PREMIUM" DEFINED.

"Premium" is the consideration for insurance by whatever name called. Any "assessment," or any "membership," "policy," "survey," "inspection," "service" or similar fee or other charge in consideration for an insurance contract is deemed part of the premium; provided that producer fees charged pursuant to section41-1030, Idaho Code, shall not be considered a premium unless the fee relates to a surplus line policy.

41-1807. POWER TO CONTRACT -PURCHASE OF INSURANCE BY MINORS.

(1) Any person of competent legal capacity may contract for insurance.
(2) Any minor not less than fifteen (15) years of age, notwithstanding his minority, may contract for annuities or for insurance upon his own life, body, health, property, liabilities or other interests, or on the person of another in whom the minor has an insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under (a) any contract for annuity or for insurance upon his own life, body or health, or (b) any contract such

minor effected upon his own property, liabilities or other interests, or on the person of another, as might be exercised by a person of full legal age, and may at any time surrender his interest in any such contracts and give valid discharge for any benefit accruing or money payable thereunder. Such a minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated, shall not be bound by any unperformed agreement to pay by promissory note or otherwise, any premium on any such annuity or insurance contract.

(3) Any annuity contract or policy of life or disability insurance procured by or for a minor under subsection (2) above, shall be made payable either to the minor or his estate or to a person having an insurable interest in the life of the minor.

41-1812. FILING, USE AND DISAPPROVAL OF FORMS.

(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be delivered, or issued for delivery in this state, unless the form has been filed with the director. This provision shall not apply to surety bonds, or to specially rated inland marine risks, nor to policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the director. As to forms for use in property, marine (other than wet marine and transportation insurance), casualty and surety insurance coverages the filing required by this subsection may be made by rating organizations on behalf of its members and subscribers; but this provision shall not be deemed to prohibit any such member or subscriber from filing any such forms on its own behalf.

(2) Every such filing shall be submitted with a certification, in such form as may be determined by the director, by an officer of the insurer that each policy, form, endorsement, or rider in use complies with Idaho law. The director shall have the power to examine such filings to determine whether the policies, forms, endorsements, and riders, as filed, comply with the certification of the insurer and with Idaho law relating to the content of such documents. Upon a determination that any document filed in accordance with this section does not comply with Idaho law, the director shall, in accordance with the Idaho administrative procedure act, prohibit the use of such policy, form, endorsement, rider or other document.

(3) The director may, by order, exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in such order, to which, in his opinion, this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

41-1826. ASSIGNMENT OF POLICIES.

A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or disability policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

41-1828. PAYMENT DISCHARGES INSURER -PAYMENT TO MARITAL COMMUNITY.

(1) Whenever the proceeds of or payments under a life or disability insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by such assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.

(2) Where the person designated in the policy or contract or by assignment as being entitled thereto is a member of a marital community, whether husband or wife, and the policy or contract is upon the life or disability of either, he or she may receive payment, and shall be and is constituted agent of the marital community with authority to give full acquittance therefor; and such payment to the marital community agent so designated shall fully discharge the insurer from all claims under the policy or contract, but no rights of either member of the marital community, as between themselves, to accounting or division shall be impaired or affected by such payment.

41-1833. EXEMPTION OF PROCEEDS -LIFE INSURANCE.

(1) If a policy of insurance, whether heretofore or hereafter issued, is effected by any person on his own life, or on another life, in favor of a person other than himself, or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance

is assigned or in any way made payable to any such person, the lawful beneficiary or assignee thereof, other than the insured or the person so effecting such insurance or executors or administrators of such insured or the person so effecting such insurance, shall be entitled to its proceeds and avails against the creditors and representatives of the insured and of the person effecting the same, whether or not the right to change the beneficiary is reserved or permitted, and whether or not the policy is made payable to the person whose life is insured if the beneficiary or assignee shall predecease such person, and such proceeds and avails shall be exempt from all liability for any debt of the beneficiary existing at the time the policy is made available for his use: provided, that subject to the statute of limitations, the amount of any premiums for such insurance paid with intent to defraud creditors, with interest thereon, shall inure to their benefit from the proceeds of the policy; but the insurer issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless, before such payment, the insurer shall have received written notice at its home office, by or in behalf of a creditor, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specification of the amount claimed.

(2) For the purposes of subsection (1) above, a policy shall also be deemed to be payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by such clause.

(3) This section shall not be affected by the terms of section 15-6-107, Idaho Code.

41-1835. EXEMPTION OF PROCEEDS -GROUP INSURANCE.

(1) A policy of group life insurance or group disability insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of such insured individual or his beneficiary or of any other person having a right under the policy. The proceeds thereof, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his debts.

(2) This section shall not apply to group insurance issued pursuant to this code to a creditor covering his debtors, to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

(3) This section shall not be affected by the terms of section 15-6-107, Idaho Code.

41-1836. EXEMPTION OF PROCEEDS -ANNUITY CONTRACTS -ASSIGNABILITY OF RIGHTS.

(1) The benefits, rights, privileges and options which under any annuity contract heretofore or hereafter issued are due or prospectively due the annuitant, shall not be subject to execution nor shall the annuitant be compelled to exercise any such rights, powers, or options, nor shall creditors be allowed to interfere with or terminate the contract, except:

(a) As to amounts paid for or as premium on any such annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of the payments to the annuitant out of which the creditor seeks to recover. Any such notice shall specify the amount claimed or such facts as will enable the insurer to ascertain such amount, and shall set forth such facts as will enable the insurer to ascertain the annuity contract, the annuitant and the payments sought to be avoided on the ground of fraud.

(b) The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity contracts under which he is an annuitant, shall not at any time exceed one thousand two hundred fifty dollars ($1,250) per month for the length of time represented by such installments, and that such periodic payments in excess of one thousand two hundred fifty dollars ($1,250) per month shall be subject to garnishee execution to the same extent as are wages and salaries.

(c) If the total benefits presently due and payable to any annuitant under all annuity contracts under which he is an annuitant, shall at any time exceed payment at the rate of one thousand two hundred fifty dollars ($1,250) per month, then the court may order such annuitant to pay to a judgment creditor or apply on the judgment, in installments, such portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(d) As to any deferred annuity contract having a cash surrender provision and from which no periodic payments are being made, the cash surrender value of the deferred annuity contract, not to exceed premiums paid into the deferred annuity contract within six (6) months prior to the filing of a bankruptcy petition, as defined in 11 U.S.C. section 101, or the date of attachment or levy on execution, as defined in section 11-201, Idaho Code, whichever is applicable.

(2) If the contract so provides, the benefits, rights, privileges or options accruing under such contract to a beneficiary or assignee shall not be transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained herein for the annuitant, shall apply with respect to such beneficiary or assignee.

(3) An annuity contract within the meaning of this section shall be any obligation to pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not such sums are payable to one (1) or more persons, jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives, or for a specified term or terms.

(4) This section shall not be affected by the terms of section 15-6-107, Idaho Code.

41-1839. ALLOWANCE OF ATTORNEY'S FEES IN SUITS AGAINST OR IN ARBITRATION WITH INSURERS.

(1) Any insurer issuing any policy, certificate or contract of insurance, surety, guaranty or indemnity of any kind or nature whatsoever that fails to pay a person entitled thereto within thirty (30) days after proof of loss has been furnished as provided in such policy, certificate or contract, or to pay to the person entitled thereto within sixty (60) days if the proof of loss pertains to uninsured motorist or underinsured motorist coverage benefits, the amount that person is justly due under such policy, certificate or contract shall in any action thereafter commenced against the insurer in any court in this state, or in any arbitration for recovery under the terms of the policy, certificate or contract, pay such further amount as the court shall adjudge reasonable as attorney's fees in such action or arbitration.

(2) In any such action or arbitration, if it is alleged that before the commencement thereof, a tender of the full amount justly due was made to the person entitled thereto, and such amount is thereupon deposited in the court, and if the allegation is found to be true, or if it is determined in such action or arbitration that no amount is justly due, then no such attorney's fees may be recovered.

(3) This section shall not apply as to actions under the worker's compensation law, title 72, Idaho Code. This section shall not apply to actions or arbitrations against surety insurers by creditors of or claimants against a principal and arising out of a surety or guaranty contract issued by the insurer as to such principal, unless such creditors or claimants shall have notified the surety of their claim, in writing, at least sixty (60) days prior to such action or arbitration against the surety. The surety shall be authorized to determine what portion or amount of such claim is justly due the creditor or claimant and payment or tender of the amount so determined by the surety shall not be deemed a volunteer payment and shall not prejudice any right of the surety to indemnification and/or subrogation so long as such determination and payment by the surety be made in good faith. Nor shall this section apply to actions or arbitrations against fidelity insurers by claimants against a principal and arising out of a fidelity contract or policy issued by the insurer as to such principal unless the liability of the principal has been acknowledged by him in writing or otherwise established by judgment of a court of competent jurisdiction.

(4) Notwithstanding any other provision of statute to the contrary, this section and section 12-123, Idaho Code, shall provide the exclusive remedy for the award of statutory attorney's fees in all actions or arbitrations between insureds and insurers involving disputes arising under policies of insurance. Provided, attorney's fees may be awarded by the court when it finds, from the facts presented to it that a case was brought, pursued or defended frivolously, unreasonably or without foundation. Section 12-120, Idaho Code, shall not apply to any actions or arbitrations between insureds and insurers involving disputes arising under any policy of insurance.

41-1903. STANDARD PROVISIONS REQUIRED.

(1) No policy of life insurance other than group, and pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this state unless it contains in substance all of the applicable provisions required by sections41-1904 to41-1915, [Idaho Code,] inclusive, of this chapter. This section shall not apply to annuity contracts nor to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(2) Any of such provisions or portions thereof not applicable to single premium or term policies shall to that extent not be incorporated therein.

41-1904. GRACE PERIOD.

There shall be a provision that a grace period of thirty (30) days, or, at the option of the insurer, of one (1) month of not less than thirty (30) days, or of four (4) weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first policy year may be made, during which period of grace the policy shall continue in full force; the insurer may impose an interest charge not in excess of six per cent (6%) per annum for the number of days of grace elapsing before the payment of the premium, and, whether or not such interest charge is imposed, if a claim arises under the policy during such period of grace the amount of any premium due or overdue, together with interest and any deferred instalment of the annual premium, may be deducted from the policy proceeds.

41-1905. INCONTESTABILITY.

There shall be a provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

41-1906. ENTIRE CONTRACT.

There shall be a provision that the policy, or the policy and the application therefor if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties, and that all statements contained in such an application shall, in the absence of fraud, be deemed representations and not warranties.

41-1907. MISSTATEMENT OF AGE.

There shall be a provision that if the age of the insured or of any other person whose age is considered in determining the premium or benefit has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

41-1908. DIVIDENDS.

(1) There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy provided the policy is in force and all premiums to that date are paid. Except as hereinafter provided, any dividend becoming payable shall at the option of the party entitled to elect such option be either:

(a) Payable in cash, or

(b) Applied to any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than thirty (30) days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of (a) above even though the policy provides that payment of such dividend is to be deferred for a specified period, provided such period does not exceed six (6) years from the date of apportionment and that interest will be added to such dividend at a specified rate. If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under such nonforfeiture provision shall be applied in the manner set forth in the policy.

(2) In participating industrial life insurance policies, in lieu of the provision required in subsection (1) above, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

41-1909. POLICY LOAN.

(1) There shall be a provision that after three (3) full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy. A policy issued after July 1, 1975, and prior to July 1, 1982, shall contain either, but not both of the following policy loan interest rate provisions:

(a) A provision that a policy loan shall bear interest at a specified rate (not exceeding eight per cent (8%) per annum); or

(b) A provision that all loans under the policy, including outstanding loans, shall bear interest at a variable rate (not exceeding eight per cent (8%) per annum), specified from time to time by the insurer.

The effective date of any increase in such variable rate shall be not less than one (1) year after the effective date of the establishment of the previous rate. If the interest rate is increased, the amount of such increase shall not exceed one per cent (1%) per annum. 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,

1. when a loan is made and when notification of interest due is furnished, give notice of the variable rate currently effective;
2. as to any loans outstanding forty (40) days before the effective date of any increase in the variable rate, give notice of any such increase at least thirty (30) days before such effective date; and
3. as to any loans made during the forty (40) days before the effective date of the increase, give notice of such increase when the loan is made. Every such notice shall be given as directed by the policy owner and any assignee as shown on the records of the insurer at its home office.

(2) (a) Policies issued on or after July 1, 1982 shall provide for policy loan interest rates as follows:

1. A provision permitting a maximum interest rate of not more than eight per cent (8%) per annum; or
2. A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

(b) The rate of interest charged on a policy loan made under subsection (2)(a)2. shall not exceed the higher of the following:

1. The published monthly average for the calendar month ending two(2) months before the date on which the rate is determined; or
2. The rate used to compute the cash surrender values under the policy during the applicable period plus one per cent (1%) per annum.

(c) For purposes of this section the "published monthly average" means:

1. Moody's Corporate Bond Yield Average -Monthly Average Corporates as published by Moody's Investors Service, Inc. or any successor thereto; or
2. In the event that Moody's Corporate Bond Yield Average -Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the director.

(d) If the maximum rate of interest is determined pursuant to subsection (2)(a)2., the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(e) The maximum rate for each policy must be determined at regular intervals at least once every twelve (12) months, but not more frequently than once in any three (3) month period. At the intervals specified in the policy:

1. The rate being charged may be increased whenever such increase as determined under subsection (2)(b) would increase that rate by one-half per cent (.5%) or more per annum; or
2. The rate being charged must be reduced whenever such reduction as determined under subsection (2)(b) would decrease that rate by one-half per cent (.5%) or more per annum.

(f) The life insurer shall:

1. Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;
2. Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in (f)3. hereof;
3. Sent [Send] to policyholders with loans reasonable advance notice of any increase in the rate; and
4. Include in the notices required above the substance of the pertinent provisions of subsections (2)(a) and (2)(d).

(g) 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 life 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.

(h) The substance of the pertinent provisions of subsections (2)(a) and (2)(d) shall be set forth in the policies to which they apply.

(i) For purposes of this section:

1. The rate of interest 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.
2. The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due.
3. The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.
4. The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(j) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

(k) The provisions of this section shall not apply to any insurance contract issued before July 1, 1981 unless the policyholder agrees in writing to the applicability of such provisions.

(3) The loan value of the policy shall be at least equal to the cash surrender value at the end of the then current policy year, provided that the insurer may deduct, either from such loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and any interest which may be allowable on the loan to the end of the current policy year. The policy may also provide that if interest on any indebtedness is not paid when due it shall then be added to the existing indebtedness and shall bear interest at the same rate, and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six (6) months after application therefor. The policy, at the insurer's option, may provide for automatic premium loan, subject to an election of the party entitled to elect.

(4) This section shall not apply to term policies nor to term insurance benefits provided by rider or supplemental policy provisions, or to industrial life insurance policies.

41-1910. TABLE OF INSTALMENTS.

In case the policy provides that the proceeds may be payable in instalments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed instalments.

41-1911. REINSTATEMENT.

There shall be a provision that unless:

(1) The policy has been surrendered for its cash surrender value, or

(2) Its cash surrender value has been exhausted, or

(3) The paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three (3) years (or two (2) years in the case of industrial life insurance policies) from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears with interest at a rate not exceeding eight per cent (8%) per annum compounded annually and the payment or reinstatement of any other policy indebtedness with interest at a rate not exceeding the applicable policy loan rate or rates determined in accordance with the policy's provisions.

41-1912. PAYMENT OF PREMIUMS.

There shall be a provision relative to the payment of premiums.

41-1913. PAYMENT OF CLAIMS.

There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy and/or proof of the interest of the claimant. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, such period shall not exceed two (2) months from the receipt of such proofs.

41-1917. STANDARD PROVISIONS -ANNUITY AND PURE ENDOWMENT CONTRACTS.

(1) No annuity or pure endowment contract, other than reversionary annuities (also called survivorship annuities) or group annuities and except as stated herein, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in sections41-1918 to41-1923, inclusive, of this chapter. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

(2) This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

41-1918. GRACE PERIOD -ANNUITIES.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that there shall be a period of grace of one month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding six per cent (6%) per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

41-1919. INCONTESTABILITY -ANNUITIES.

If any statements, other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to section41-1921 of this chapter, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two (2) years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means.

41-1920. ENTIRE CONTRACT -ANNUITIES.

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

41-1921. MISSTATEMENT OF AGE OR SEX -ANNUITIES.

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof with interest at the rate to be specified in the contract but not exceeding six per cent (6%) per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

41-1922. DIVIDENDS -ANNUITIES.

If an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

41-1923. REINSTATEMENT -ANNUITIES.

In an annuity or pure endowment contract, other than a reversionary or group annuity, there shall be a provision that the contract may be reinstated at any time within one year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding six per cent (6%) per annum payable annually, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

41-1930. POLICY SETTLEMENTS.

Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the policy or as agreed to in writing by the insurer and the policyholder. Upon maturity of a policy, in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries. The insurer shall not be required to segregate the funds so held but may hold them as part of its general assets.

41-1935. LIFE INSURANCE AND ANNUITIES -TWENTY DAY FREE EXAMINATION.

(1) Every life insurance policy to which the provisions of section41-1927, Idaho Code, apply and every annuity contract shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the life insurance policy or annuity contract is issued shall be permitted to return the life insurance policy or annuity within twenty (20) days of its delivery to such person, and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy or contract under appropriate caption, and if not so printed on the face page of the policy or contract adequate notice of the provision shall be printed or stamped conspicuously on the face page.

(2) The policy or contract may be so returned to the insurer at its home or branch office or to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy or contract had not been issued.

41-1950. SHORT TITLE AND SCOPE.

(1) Sections41-1950 through41-1965, Idaho Code, may be cited as the "Life Settlements Act."

(2) Nothing contained herein is intended to abrogate or conflict with the Idaho uniform securities act contained in chapter 14, title 30, Idaho Code, or supersede the duty of persons to comply with that or any other applicable law. Given the combined interest and regulation of life settlements by the department and the department of finance, the director and the director of the department of finance should cooperate in the exercise of discretionary acts and enforcement of the applicable laws within their respective authority and responsibility.

(3) Unless clearly inapplicable, other provisions and chapters of title 41, Idaho Code, apply to licensees and persons subject to sections41-1950 through41-1965, Idaho Code, including, but not limited to, chapters 1 through 5, 10, 13, 18 and 19, title 41, Idaho Code. Specifically, section41-220, Idaho Code, applies to licensees under sections41-1950 through41-1965, Idaho Code.

41-1951. DEFINITIONS.

In sections41-1950 through41-1965, Idaho Code:

(1) "Advertising" means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy pursuant to a life settlement contract.

(2) "Business of life settlements" means an activity involved in, but not limited to, the offering to enter into, soliciting, negotiating, procuring or effectuating a life settlement contract. The transaction of the business of life settlements is within the scope of the transaction of the business of insurance as provided in section41-112, Idaho Code.

(3) "Chronically ill" means:

(a) Being unable to perform at least two (2) activities of daily living such as eating, toileting, transferring, bathing, dressing or continence; or

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(4) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a life settlement provider, credit enhancer or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, but:

(a) Whose principal activity related to the transaction is providing funds to effect the life settlement or purchase of one (1) or more settled policies; and

(b) Who has an agreement in writing with one (1) or more licensed life settlement providers to finance the acquisition of life settlement contracts.

"Financing entity" does not include a nonaccredited investor. An "accredited investor" is defined by rule 501 of regulation D, 17 CFR 230.501(a).

(5) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to section41-1008, Idaho Code.

(6) "Life settlement broker" or "broker" means a person who, working exclusively on behalf of an owner and for a fee, commission or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and

one (1) or more life settlement providers or one (1) or more life settlement brokers. Notwithstanding the manner in which the life settlement broker is compensated, a life settlement broker is deemed to represent only the owner, and not the insurer or the life settlement provider, and owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interest of the owner. Nothing in this definition reduces or impairs the scope of the definitions in section 30-14-102, Idaho Code, including, but not limited to, agent, broker-dealer, investment adviser, and investment adviser representative. The term does not include an attorney, certified public accountant or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the owner and whose compensation is not paid directly or indirectly by the life settlement provider or purchaser.

(7) "Life settlement contract" means an agreement between an owner and a life settlement provider or any affiliate, as that term is defined in section41-3802(1), Idaho Code, of the life settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy, in return for the owner's present or future assignment, transfer, sale, hypothecation, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. Nothing in this definition reduces or impairs the scope of the definition of security contained in section 30-14-102(28), Idaho Code.

(a) "Life settlement contract" includes a premium finance loan made for a life insurance policy on or before the date of issuance of the policy where one (1) or more of the following conditions apply:

(i) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(ii) The owner or the insured receives on the date of the premium finance loan a guarantee of a future life settlement value of the policy; or

(iii) The owner or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(b) "Life settlement contract" includes the transfer, for compensation or value, of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other person was formed or availed of for the principal purpose of acquiring one (1) or more life insurance policies which life insurance contract insures the life of a person residing in this state.

(c) "Life settlement contract" does not include any of the following:

(i) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms;

(ii) A loan, the proceeds of which are used solely to pay:

(A) Premiums for the policy; and

(B) The costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(iii) A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that neither the default itself nor the transfer of the policy in connection with the default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under sections41-1950 through41-1965, Idaho Code;

(iv) A loan made by a lender that does not violate the Idaho credit code, provided that the premium finance loan is not described in paragraph (a) of this subsection;

(v) An agreement where all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(vi) Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement:

(A) Between one (1) or more shareholders in a corporation or between a corporation and one (1) or more of its shareholders or one (1) or more trusts established by its shareholders;

(B) Between one (1) or more partners in a partnership or between a partnership and one (1) or more of its partners or one (1) or more trusts established by its partners; or

(C) Between one (1) or more members in a limited liability company or between a limited liability company and one (1) or more of its members or one (1) or more trusts established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(ix) Any other contract, transaction or arrangement exempted from the definition of life settlement contract by the director based on a determination that the contract, transaction or arrangement is not of the type intended to be regulated by sections41-1950 through41-1965, Idaho Code.

(8) "Life settlement provider" or "provider" means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner resident in this state. Nothing in this definition reduces or impairs the scope of the definitions of section 30-14-102, Idaho Code, including, but not limited to, agent, broker-dealer, investment adviser, and investment adviser representative. "Life settlement provider" does not include:
(a) A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan;
(b) A premium finance company making premium finance loans that takes an assignment of a life insurance policy solely as collateral for a loan;
(c) The insurer of the life insurance policy;
(d) An authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a life settlement provider, purchaser, financing entity, special purpose entity or related provider trust;
(e) A financing entity;
(f) A special purpose entity;
(g) A related provider trust; or
(h) Any other person that the director determines is not the type of person intended to be covered by the definition of life settlement provider.

(9) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and enters or seeks to enter into a life settlement contract. For the purposes of sections41-1950 through41-1965, Idaho Code, an owner shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed.
(a) If there is more than one (1) owner on a single policy and the owners are residents of different states, the transaction shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one (1) owner agreed upon in writing by all the owners.
(b) "Owner" does not include:
(i) A licensee under sections41-1950 through41-1965, Idaho Code, including a life insurance producer acting as a life settlement broker pursuant to sections41-1950 through41-1965, Idaho Code;
(ii) Qualified institutional buyer as defined, respectively, in rule 144A, 17 CFR 230.144A, promulgated under the federal securities act of 1933, 15 USC section 77a et seq., as amended;
(iii) A financing entity;
(iv) A special purpose entity; or
(v) A related provider trust.

(10) "Policy" means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(11) "Premium finance loan" means a loan made primarily for the purpose of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(12) "Related provider trust" means a titling trust or other trust established by a licensed life settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed life settlement provider under which the licensed life settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to life settlement transactions available to the director as if those records and files were maintained directly by the licensed life settlement provider.

(13) "Settled policy" means a life insurance policy or certificate that has been acquired by a life settlement provider pursuant to a life settlement contract.

(14) "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:
(a) For a financing entity or licensed life settlement provider;
(b) In connection with a transaction in which the securities in the special purposes entity are acquired by the owner or by "qualified institutional buyers" as defined in rule 144A, 17 CFR 230.144A, promulgated under the federal securities act of 1933, as amended; or
(c) In connection with a transaction in which the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(15) "Stranger-originated life insurance" or "STOLI" means an act, plan, practice, or arrangement to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person who, at the time of policy inception, could not lawfully initiate the policy himself or itself, and where, at the time of inception, there is an arrangement or agreement, whether oral or written, to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of an insurable

interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in subsection (7)(c) of this section.

(16) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death within twenty-four (24) months or less.

41-1952. LICENSE REQUIREMENT.

(1) A person shall not act as a life settlement provider or life settlement broker where the owner of the life insurance policy is a resident of this state without first obtaining a license from the director as a life insurance producer under chapter 10, title 41, Idaho Code, and complying with the additional requirements set forth in sections41-1950 through41-1965, Idaho Code.

(2) Not later than ten (10) days from the first day of operating as a life settlement broker or provider, and thereafter upon renewal of the life insurance producer license, the life insurance producer shall notify the director that he or she is acting as a life settlement broker or provider on a form prescribed by the director, and shall pay any applicable fee to be determined by the director specified by rule pursuant to section41-401, Idaho Code. Notification shall include an acknowledgment by the life insurance producer that he or she will operate as a life settlement broker in accordance with sections41-1950 through41-1965, Idaho Code.

(3) The insurer that issued the policy being settled shall not be responsible for any act or omission of a life settlement broker or life settlement provider arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a life settlement contract from the life settlement provider or life settlement broker in connection with the life settlement contract.

41-1953. FILING OF LIFE SETTLEMENT CONTRACTS AND DISCLOSURE STATEMENTS.

A person shall not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with the director accompanied by a certification that the form is in compliance with sections41-1950 through41-1965, Idaho Code. The director may disapprove a life settlement contract form or disclosure statement form if, in the director's opinion, the contract or provisions contained therein fail to meet the requirements of sections41-1950 through41-1965, Idaho Code, or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner. At the director's discretion, the director may require the submission of advertising material.

41-1954. REPORTING REQUIREMENTS AND PRIVACY.

(1) Each life settlement provider shall file with the director, on or before March 1 of each year, an annual statement containing such information on a form prescribed by the director or as prescribed by rule. Such information shall be limited to only those transactions where the owner is a resident of this state.

(2) Except as otherwise allowed or required by law, a life settlement provider, life settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure is:

(a) Necessary to effect a life settlement between the owner and a life settlement provider and the owner and insured have provided prior written consent to the disclosure;

(b) Provided in response to an investigation or examination by the director or any other governmental officer or agency;

(c) A term of or condition to the transfer of a policy by one (1) life settlement provider to another life settlement provider;

(d) Necessary to permit a financing entity, related provider trust or special purpose entity to finance the purchase of policies by a life settlement provider and the owner and insured have provided prior written consent to the disclosure;

(e) Necessary to allow the life settlement provider or life settlement broker or their authorized representatives to make contacts for the purpose of determining health status;

(f) Required to purchase stop loss coverage or financial guaranty insurance; or

(g) Permitted by any other provision of applicable law.

41-1955. EXAMINATION AND RECORDS.

(1) A person required to be licensed by sections41-1950 through41-1965, Idaho Code, is subject to examination as authorized in chapter 2, title 41, Idaho Code, and shall for five (5) years retain copies of all:

(a) Proposed, offered and executed contracts, purchase agreements, underwriting documents, policy forms, executed disclosure statements and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later;

(b) All checks, drafts or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date of the transaction; and

(c) All other records and documents related to the requirements of sections41-1950 through41-1965, Idaho Code.

(2) The provisions of this section does not relieve a person of the obligation to produce these documents to the director after the retention period has expired if the person has retained the documents.

(3) Records required to be retained by this section must be legible and complete and in accordance with section 28-50-107, Idaho Code, and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

41-1956. DISCLOSURE TO OWNER UPON APPLICATION.

With each application for a life settlement contract, a life settlement provider or life settlement broker shall provide the owner with at least the following disclosures no later than the time the application for the life settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the owner and the life settlement provider or life settlement broker, and shall provide the following information:

(1) There are possible alternatives to life settlement contracts including any accelerated death benefits or policy loans offered under the owner's life insurance policy.

(2) That a life settlement broker represents exclusively the owner, and not the insurer or the life settlement provider, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

(3) Some or all of the proceeds of the life settlement may be taxable under federal and state law, and assistance should be sought from a professional tax advisor.

(4) Proceeds of the life settlement could be subject to the claims of creditors.

(5) Receipt of the proceeds of a life settlement may adversely affect the owner's eligibility for medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(6) The owner has the right to rescind a life settlement contract within twenty (20) days of the date it is executed by all parties. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given, and the owner repays all proceeds and any premiums, loans and loan interest paid on account of the life settlement contract within the rescission period. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all life settlement proceeds and any premiums, loans and loan interest.

(7) Funds will be sent to the owner within three (3) business days after the life settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(8) Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the owner. Assistance should be sought from a financial adviser.

(9) Disclosure to an owner shall include distribution of a brochure describing the process of life settlements. The national association of insurance commissioners (NAIC) form for the brochure shall be used unless another form is developed or approved by the director.

(10) The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement between the owner and the life settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two (2) years."

(11) Following execution of a life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in sections41-1950 through41-1965, Idaho Code. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less. All such contacts shall be made only by a life settlement provider licensed in the state in which the owner resided at the time of the life settlement, or by the authorized representative of a duly licensed life settlement provider.

41-1957. DISCLOSURE TO OWNER BY PROVIDER UPON SETTLEMENT CONTRACT.

A life settlement provider shall provide the owner with at least the following disclosures prior to the time the owner signs the life settlement contract. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and shall provide the following information:

(1) The affiliation, if any, between the life settlement provider and the issuer of the insurance policy to be settled;

(2) The name, business address and telephone number of the life settlement provider;

(3) If an insurance policy to be settled has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be settled, the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed life settlement;

(4) The dollar amount of the current death benefit payable under the policy or certificate. If known, the life settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the extent to which the owner's interest in those benefits will be transferred as a result of the life settlement contract; and

(5) The name, business address and telephone number of the independent third party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

41-1958. DISCLOSURE TO OWNER BY BROKER UPON SETTLEMENT CONTRACT.

A life settlement broker shall provide the owner with at least the following disclosures prior to the time the owner signs the life settlement contract. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(1) The name, business address and telephone number of the life settlement broker;

(2) A full, complete and accurate description of all offers, counteroffers, acceptances and rejections relating to the proposed life settlement contract;

(3) A written disclosure of any affiliations or contractual arrangements between the life settlement broker and any person making an offer in connection with the proposed life settlement contracts;

(4) The amount and method of calculating the broker's compensation, which term "compensation" includes anything of value to be paid or given to a life settlement broker for the placement of a policy; and

(5) Where any portion of the life settlement broker's compensation is taken from a proposed life settlement offer, the total amount of the life settlement offer and the percentage of the life settlement offer comprised by the life settlement broker's compensation.

41-1959. NOTICE OF CHANGE BY PROVIDER.

If the life settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty (20) days after the change.

41-1960. GENERAL RULES.

(1) A life settlement provider entering into a life settlement contract shall first obtain:

(a) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a life settlement contract; and

(b) A document in which the insured consents to the release of his or her medical records to a licensed life settlement provider, life settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

(2) Within twenty (20) days after an owner executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to settle the policy, the life settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a settled policy. The notice shall be accompanied by the documents required by subsection (3) of this section.

(3) The life settlement provider shall deliver:

(a) A copy of the medical release required under subsection (1)(b) of this section;

(b) A copy of the owner's application for the life settlement contract;

(c) The notice required under subsection (2) of this section; and

(d) A request for verification of coverage to the insurer that issued the life policy that is the subject of the life transaction. The NAIC's form for verification of coverage shall be used unless another form is developed and approved by the director.

(4) The insurer shall respond to a request for verification of coverage submitted on an approved form by a life settlement provider or life settlement broker within thirty (30) calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at that time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on an NAIC form or any other form approved by the director. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying authorization signed by the owner. Failure by the insurer to meet its obligations under this subsection shall be a violation of section41-1964, Idaho Code.

(5) Prior to or at the time of execution of the life settlement contract, the life settlement provider shall obtain a witnessed document in which the owner consents to the life settlement contract, represents that the owner has a full and complete understanding of the life settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the life settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(6) If a life settlement broker performs these activities required of the life settlement provider, the provider is deemed to have fulfilled the requirements of this section.

(7) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state and federal law relating to confidentiality of medical information.

(8) All life settlement contracts entered into in this state, or covering a resident of this state as owner, shall provide the owner with an absolute right to rescind the contract within twenty (20) calendar days of the date upon which the life settlement contract is executed by all parties. Rescission by the owner is conditioned upon the owner both giving notice and repaying to the life settlement provider within the rescission period all proceeds of the settlement and any premiums, loans and loan interest paid

by or on behalf of the life settlement provider in connection with or as a consequence of the life settlement. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded, subject to repayment to the life settlement provider or other person of all life settlement proceeds, and any premiums, loans and loan interest that have been paid by the life settlement provider or other person. In the event of any rescission, if the life settlement provider has paid commissions or other compensation to a life settlement broker in connection with the rescinded transaction, the life settlement broker shall refund all such commissions and compensation to the life settlement provider within five (5) business days following receipt of written demand from the life settlement provider, which demand shall be accompanied by either the owner's notice of rescission if rescinded at the election of the owner, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

(9) The life settlement provider shall instruct the owner to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to an independent escrow agent. Within three(3) business days after the date the escrow agent receives the documents, or from the date the life settlement provider receives the documents, if the owner erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the life settlement into an escrow or trust account maintained in a state or federally-chartered financial institution whose deposits are insured by the federal deposit insurance corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the life settlement provider or related provider trust or other designated representative of the life settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the owner.

(10) Failure to tender consideration to the owner for the life settlement contract within the time set forth in the disclosure pursuant to section41-1956(7), Idaho Code, renders the life settlement contract voidable by the owner for lack of consideration until the time consideration is tendered to and accepted by the owner.

(11) Contacts with the insured for the purpose of determining the health status of the insured by the life settlement provider or life settlement broker after the life settlement has occurred shall only be made by the life settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than once per month for insureds with a life expectancy of one (1) year or less. The provider or broker shall explain the procedure for these contacts at the time the life settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Life settlement providers and life settlement brokers shall be responsible for the actions of their authorized representatives.

41-1961. PERMITTED LIFE SETTLEMENTS AND SUPPORTING DOCUMENTATION.

(1) It is a violation of the provisions of sections41-1950 through41-1965, Idaho Code, for any person to enter into a life settlement contract at any time prior to the issuance of a policy which is the subject of a life settlement contract or within a two (2) year period commencing with the date of issuance of the insurance policy or certificate unless the owner certifies to the life settlement provider that one (1) or more of the following conditions have been met within the two (2) year period:

(a) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four (24) months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(b) As part of the certification, the owner submits independent evidence to the life settlement provider that one (1) or more of the following conditions have been met within the two (2) year period:

(i) The owner or insured is terminally or chronically ill;

(ii) The owner's spouse dies;

(iii) The owner divorces his or her spouse;

(iv) The owner retires from full-time employment;

(v) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or

(vi) A final order, judgment or decree is entered by a court of competent jurisdiction on the application of a creditor or the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee or liquidator to all or a substantial part of the owner's assets.

(2) Copies of the independent evidence described in subsection (1)(b) of this section and documents required in section41-1960(1) through (5), Idaho Code, shall be submitted to the insurer when the life settlement provider or other party entering into a life settlement contract with an owner submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the life settlement provider that the copies are true and correct copies of the documents received by the life settlement provider.

(3) If the life settlement provider submits to the insurer a copy of the owner or insured's certification described in and the independent evidence required by subsection (1)(b) of this section when the provider submits a request to the insurer to effect

the transfer of the policy or certificate to the life settlement provider, the copy shall be deemed to conclusively establish that the life settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

(4) No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, life settlement provider or life settlement broker sign any forms, disclosures, consent or waiver form that has not been filed with the director for use in connection with life settlement contracts in this state.

(5) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty (30) days with written acknowledgment confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise seek to interfere with any life settlement contract lawfully entered into in this state.

41-1962. PROHIBITED PRACTICES AND CONFLICTS OF INTEREST.

(1) It is a violation of the provisions of sections41-1950 through41-1965, Idaho Code, for any person to engage in any act that constitutes or promotes a STOLI regarding any resident of this state.

(2) With respect to any life settlement contract or insurance policy, no life settlement broker knowingly shall solicit an offer from, effectuate a life settlement with or make a sale to any life settlement provider, life settlement purchaser, financing entity or related provider trust that is an affiliate of such life settlement broker unless such relationship is first disclosed to the owner.

(3) With respect to any life settlement contract or insurance policy, no life settlement provider knowingly shall enter into a life settlement contract with an owner, if, in connection with such life settlement contract, anything of value will be paid to a life settlement broker that is an affiliate of such life settlement provider or any investor, financing entity or related provider trust that is involved in such life settlement contract unless such relationship is first disclosed to the owner.

(4) No person shall enter into a premium finance agreement with any other person or affiliate thereof pursuant to which such person shall receive any proceeds, fees or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any life settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of such agreement; provided further that any payments, charges, fees or other amounts in addition to the amounts required to pay the principal, interest and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of overpayment.

(5) In the solicitation, application or issuance of a life insurance policy, no person shall employ any device, scheme or artifice that would result in a violation of section41-1804, Idaho Code.

(6) No life settlement provider shall enter into a life settlement contract unless the life settlement promotional, advertising and marketing materials, as may be prescribed by rule, have been filed with the director. In no event shall any marketing materials expressly reference that the insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of the provisions of sections41-1950 through41-1965, Idaho Code.

(7) No life insurance producer, insurance company, life settlement broker or life settlement provider shall make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

41-1963. ADVERTISING FOR LIFE SETTLEMENTS.

No person required to be licensed pursuant to sections41-1950 through41-1965, Idaho Code, shall engage in any false or misleading advertising, solicitation, or practice. In no case shall a life settlement broker or provider directly or indirectly market, advertise, solicit or otherwise promote the purchase of a new policy with the primary emphasis on settling the policy or use the words "free," "no cost" or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy.

41-1964. PENALTY -UNFAIR TRADE PRACTICES.

A violation of the provisions of sections41-1950 through41-1965, Idaho Code, shall be considered an unfair trade practice under chapter 13, title 41, Idaho Code, subject to the penalties contained in that chapter.

41-1965. AUTHORITY TO PROMULGATE RULES.

The director shall have the authority to promulgate rules implementing the provisions of sections41-1950 through41-1964, Idaho Code.

41-2003. EMPLOYEE GROUPS.

The lives of a group of individuals may be insured under a policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one (1) or more subsidiary corporations, and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation, by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(2) The premium for the policy shall be paid from the employer's funds or funds contributed by him, from funds contributed by the insured employees, or from both. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or who have rejected the coverage in writing.

41-2004. LABOR UNION GROUPS.

The lives of a group of individuals may be insured under a policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.

(2) The premium for the policy shall be paid by the policyholder, from the union's funds, from funds contributed by the insured members specifically for their insurance, or from both. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or who have rejected the coverage in writing.

41-2005. DEBTOR GROUPS.

The lives of a group of individuals may be insured under a policy issued to a creditor, or to a trustee or trustees or agent designated by two (2) or more creditors, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one (1) or more subsidiary corporations, and the debtors of one (1) 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 through stock ownership, contract, or otherwise.

(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. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent (75%) of the then eligible debtors elect to pay the required charges. 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, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred (100) persons yearly, or may reasonably be expected to receive at least one hundred (100) new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured. The policy may exclude from the classes eligible for insurance classes of debtors determined by age.

(4) The amount of insurance on the life of a debtor shall at no time exceed the amount owed by him to the creditor, or one hundred fifty thousand dollars ($150,000), whichever is less.

(5) The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

41-2006. PUBLIC EMPLOYEE GROUPS.

The lives of a group of individuals may be insured under a policy issued to the departmental head or to an association of public employees formed for purposes other than obtaining insurance and having, when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five percent (75%) of the number of employees eligible for membership in such classes, which association or departmental head shall be deemed the policyholder, to insure members of such association or public

employees for the benefit of persons other than the departmental head, the association or any of its officials, subject to the following requirements:

(1) The persons eligible for insurance under the policy shall be all of the members of the association or employees of the department, or all of any class or classes thereof determined by conditions pertaining to their employment or to their membership in the association, or both.

(2) The premium for the policy shall be paid by the policyholder, either from the association's own funds or from charges collected from the insured members or employees specifically for the insurance, or from both. Any charges collected from the insured members or employees specifically for the insurance, and the dues of the association if they include the cost of insurance, shall be collected through deductions by the employer from salaries of the members or employees. Such deductions from salary may be paid by the employer to the association or directly to the insurer. No policy may be placed in force unless and until at least seventy-five percent (75%) of the then-eligible members of the association or employees of the department, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have authorized their employer to make the required deductions from salary.

(3) Charges collected from the insured members or employees specifically for the insurance, and the dues of the association if they include the cost of insurance, shall be determined according to each attained-age group or in not less than four (4) reasonably spaced attained-age groups. In no event shall the rate of such dues or charges be level for all members or employees regardless of attained age.

(4) The policy must cover at least five (5) persons at the date of issue.

(5) The amounts of insurance under the policy must be based upon some plan precluding individual selection by the members, the employees, or by the association. Such amounts shall in no event exceed three thousand dollars ($3,000) in the case of any member or employee and shall not exceed five hundred dollars ($500) in the case of retired members or employees and members or employees over age sixty-five (65) years.

(6) As used herein, "employees" means employees of the United States government, or of any state, or of any political subdivision or instrumentality of any of them.

(7) Groups heretofore or hereafter written under section 67-5763, Idaho Code, are not subject to this section.

41-2007. TRUSTEE GROUPS.

The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established in this state by two (2) or more employers in the same industry or to the trustees of a fund established by one (1) or more labor unions, or by one (1) or more employers and one (1) or more labor unions, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or

classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both. The policy may provide that the term "employees" shall include retired employees, and the individual proprietor or partners if an employer is an individual proprietor or a partnership. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees, or their employees, or both, if their duties are principally connected with such trusteeship.

(2) The premium for the policy shall be paid by the trustees from funds contributed by the employer or employers of the insured persons, or by the union or unions, or from funds contributed by the insured persons, or from any combination of these. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or who have rejected the coverage in writing.

(3) The policy shall not require that, if a participating employer discontinues membership in the association, the insurance of his employees shall cease solely by reason of such discontinuance.

41-2008. CREDIT UNION GROUPS.

The lives of a group of individuals may be insured under a policy issued to a credit union, which shall be deemed the policyholder, to insure eligible members of the credit union for the benefit of persons other than the credit union or its officials, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the credit union, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or all of any class or classes thereof determined by conditions pertaining to their age or membership in the credit union or both.

(2) The premium for the policy shall be paid by the policyholder, either wholly from the credit union's funds, or partly from such funds and partly from funds contributed by the insured members, specifically for their insurance. No policy shall be issued for which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance.
(3) The policy must cover at least twenty-five (25) members at the date of issue.
(4) The amount of insurance under the policy shall not exceed the amount of the total shares and deposits of the member in or with the credit union.

41-2009. DEPENDENTS' COVERAGE.

Any group life policy issued under section41-2003 (employee groups), or41-2004 (labor union groups), or41-2006 (public employee groups), or41-2007 (trustee groups) may be extended to insure the employees or members against loss due to the death of their spouses and minor children, or any class or classes thereof, subject to the following requirements:

(1) The premium for the insurance shall be paid by the policyholder, either from the employer's or union's funds or funds contributed by the employer or union, or from funds contributed by the insured employees or members, or from both. If no part of the premium is to be derived from funds contributed by the employees or members, all eligible employees or members, excluding any as to whose family members evidence of insurability is not satisfactory to the insurer, must be insured with respect to their spouses and children.
(2) Upon termination of the insurance with respect to the members of the family of any employee or member by reason of the employee's or member's termination of employment, termination of membership in the class or classes eligible for coverage under the policy, or death, the spouse shall be entitled to have issued by the insurer, without evidence of insurability, an individual policy of life insurance, without disability or other supplementary benefits, providing application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, subject to the requirements of subsections (1),
(2) and (3) of section41-2018, Idaho Code. If any group policy terminates or is amended so as to terminate the insurance of any class of employees or members and the employee or member is entitled to have issued an individual policy, under section41-2019, Idaho Code, the spouse shall also be entitled to have issued by the insurer an individual policy, subject to the conditions and limitations provided above. If the spouse dies within the period during which he would have been entitled to have an individual policy issued in accordance with this provision, the amount of life insurance which he would have been entitled to have issued under such 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 therefor has been made.
(3) Notwithstanding section41-2017, Idaho Code, only one (1) certificate need be issued for delivery to an insured person if a statement concerning any dependent's coverage is included in such certificate.

41-2010. PROVISIONS REQUIRED IN GROUP CONTRACTS.

No policy of group life insurance shall be delivered in this state unless it contains in substance the provisions set forth in sections41-2011 through41-2020 of this chapter or provisions which in the opinion of the director are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder; except, however, that:

(1) Sections41-2016 to41-2020 inclusive shall not apply to policies issued to a creditor to insure debtors of such creditor;
(2) The standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and
(3) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the director is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

41-2011. GRACE PERIOD.

The group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

41-2012. INCONTESTABILITY.

The group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premium, 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 such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him.

41-2013. APPLICATION -STATEMENTS DEEMED REPRESENTATIONS.

The group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued and become a part of the contract; that all statements made by the policyholder or by the persons insured

shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his beneficiary.

41-2014. INSURABILITY.

The group life insurance policy shall contain a provision setting forth the conditions, if any, 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.

41-2015. MISSTATEMENT OF AGE.

The group life insurance policy shall contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

41-2016. PAYMENT OF BENEFITS.

The group life insurance policy shall contain a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary as to all or any part of such sum living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding five hundred dollars ($500) to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

41-2017. CERTIFICATE.

The 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 a statement as to the insurance protection to which he is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in sections41-2018,41-2019 and41-2020 following.

41-2018. CONVERSION ON TERMINATION OF ELIGIBILITY.

There shall be a provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, and provided further that:

(1) The individual policy shall, at the option of such person, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

(2) The individual policy shall be 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 is or becomes eligible under the same or any other group policy within thirty-one (31) days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in instalments 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

(3) The premium on the individual policy shall be 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 his age attained on the effective date of the individual policy.

41-2019. CONVERSION ON TERMINATION OF POLICY.

The 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 insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five (5) years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by section41-2018, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(1) 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 (31) days after such termination, and

(2) Two thousand dollars ($2,000).

41-2020. DEATH PENDING CONVERSION.

The group life insurance policy shall contain a provision that if a person insured under the policy dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with sections41-2018 and41-2019 and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such 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 therefor has been made.

41-2025. ASSIGNMENT OF INCIDENTS OF OWNERSHIP IN GROUP LIFE INSURANCE POLICIES, INCLUDING CONVERSION PRIVILEGES.
Nothing in this insurance code or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of his incidents of ownership under such policy, including but not limited to the privilege to have issued to him an individual policy of life insurance pursuant and subject to the provisions of sections41-2018,41-2019 and41-2021, Idaho Code, and the right to name a beneficiary. Subject to the terms of the policy or agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership thereunder, such an assignment by an insured, made either before or after the effective date [February 25, 1970] of this act, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with sections41-2018 and41-2019, Idaho Code, prior to receipt of notice of the assignment.

41-2303. SCOPE OF CHAPTER.
All life insurance and all disability insurance in connection with loans or other credit transactions shall be subject to the provisions of this chapter; except, that insurance in connection with a loan or other credit transaction of more than fifteen (15) years duration shall not be subject to this chapter, nor shall insurance be subject to this chapter where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

41-2304. DEFINITIONS.
For the purposes of this chapter:
(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.
(2) "Credit disability insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.
(3) "Creditor" means the lender of money or vendor of goods, services or property, including a lessor under a lease intended as a security, 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 or vendor, 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.
(4) "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.
(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

41-2305. FORMS OF CREDIT LIFE INSURANCE AND CREDIT DISABILITY INSURANCE.
Credit life insurance and credit disability insurance shall be issued only in the following forms:
(1) Individual policies of life insurance issued to debtors on the term plan.
(2) Individual policies of disability insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance.
(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan.
(4) Group policies of disability insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide such coverage.

41-2307. TERM OF CREDIT LIFE INSURANCE AND CREDIT DISABILITY INSURANCE.
The term of any credit life insurance or credit disability insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. 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. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section41-2310.

41-2311. ISSUANCE OF POLICIES.
All policies of credit life insurance and credit disability insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the director.

41-2902. "RECIPROCAL INSURER" DEFINED.
A "reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney in fact to provide reciprocal insurance among themselves. When all participants in a reciprocal insurer are political

subdivisions of the state of Idaho, such interexchange may be accomplished by a joint exercise of powers agreement pursuant to chapter 23, title 67, Idaho Code.

41-3201. FRATERNAL BENEFIT SOCIETIES.

Any incorporated society, or- der or supreme lodge, without capital stock, including one exempted under the provisions of section41-3237(1)(b), Idaho Code, whether incorporated or not, 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 which provides bene- fits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

41-3210. ORGANIZATION.

A domestic society organized on or after the effective date of this act shall be formed as follows:

(1) Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:
   (a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;
   (b) 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 in this chapter;
   (c) The names and residences of the incorporators and the names, residences and official titles of all the 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 (1) year from the date of issuance of the permanent certificate of authority.

(2) 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 (1) year shall be filed with the director, who may require such further information as the director deems necessary. The bond with sureties approved by the director shall be in such amount, not less than three hundred thousand dollars ($300,000), nor more than one million five hundred thousand dollars ($1,500,000), as required by the director. 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 director shall so certify, retain and file the articles of incorporation and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the director upon cause shown, unless the five hundred (500) applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(4) Upon receipt of a preliminary certificate of authority from the director, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so 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:
   (a) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;
   (b) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;
   (c) There has been submitted to the director, under oath of the president or secretary, or corresponding officer of the society, 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 premiums therefor; and
   (d) It shall have been shown to the director, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars ($150,000). Said 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 (1) year, as herein provided, such premiums shall be returned to said applicants.

(5) The director may make such examination and require such further information as the director deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the director shall issue to the society a certificate of authority to that effect and that the society is authorized to transact 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 director shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this state at the time this act becomes effective shall not be required to reincorporate.

41-3611. SUBROGATION OF ASSOCIATION TO RIGHTS OF CLAIMANTS -RECEIVER, LIQUIDATOR, OR SUCCESSOR BOUND BY ASSOCIATION CLAIM SETTLEMENTS-PERIODIC FILING OF STATEMENTS OF PAID CLAIMS WITH RECEIVER OR LIQUIDATOR.

(1) Any person recovering under this act shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this act shall cooperate with the association to the same extent as such 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 such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(2) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of claims made by the association or a similar organization in another state to the extent such determinations or settlements satisfy obligations of the association. The receiver shall not be bound in any way by such determinations or settlements to the extent there remains a claim against the insolvent insurer. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this act against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(3) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

41-4301. SHORT TITLE.

This chapter shall be known and may be cited as the "Idaho Life and Health Insurance Guaranty Association Act."

41-4302. PURPOSE.

(1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in section41-4303(1), Idaho Code, against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts specified in section41-4303(2), Idaho Code, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide the protection stated in subsection (1) of this section, an association of insurers will pay benefits and continue coverages as provided for and limited by this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

41-4303. COVERAGE AND LIMITATIONS.

(1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) of this section:

(a) To persons, except for nonresident certificate holders under group policies or contracts who, regardless of where they reside, are the beneficiaries, assignees or payees of the persons covered under paragraph

(b) of this subsection.

(b) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The insurer that issued the policies or contracts is domiciled in this state;
2. The states in which the persons reside have associations similar to the association created by this chapter; and
3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(c) For structured settlement annuities specified in subsection (2) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (d) and (e) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under both of the following conditions:

1. (A) The contract owner of the structured settlement annuity is a resident; or

(B) The contract owner of the structured settlement annuity is not a resident; but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created in this chapter; and

2. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) The provisions of this chapter shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state.

(e) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, the provisions of this chapter shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2) (a) The provisions of this chapter shall provide coverage to the persons specified in subsection (1) of this section for direct, non-group life, health or annuity policies or contracts and for certificates under direct group policies and contracts and for supplemental contracts to any of these, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(b) The provisions of this chapter shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four (4) year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier; and
2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured including, but not limited to, benefits payable by an employer, association or other person under:

1. A multiple employer welfare arrangement as defined in section 3(40) of the employee retirement income security act of 1974, 29 U.S.C. section 1002(40);
2. A minimum premium group insurance plan;
3. A stop-loss group insurance plan; or
4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience rating credits;
2. Voting rights; or
3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) A portion of a policy or contract to the extent that the assessments required in section41-4309, Idaho Code, with respect to the policy or contract are preempted by federal or state law;

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;
2. Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;
3. Misrepresentations of or regarding policy benefits;
4. Extra-contractual claims; or
5. A claim for penalties or consequential or incidental damages;

(ix) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) An unallocated annuity contract;

(xi) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; and

(xii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to 42 U.S.C. part C or 42 U.S.C. part D, commonly known as medicare parts C and D, or any regulations issued pursuant thereto.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b) Subject to the aggregate per life limitation in paragraph (c) of this subsection with respect to one (1) policy or contract:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) Three hundred thousand dollars ($300,000) in health insurance claims or benefit payments or one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for health benefits, except for major medical insurance as defined in section41-4305, Idaho Code, and as provided for in subparagraph (iii) of this paragraph;

(iii) Five hundred thousand dollars ($500,000) for major medical insurance as defined in section41-4305, Idaho Code;

(iv) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(v) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(c) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) life under paragraph (b) of this subsection, except with respect to benefits for major medical insurance as provided in paragraph (b)(iii) of this subsection, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to any one (1) life; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner; or

(d) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under the provisions of this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(e) For purposes of this act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(4) In performing its obligations to provide coverage under section41-4308, Idaho Code, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

41-4304. CONSTRUCTION.

The provisions of this chapter shall be construed to effect the purpose under section 41-4302, Idaho Code.

41-4305. DEFINITIONS.

As used in this chapter:

(1) "Account" means any of the three (3) accounts maintained pursuant to section41-4306, Idaho Code.

(2) "Association" means the Idaho life and health insurance guaranty association.

(3) "Authorized assessment" or "authorized," when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(5) "Called assessment" or "called," when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section41-4303, Idaho Code.

(7) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under section41-4303, Idaho Code.

(8) "Director" means the director of the Idaho department of insurance.

(9) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.

(10) "Impaired insurer" means a member insurer:

(a) Deemed by the director after the effective date of this chapter to be potentially unable to fulfill its contractual obligations and not an insolvent insurer; or

(b) Which, after the effective date of this chapter, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Insolvent insurer" means a member insurer which, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(12) (a) "Major medical insurance" means, solely for purposes of this chapter, health insurance policies, contracts or certificates that are issued to provide hospital and medical-surgical coverage.

(b) "Major medical insurance" shall not include insurance policies, contracts or certificates:

(i) Issued by an insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance or specified disease or hospital confinement indemnity insurance; or

(ii) For medicare supplement insurance or for coverage supplemental to the coverage provided under the civilian health and medical program of the uniformed services (CHAMPUS).

(13) (a) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section41-4303, Idaho Code, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn.

(b) "Member insurer" does not include:

(i) A hospital or medical service corporation or organization, whether profit or nonprofit;

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

(v) An insurance exchange;

(vi) An organization that issues charitable gift annuities under section41-120, Idaho Code;

(vii) A mutual benefit association;

(viii) A reciprocal insurer;

(ix) A limited managed care plan;

(x) A self-funded health care plan; or

(xi) A consumer operated and oriented plan established under section 1322 of the patient protection and affordable care act, P.L. 111-148.

(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto.

(15) "Owner," "policy owner" or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(16) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(17) (a) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits.

(b) "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section41-4303(2), Idaho Code, except that assessable

premium shall not be reduced on account of section41-4303(2)(b)(iii), Idaho Code, relating to interest limitations and section41-4303(3)(b), (c) and (d), Idaho Code, relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:

(i) Premiums on an unallocated annuity contract; or

(ii) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(18) (a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors contained in subparagraphs (i) through (v) of this paragraph.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) "Principal place of business" of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(20) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories or protectorates that do not have an association similar to the association created in this chapter, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(21) "State" means a state or a commonwealth of the United States, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(22) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(24) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

41-4306. CREATION OF THE ASSOCIATION.

(1) This chapter continues the existence of the nonprofit legal entity known as the Idaho life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section41-4310, Idaho Code, and shall exercise its powers through a board of directors provided for under section41-4307, Idaho Code. For purposes of administration and assessment, the association shall continue the existence and maintenance of three (3) accounts:

(a) Life insurance account;

(b) Health insurance account, formerly designated the "disability insurance account"; and

(c) Annuity account.

(2) The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

41-4307. BOARD OF DIRECTORS.

(1) The board of directors of the association shall consist of not fewer than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board of directors shall be selected by member insurers subject to the approval of the director. Vacancies on the board of directors shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the director.

(2) In approving selections, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors 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 of directors shall not otherwise be compensated by the association for their services.

41-4308. POWERS AND DUTIES OF THE ASSOCIATION.

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; and

(b) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a) (i) 1. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days' notice of the termination, pursuant to subparagraph (i) of this paragraph, of the benefits provided;

(iii) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv) of this paragraph, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class:

(iv) 1. In providing the substitute coverage required under subparagraph (iii) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy;

2. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy; and

3. The association may reinsure any alternative or reissued policy;

(v) 1. Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance director. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be

provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten; and

3. Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance director;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(viii) When proceeding under this paragraph (b) of this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section41-4303(2)(b)(iii), Idaho Code.

(c) With respect to health benefit plans that are subject to state or federal guaranteed issue requirements, the association may terminate the policies upon entry of an order of liquidation with approval of the director.

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association 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 association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; or

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to chapter 8, title 41, Idaho Code, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of state assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the director shall have the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the director, upon the director's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals

for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11) (a) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require a written instrument of assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(c) In addition to paragraphs (a) and (b) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code, section 130.

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs (a) through (d) of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section41-4309, Idaho Code, and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(g) Reorganize itself with the prior written approval of the director from a nonprofit association into a corporation or other legal form of nonprofit entity permitted by the laws of the state of Idaho;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and

(i) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(13) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation.

(15) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under this chapter shall be in Ada county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the provisions of this chapter.

(18) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) A fixed interest rate;

(ii) Payment of dividends with minimum guarantees; or

(iii) A different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

41-4309. ASSESSMENTS.

(1) 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 such time and for such amounts as the board of directors finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight percent (8%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section41-4308, Idaho Code, with regard to an impaired or an insolvent insurer.

(3) (a) The amount of a class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board of directors may provide that it be credited against future class B assessments. The total of all nonpro rata assessments shall not exceed three hundred dollars ($300) per member insurer in any one (1) calendar year.

(b) The amount of a class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of a class B assessment for long-term care insurance shall be allocated according to a methodology selected by the association and approved by the director, which methodology shall provide for fifty percent (50%) of the assessment to be allocated to health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under this subsection and subsection (2) 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. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, 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. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5) (a) The total of all class B assessments authorized by the association with respect to a member insurer for each account shall not in one (1) calendar year exceed two percent (2%) of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in an account, does not provide in any one (1) year in an account an amount sufficient to carry out

the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(b) The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount, as determined by the board of directors in its discretion, may be retained by the association in any account to provide funds for the continuing and future expenses of the association and for future loss claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) 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 director for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9) (a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with the request.

41-4310. PLAN OF OPERATION.

(1) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless it has not been disapproved within thirty (30) days.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under section41-4307, Idaho Code;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;

(f) Establish any additional procedures for assessments under section41-4309, Idaho Code; and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under section41-4308(12)(c), Idaho Code, and section41-4309, Idaho Code, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a 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 director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

TITLE 41 INSURANCE
CHAPTER 47
SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

41-4701. SHORT TITLE.
This chapter shall be known and may be cited as the "Small Employer Health Insurance Availability Act."

41-4702. PURPOSE.
The purpose and intent of this chapter is to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.
This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

41-4703. DEFINITIONS.
As used in this chapter:
(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 41-4706, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.
(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.
(5) "Board" means the board of directors of the small employer reinsurance program and the individual high risk reinsurance pool as provided for in section 41-5502, Idaho Code.
(6) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For the purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.
(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.
(8) "Catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.
(9) "Class of business" means all or a separate grouping of small employers established pursuant to section 41-4705, Idaho Code.
(10) "Control" shall be defined in the same manner as in section 41-3802(2), Idaho Code.
(11) "Dependent" in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.
(12) "Director" means the director of the department of insurance of the state of Idaho.
(13) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours or, by agreement between the employer and the carrier, an employee who works between twenty(20) and thirty (30) hours per week. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, seasonal or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.
(14) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
(15) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a

supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issues for a period of twelve (12) months or less.

(16) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, or the involuntary termination of the qualifying previous coverage; and

(iii) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(b) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

(d) The individual first becomes eligible.

(e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of such birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(18) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(19) "Plan of operation" means the plan of operation of the program established pursuant to section 41-4711, Idaho Code.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(a) The deductible/limit year used under the plan;

(b) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(c) If the plan does not impose deductibles or limits on a yearly basis or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(d) In any other case, the plan year is the calendar year.

(21) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(22) "Program" means the Idaho small employer reinsurance program created in section 41-4711, Idaho Code.

(23) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool or any other similar publicly sponsored program; or

(b) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(24) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(25) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to section 41-4711, Idaho Code.

(26) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(27) "Risk-assuming carrier" means a small employer carrier whose application is approved by the director pursuant to section 41-4710, Idaho Code.

(28) "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) but no more than fifty (50) eligible employees on business days during the preceding calendar year and that employs at least two (2) but no more than fifty (50) eligible employees on the first day of

the plan year, the majority of whom were and are employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(29) "Small employer basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 41-4712, Idaho Code.

(30) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one (1) or more small employers in this state.

(31) "Small employer catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(32) "Small employer standard health benefit plan" means a health benefit plan developed pursuant to section 41-4712, Idaho Code.

41-4704. APPLICABILITY AND SCOPE.

With the exception of a health benefit plan subject to regulation under chapter 52, title 41, Idaho Code, and to the extent permitted by federal law, the provisions of this chapter shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125 or section 106 of the United States internal revenue code.

(4) (a) Except as provided in subsection (b) of this section, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier and any restrictions or limitations imposed in this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one (1) carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority pursuant to the provisions of chapter 39, title 41, Idaho Code, may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of sections 41-510 and 41-511, Idaho Code, shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one (1) or more health benefit plans delivered or issued for delivery to small employers in this state.

41-4705. ESTABLISHMENT OF CLASSES OF BUSINESS.

(1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one (1) type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage to one (1) or more association groups that meet the requirements of section 41-2202, Idaho Code.

(2) A small employer carrier may establish up to nine (9) separate classes of business under the provisions of subsection (1) of this section.

(3) The director may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with the provisions of subsection (2) of this section in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.

41-4706. RESTRICTIONS RELATING TO PREMIUM RATES.

(1) Premium rates for health benefit plans subject to the provisions of this chapter shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:
  (i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;
  (ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and
  (iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to section 41-4711, Idaho Code, or chapter 55, title 41, Idaho Code.

(f) (i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(h) The small employer carrier shall not use case characteristics, other than age, individual tobacco use, geography, as defined by rule of the director, or gender, without prior approval of the director.

(i) A small employer carrier may utilize age as a case characteristic in establishing premium rates, provided that the same rating factor shall be applied to all dependents under twenty-five (25) years of age, and the same rating factor may be applied on an annual basis as to individuals or nondependents twenty (20) years of age or older.

(j) The director may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including rules that:
  (i) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;
  (ii) Prescribe the manner in which case characteristics may be used by small employer carriers; and
  (iii) Prescribe the manner in which a small employer carrier is to demonstrate compliance with the provisions of this section, including requirements that a small employer carrier provide the director with actuarial certification as to such compliance.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(3) The director may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one (1) or more small employers included within a class of business of a small employer carrier for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
  (a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;
  (b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to renewability of policies and contracts; and
(d) The provisions relating to any preexisting condition provision.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (4)(a) of this section available to the director upon request. Except in cases of violations of the provisions of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

41-4707. RENEWABILITY OF COVERAGE.

(1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or intentional misrepresentation of material fact by the small employer;

(c) Noncompliance with the carrier's minimum participation requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) In the case of health benefit plans that are made available in the small employer market only through one (1) or more associations as defined in section 41-2202, Idaho Code, the membership of an employer in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;

(f) The small employer no longer meets the requirements of section 41-4703(28), Idaho Code;

(g) The small employer carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to small employers in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than fifteen percent (15%) of its total number of employees and dependents in all lines of business regulated by this chapter in a twelve (12) month period. The carrier shall:

(i) Provide advance written or electronic notice of its decision under this paragraph to the director;

(ii) Provide notice of the discontinuation to all affected employers and employees or dependents at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected employers;

(iii) Offer to each affected employer, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to small employers in this state;

(iv) In exercising the option to discontinue the health benefit plan and in offering the option to purchase all other health benefit plans under the provisions of this paragraph, act uniformly without regard to:

1. The claims experience of an affected employer;
2. Any health status-related factor relating to any affected employee or dependent; or
3. Any health status-related factor relating to any new employee or dependent who may become eligible for the coverage; and

(v) Offer the new products at rates that comply with section 41-4706(1)(c), Idaho Code.

(h) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

(i) Provide advance notice of its decision under this paragraph to the director in each state in which it is licensed; and

(ii) Provide notice of the decision not to renew coverage to all affected small employers and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or

(i) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(h) of this section shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of a small employer carrier doing business in one (1) established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

41-4708. AVAILABILITY OF COVERAGE -PREEXISTING CONDITIONS -PORTABILITY.

(1) Every small employer carrier shall, as a condition of offering health benefit plans in this state to small employers, actively offer to small employers all benefit plans, including the small employer basic health benefit plan, the small employer standard health benefit plan, and the small employer catastrophic health benefit plan.

(2) (a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the small employer basic, standard and catastrophic health benefit plans to be used by the carrier. A health benefit plan filed pursuant to the provisions of this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic, standard or catastrophic health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(3) Health benefit plans covering small employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(b) Genetic information shall not be considered as a condition described in this subsection in the absence of a diagnosis of the condition related to such information.

(c) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan.

(e) (i) Except as provided in paragraph (e)(iv) of this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(f) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph (d) of this subsection.

(ii) A small employer carrier shall not modify a basic, standard or catastrophic health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier shall not be required to offer coverage or accept applications pursuant to the provisions of subsection (1) of this section in the case of the following:

(i) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;
(ii) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or
(iii) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier that cannot offer coverage pursuant to the provisions of subsection (4)(a)(iii) of this section may not offer coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

(5) A small employer carrier shall not be required to provide coverage to small employers pursuant to the provisions of subsection (1) of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) of this section would place the small employer carrier in a financially impaired condition.

41-4708B. CONVERSION PLAN -WHEN REQUIRED.

Any group carrier doing business in the state of Idaho that does not have an individual product on file with the department of insurance shall provide a conversion plan to all group insureds. The conversion plan shall provide benefits at least equal to the standard health benefit plan developed pursuant to section 41-4712, Idaho Code. The premium under the plan shall not exceed one hundred twenty-five percent (125%) of the index rate for groups.

41-4709. NOTICE OF INTENT TO OPERATE AS A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.

(1) (a) Each small employer carrier shall notify the director within thirty (30) days of the effective date of this chapter of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to the provisions of section 41-4710, Idaho Code.

(b) The decision shall be binding for a five (5) year period except that the initial decision shall be binding for two (2) years. The director may permit a carrier to modify its decision at any time for good cause shown.

(c) The director shall establish an application process for small employer carriers seeking to change their status under the provisions of this subsection.

(2) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

41-4710. APPLICATION TO BECOME A RISK-ASSUMING CARRIER.

(1) A small employer carrier may apply to become a risk-assuming carrier by filing an application with the director in a form and manner prescribed by the director.

(2) The director shall consider the following factors in evaluating an application filed under the provisions of subsection (1) of this section:

(a) The carrier's financial condition;

(b) The carrier's history of rating and underwriting small employer groups;

(c) The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable;

(d) The carrier's experience with managing the risk of small employer groups; and

(e) The extent to which a carrier has and will be able to maintain reinsurance pursuant to the provisions of subsection (4)(c) of section 41-4704, Idaho Code.

(3) The director shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the director, the carrier may request a hearing.

(4) The director may rescind the approval granted to a risk-assuming carrier under the provisions of this section if the director finds that:

(a) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with the provisions of section 41-4708, Idaho Code, without the protection afforded by the program;

(b) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(c) The carrier has failed to provide coverage to eligible small employers as required in section 41-4708, Idaho Code.

(5) A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of section 41-4711, Idaho Code, except to the extent such small employer carrier is subject to assessment for additional funding pursuant to the provisions of subsection (12)(c) of section 41-4711, Idaho Code.

41-4711. SMALL EMPLOYER CARRIER REINSURANCE PROGRAM.

(1) All carriers shall be subject to the provisions of this section.

(2) There is hereby created an independent public body corporate and politic to be known as the Idaho small employer health reinsurance program. The program will perform an essential governmental function in the exercise of powers conferred upon it in this act and any assessments imposed or collected pursuant to the operation of the program shall at all times be free from taxation of every kind.

(3) The program shall operate subject to the supervision and control of the board established in section 41-5502, Idaho Code.

(4) Each carrier shall make a filing with the director containing the carrier's earned health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(5) The board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the director.

(6) If the board fails to submit a suitable plan of operation, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall approve the plan of operation submitted by the board, or adopt a temporary plan of operation if the board fails to submit a suitable plan. The director shall amend or rescind any plan adopted under the provisions of this subsection at the time a plan of operation is submitted by the board and approved by the director.

(7) The plan of operation shall:
   (a) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the director;
   (b) Establish procedures for selecting an administrator, which shall be properly licensed in this state, and setting forth the powers and duties of the administrator;
   (c) Establish procedures for reinsuring risks in accordance with the provisions of this section;
   (d) Establish procedures for collecting assessments from carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and
   (e) Provide for any additional matters necessary for the implementation and administration of the program.

(8) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:
   (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
   (b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any carrier;
   (c) Take any legal action necessary to avoid the payment of improper claims against the program;
   (d) Define the health benefit plans, which plans shall allow coordination of benefits, for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter;
   (e) Establish rules, conditions and procedures for reinsuring risks under the program, including broad discretion to operate the small employer reinsurance program;
   (f) Establish actuarial functions as appropriate for the operation of the program;
   (g) Assess carriers in accordance with the provisions of subsection (12) of this section, and to make advance interim assessments of carriers as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;
   (h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;
   (i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(9) A carrier may reinsure with the program as provided for in this subsection:
   (a) With respect to a small employer basic, standard or catastrophic health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a small employer basic, standard or catastrophic health benefit plan.
   (b) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.
   (c) A small employer carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of the reinsured small

employer may be reinsured within sixty (60) days of the commencement of his coverage. Newborn dependents of insureds are not eligible for reinsurance unless a parent is already reinsured.

(d) (i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars ($5,000) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next fifty thousand dollars ($50,000) of benefit payments during a calendar year and the program shall reinsure the remainder.

(ii) The board annually may adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the department of labor, bureau of labor statistics, unless the board proposes and the director approves a lower adjustment factor.

(e) A reinsuring carrier may terminate reinsurance with the program for one (1) or more of the reinsured employees or dependents on any anniversary of the health benefit plan.

(f) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(10) (a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under the provisions of this chapter.

(b) Premiums for the program shall be as established by the board.

(c) The board periodically shall review the methodology established under the provisions of paragraph (10)(a) of this section, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(11) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 41-4706, Idaho Code.

(12) (a) Prior to March 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of carriers.

(c) (i) For the assessment of March 1, 1995, and prior to March 1 of each succeeding year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(ii) The assessments shall be determined by multiplying net losses, if net earnings are negative, as defined by subsection (12)(a) of this section, by a fraction, the numerator of which shall be the carrier's total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease, and hospital confinement indemnity in this state as reported in the carrier's annual report pursuant to subsection (16) of this section, and the denominator of which shall be the total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease and hospital confinement indemnity in this state.

(d) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(e) Each carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carriers with the board or with the director.

(f) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(g) A carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a carrier if the director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this

subsection. The carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any groups with the program until such time as it pays the assessments.

(13) (a) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required under the provisions of this chapter shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

(b) Neither the board nor its employees shall be liable for any obligations of the program. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members and employees.

(14) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of small employer basic, standard and catastrophic health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

(15) The program shall be exempt from any and all taxes.

(16) Each carrier shall file with the director, in a form and manner to be prescribed by the director, an annual report. The report shall state the number of resident persons insured under the carrier's health benefit plan.

(17) If a reinsuring small employer carrier attempts to reinsure or reinsures an entire employer group, an employee, or a dependent of such employee that, immediately prior to the commencement of such coverage, it covered under a health benefit plan, the board shall assess all costs and losses incurred by the program for claims and administrative expenses relating to such group, employee or dependent of such employee only to the said reinsuring small employer carrier.

(18) Subsection (17) of this section shall apply to assessments made for the 1994 calendar year and each year thereafter.

41-4712. SMALL EMPLOYER HEALTH BENEFIT PLANS.

(1) The board, in addition to its other powers and duties, shall establish the form and level of coverages, including benefit levels, cost-sharing levels, exclusions and limitations for the small employer basic, standard and catastrophic health benefit plans to be made available by small employer carriers pursuant to section 41-4708, Idaho Code, with an emphasis on making coverage available for preventive care.

(2) The board shall also design a small employer basic, standard and catastrophic health benefit plan which each contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of managed care organizations, including any restrictions imposed by federal law. The plans or changes established by the board may include cost containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management;

(c) Selective contracting with hospitals, physicians and other health care providers;

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.

(3) The board shall submit the plans or changes approved by the board to the director for approval not later than March 1 of each year. The director shall promulgate the approved plans pursuant to the provisions of section 41-4715, Idaho Code.

(4) Small employer carriers desiring to issue a small employer basic, standard or catastrophic health benefit plan differing from the form and level of coverage approved by the board and the director shall submit such plan to the board for review to insure that such proposed plan is commensurate with the benefit levels, cost-sharing levels, exclusions, and limitations for the plan developed and approved pursuant to the provisions of this section.

(5) The board may appoint an advisory committee to assist in the development of and any changes to the small employer basic, standard and catastrophic health benefit plans.

41-4713. PERIODIC MARKET EVALUATION.

The board, in consultation with members of the committee, shall study and report at least every three (3) years to the director on the effectiveness of chapters 47 and 52, title 41, Idaho Code. The report shall analyze the effectiveness of the chapters in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group and individual health insurance marketplace. The report shall address whether carriers and agents are fairly and actively marketing or issuing health benefit plans to small employers and individuals in fulfillment of the purposes of the chapters. The report may contain recommendations for market conduct or other regulatory standards or action.

41-4715. ADMINISTRATIVE PROCEDURES.

The director shall promulgate rules and regulations in accordance with the provisions of chapter 52, title 67, Idaho Code, for the implementation and administration of the small employer health coverage reform act.

41-4716. STANDARDS TO ASSURE FAIR MARKETING.

(1) Each small employer carrier shall actively market health benefit plan coverage, including the small employer basic, standard and catastrophic health benefit plans, to eligible small employers in the state.

(2) (a) Except as provided in subsection (2)(b) of this section, no small employer carrier or agent shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(ii) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) The provisions of subsection (2)(a) of this section shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (2)(b) of this section, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) The provisions of subsection (a) of this section shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a small employer basic, standard or catastrophic health benefit plan.

(5) No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation or geographic location of the small employers placed by the agent with the small employer carrier.

(6) No small employer carrier or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(8) The director may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of the provisions of this section by a small employer carrier or an agent shall be an unfair trade practice pursuant to the provisions of section 41-1302, Idaho Code.

(b) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to the provisions of this section as if it were a small employer carrier.

BULLETIN N0. 18-06 (Replaced by 03-08)

DATE: July 13, 2018

TO: Property and Casualty Insurers and Insurance Producers Writing Property and Casualty Business in Idaho

FROM: Dean L. Cameron, Director

SUBJECT: Certificates of Insurance

Background and Introduction

In 2012, Idaho Code §41-1850, concerning the filing and use of certificates of insurance was added by SB 1390, which also amended Idaho Code §41-1823, applicable to binders. In 2018, HB 522 amended Idaho Code §41-1850 to allow certificates of insurance to include a reference to a contract or project number or description. This bulletin modifies and updates Bulletin 12-08 by highlighting certain provisions of Idaho Code §41-1850 and supersedes Bulletin Nos. 12-03, 08-03 and 68-1 on the same subject.

Certificates of Insurance

Idaho Code §41-1850(2) prohibits any person from preparing, issuing or knowingly requesting the issuance of a certificate of insurance unless the form of the certificate has been filed with the Director of the Department of Insurance (Director) by or on behalf of an insurer. The Director has received and accepted filings of certificate of insurance forms filed by ISO and certain carriers. Consistent with Idaho Code §41-1850(5), if a carrier uses a filed ISO or ACORD form, that form need not be refiled by each carrier. Additionally, where other law provides for a particular certificate of insurance form to be used, once that form has been filed by or on behalf of an insurer with the Director, then individual carriers will not need to refile the form.

Pursuant to Idaho Code §41-1850(3) the Director may disapprove any form filed with the Director if the Director finds that it (i) is unfair, misleading or deceptive or violates public policy; (ii) fails to comply with the requirements of Idaho Code §41-1850; or (iii) violates any other provisions of title 41, Idaho Code, or any rule promulgated by the Director. Furthermore, although Idaho Code §41-1850(3) references the Director's authority to withdraw approval of a form, Idaho is generally a certify, file and use state other than for specific provisions, where the Director does not expressly approve filed

forms. Carriers filing certificate of insurance forms will be required to certify that the form complies with Idaho law. The Director has the authority, however, to disapprove at any time any filed form that does not comply with the requirements of Idaho Code §41-1850(3).

Idaho Code §41-1850(4) codifies elements of Bulletin Nos. 68-1 and 08-31 1 Bulletins 68-1 and 08-3, which are superseded by this bulletin, required the following language in each certificate: "This Certificate of Insurance neither affirmatively nor negatively amends, extends, nor alters the coverage afforded by the policy or policies numbered in this certificate." The Department considers this language sufficiently similar to the new statutory language to be permissible.by requiring that each certificate of insurance include the following or a similar statement:

This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not alter, amend or extend coverage, terms, exclusions and conditions afforded by the policies referenced herein Idaho Code §41-1850(6) and (7) prohibit any person from knowingly demanding or requesting or knowingly preparing or issuing a certificate of insurance or other document, record or correspondence that contains false or misleading information or purports to affirmatively or negatively alter, amend or extend coverage provided by the policy of insurance to which a certificate of insurance makes reference. Idaho Code §41-1850(10), amended in 2018, still confirms that the insurance referenced in a certificate is subject to all terms, exclusions and conditions of the policy itself. However, the amendment allows a certificate of insurance to include reference to a contract number or description or a project number or description, but by doing so the certificate may not and does not warrant that the referenced policy complies with the insurance or indemnification requirements of a contract or project.

The Director is authorized to impose an administrative penalty up to $1,000 per individual and up to $5,000 per entity, pursuant to Idaho Code §41-117 for any violation of Idaho Code §41-1850. The new legislation does not alter the authority of the Director to investigate and seek redress for violations of other provisions of the Idaho Code where such violations are associated with the issuance of a certificate of insurance, including without limitation, Idaho Code §41-1016(1)(e) (illegal for a producer to misrepresent the terms of an insurance contract), §41-1303 (illegal for any person to make a statement misrepresenting the terms of an insurance policy); and §41-293(1)(c) (insurance fraud, a felony, includes presenting to a person, with intent to defraud or deceive, a false statement material to an insurance contract).

Any questions concerning certificates of insurance or filing procedures should be directed to the Rates and Forms Section of the Department.

IDAPA 18.01.02 – SCHEDULE OF FEES, LICENSES, AND MISCELLANEOUS CHARGES

00. LEGAL AUTHORITY.

Title 41, Chapters 2 and 4, Idaho Code, Idaho Code.

01. SCOPE.

The purpose of this rule is to provide for the amounts to be collected for fees, licenses and miscellaneous charges.

02. -010. (RESERVED)

11. FEES PAYABLE IN ADVANCE.

The director will collect in advance fees, licenses, and miscellaneous charges as outlined in this rule.

12. -019. (RESERVED)

20. INSURER FEES.

01. Annual Continuation Fee. All insurers and other entities (set forth in Section 020) licensed, listed, or approved to do business in the state of Idaho will pay an annual continuation fee.
    a. The annual continuation fee is due on March 1st each year and is payment of the insurer's fees due through the following February.
    b. The annual continuation fee is charged at the time the insurer applies for admission to do business in the state of Idaho. If the application is approved, the fee paid will cover the insurer's fees through the following February.
02. Fee for Insurers. For all insurance companies receiving a certificate of authority pursuant to Title 41, Chapter 3, Idaho Code, the annual continuation fee is as follows:
    a. If insurer's policy holders' surplus at the preceding December 31 is less than ten million dollars ($10,000,000) One thousand dollars ($1,000).
    b. If insurer's policy holders' surplus at the preceding December 31 is ten million ($10,000,000) or more, but less than one hundred million ($100,000,000) -Two thousand five hundred dollars ($2,500).
    c. If insurer's policy holders' surplus at the preceding December 31 is one hundred million ($100,000,000) or greater Four thousand five hundred dollars ($4,500).
03. Fees of Other Entities. The following entities will be assessed an annual continuation fee:
    a. Five hundred dollars ($500):

i. All reinsurers, listed pursuant to Section41-515, Idaho Code.
ii. Authorized surplus line insurers.
iii. County mutual insurers.
iv. Fraternal benefit societies.
v. Hospital and/or professional service corporations.
vi. Self-funded health care plans.
vii. Domestic Risk retention groups.
viii. Petroleum clean water trusts.
ix. Rating organizations.
x. Advisory organizations.

b. One hundred dollars ($100): Purchasing groups.

04. Fees Provide. The annual continuation fee includes, but is not limited to, the following:
a. Certificate of authority renewal, license renewal, and annual registration.
b. Arson, fire and fraud investigation costs.
c. Annual statement filing.
d. Agent appointment and renewal of appointment.
e. Filings under Title 41, Chapter 38, Idaho Code, Acquisitions of Control and Insurance Holding Company Systems.
f. Filing of amendments to Articles of Incorporation.
g. Filing of amendments to Bylaws.
h. Amendments to Certificate of Authority.
i. Filing of notice of significant transactions pursuant to Section41-345, Idaho Code.
j. Quarterly statement filing.
k. Examination expenses.

05. Not Provided in Fees. Payment of the annual continuation fee will not exempt the insurer or entity from the following:
a. Fees for application for producer license.
b. Costs incurred by the Department for investigation of an applicant for producer license.
c. Attorney's fees and costs incurred by the Department when allowed pursuant to Idaho Code.
d. Costs incurred for experts and consultants when allowed by Idaho Code.
e. Penalties or fines levied by or payable to the Department of Insurance.
f. All fees set forth under Section 040.

06. Failure to Pay Fee. Failure to pay the annual continuation fee on or before March 1st each year will result in the expiration of the insurer's or entity's authority to do business in the state of Idaho pursuant to Section41-324, Idaho Code.

07. Reinstatement Fee. The reinstatement fee referenced in Section41-324(3), Idaho Code, is the amount referenced above for the insurer or entity continuation fee.

21. -029. (RESERVED)

30. PRODUCER AND MISCELLANEOUS LICENSING FEES.

01. Original License Application. The following fees are due and need to be paid with the filing
a. Administrators -three hundred dollars ($300).
b. Producers -eighty dollars ($80).
c. Designation as a managing general agent -eighty dollars ($80).
d. Adjusters and public adjusters -eighty dollars ($80).
e. Reinsurance intermediary -eighty dollars ($80).
f. Surplus line brokers -eighty dollars ($80).
g. Life settlement providers -five hundred dollars ($500).
h. Life settlement brokers -three hundred dollars ($300).
i. Independent review organization -five hundred dollars ($500).
j. Vendor of portable electronics insurance, a type of limited lines producer:
i. A vendor of portable electronic insurance who is engaged in portable electronic transactions at more than ten (10) locations in the state of Idaho -one thousand dollars ($1,000).
ii. A vendor of portable electronic insurance who is engaged in portable electronic transactions at ten(10) or fewer locations in the state of Idaho -one hundred dollars ($100).

02. Examination Fees. Each time a producer or adjuster's examination is taken for licensing under Title 41, Chapters 10 and 11, Idaho Code, the applicant may pay a fee to a third-party testing vendor in the amount established by contract between the department and the vendor.

03. Fingerprint Processing. Processing fingerprints (as applicable) -not to exceed eighty dollars ($80).

04. License Renewal. The following fees are due and need to be paid for each license to renew or continue:
a. Adjusters, public adjusters, and producers (biennial) -eighty dollars ($80), or sixty dollars ($60) if renewed electronically.

i. A vendor of portable electronic insurance who is engaged in portable electronic transactions at more than ten (10) locations in the state of Idaho -five hundred dollars ($500).

ii. A vendor of portable electronic insurance who is engaged in portable electronic transactions at ten (10) or fewer locations in the state of Idaho -one hundred dollars ($100).

b. Redesignation as managing general agent (annual) -eighty dollars ($80).

c. Administrators (biennial) -eighty dollars ($80).

i. Renewal form is filed on or before December 31.

ii. Any renewal form postmarked after December 31 includes a penalty in an amount equal to the renewal fe

iii. A renewal form postmarked after January 31 needs to be submitted as a new application with supporting documents and the full application fee.

d. Surplus line brokers (biennial) -eighty dollars ($80), or sixty dollars ($60) if renewed electronically.

e. Life settlement providers (biennial) -three hundred dollars ($300).

f. Life settlement brokers (biennial) -eighty dollars ($80).

g. Independent review organization (biennial) -three hundred dollars ($300).

31. -039. (RESERVED)

40. MISCELLANEOUS FEES.

01. Certified Copy. Certified copy of certificate of authority, license or registration Fifty dollars ($50).

02. Certificate Under Seal. Director's certificate under seal (except for those under Subsection 040.01 of this rule) Twenty dollars ($20).

03. Documents Filed. For each copy of a document filed in the DOI, a reasonable cost as fixed by the director. For rate and form filings not submitted electronically through the national System for Electronic Rate and Form Filing (SERFF) -Twenty dollars ($20) for each rate or form filed in excess of ten (10) per calendar year.

04. Insurer Service of Process. For receiving and forwarding copy of summons or other process served upon the director as process agent of an insurer -Thirty dollars ($30).

05. Agent Service of Process. For receiving and forwarding copy of summons or other process served upon the director as process agent of a nonresident producer or other person for which the director is authorized to serve as statutory agent for service of process -Thirty dollars ($30).

06. Continuing Education. Filing continuing education applications for approval and certification of subjects of courses (each application) -Twenty-five dollars ($25).

41. -049. (RESERVED)

50. REFUNDS.

All fees, licenses, and miscellaneous charges are non-refundable except as noted.

51. OVERPAYMENTS.

Overpayments of published fees will be returned only when such overpayments exceed twenty dollars ($20), or upon request of the payor.

52. -999. (RESERVED)

IDAPA 18.03.05 – CREDIT LIFE AND CREDIT DISABILITY INSURANCE

00. LEGAL AUTHORITY.

Title 41, Chapters 2 and 23, Sections41-211 and41-2314, Idaho Code.

01. SCOPE.

This rule protects the interests of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit disability insurance. Nothing in this rule chapter applies to insurance for which no identifiable charge is made to the debtor.

02. -009. (RESERVED)

10. DEFINITIONS.

The definitions set forth in Chapters 2 and 23 are applicable to these rules. In addition, the following terms have the meanings set forth below.

01. Closed-End Credit. A credit transaction that is not open-end credit.

02. Compensation. Money or anything else of value.

03. Credit Insurance. Means credit life insurance and credit disability insurance.

04. Credit Transaction. Any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services or properties sold or leased, is to be made at a future date or dates.

05. Identifiable Charge. The amount the debtor is charged for insurance which is disclosed in the credit or other instrument furnished the debtor which sets out the financial elements of the credit transactions, and including any differential in finance, interest, service or other similar charge made to debtors who are in like circumstances, except for their insured or noninsured status.

06. Net Written Premium. A gross written premium minus refunds on terminations.

07. Open-End Credit. An arrangement as defined in Section 28-41-301(26), Idaho Code, including revolving charge accounts.
08. Pre-existing Condition. A health condition, including sickness or injury, for which there has been medical advice, diagnosis or treatment within six (6) months preceding the effective date of the debtor's coverage and which exists prior to the effective date of the coverage.

11. RIGHTS AND TREATMENT OF DEBTORS.

01. Multiple Plans of Insurance. If a creditor makes available to the debtors more than one (1) plan of credit life insurance or more than one (1) of credit disability insurance, all debtors are to be informed of all such plans for which they are eligible.
02. Substitution. When a creditor requires credit life insurance, credit disability insurance, or both, as additional security for an indebtedness, the debtor will be given the option of furnishing the amount of insurance through existing policies of insurance owned or controlled by the debtor or by procuring and furnishing the coverage through any insurer authorized to transact insurance business in this state. If this subsection is applicable, the debtor will be informed by the creditor of the right to provide alternative coverage before the transaction is completed.
03. Termination of Group Credit Insurance Policy.
    a. If a debtor is covered by a group credit insurance policy providing for the payment of single premiums to the insurer, then provision will be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under such policy is to be continued for the entire period for which the single premium has been paid.
    b. If a debtor is covered by a group credit insurance policy providing for the payment of premiums to the insurer on a monthly outstanding balance basis, then the policy will provide that, in the event of termination of such policy for whatever reason, termination notice will be given to the insured debtor at least thirty (30) days prior to the effective date of termination except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The requisite notice is given by the insurer or, at the option of the insurer, by the creditor.
04. Interest on Premiums. If any direct or indirect finance, carrying, credit or service charge is made to the debtor on such insurance charges or premiums, the creditor will remit and the insurer will collect such premium within sixty (60) days after it is added to the indebtedness.
05. Renewal or Refinancing of the Indebtedness. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force will be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of such termination prior to scheduled maturity, a refund is to be paid or credited to the debtor as provided in Section 017. In any renewal or refinancing of the indebtedness, the effective date of the coverage as respects any policy provision is deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, at least to the extent of the amount and term of the indebtedness outstanding at the time of renewal and refinancing of the debt. In addition, the policy will provide that, in the event the debtor becomes disabled while insured, credit disability insurance benefits will be payable during continued disability regardless of any termination of the insurance by renewal or refinancing, unless a different provision not less favorable to the debtor is approved by the Director.
06. Maximum Aggregate Provisions. A provision in a policy or certificate that sets a maximum limit on total payments applies only to that policy or certificate except as may be provided for in Section41-2005(4), Idaho Code.
07. Involuntary Prepayment of Indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit insurance policy covering the debtor, then it is the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate:
    a. In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump sum total and permanent disability benefit under credit life coverage, an appropriate refund of the credit disability insurance premium in accordance with Section 017;
    b. In the case of prepayment by a lump sum disability claim, an appropriate refund of the credit life insurance premium in accordance with Section 017;
    c. In either case, the amount of the benefits in excess of the amount needed to repay the indebtedness after crediting any unearned interest or finance charges.
08. Amounts to be Insured. If benefits to be provided are less than the scheduled amount of indebtedness, the insurer will notify the insured of such benefit in the policy or certificate.
09. Total Disability. The policy is not to restrict coverage to those periods of total disability when the debtor is under the regular and continuing care of a physician, osteopath or chiropractor; provided, the insurer may retain the right to request medical evidence of actual total disability at reasonable intervals to justify the commencement and continued payment of benefits.
10. Permanent Disabilities. Credit disability insurance will not restrict coverage to permanent disabilities, where the debtor is in fact totally disabled for the period dictated by the policy, although such disability may be of a temporary nature.
11. Statement by Debtor. No statement made by a debtor will be used by the insurer as a basis for denying eligibility for coverage unless such statement is contained in a written application for insurance signed by the debtor.

12. Acceptable Insurance Constituting Waiver. Acceptance of insurance by the insurer will constitute a waiver of any conditions for issuance of insurance that the debtor's application revealed as breached on the date the application was made, unless a refund of all insurance charges to the debtor is actually made within thirty (30) days of the effective date of coverage.

12. (RESERVED)

13. DETERMINATION OF REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGE.

01. General Standard. Benefits provided by credit insurance policies need to be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or is expected to develop a loss ratio of not less than fifty percent (50%). The Department of Insurance has established prima facie rates as a means to achieve the loss ratio benchmark. With the exception of deviations approved under Section 019, prima facie rates filed in accordance with Section 014 as adjusted pursuant to Section 018, may be conclusively presumed to satisfy this general standard.

02. Nonstandard Coverage. If any insurer files for approval of any form, providing coverage more restrictive than that described in Section 014, the insurer will demonstrate to the satisfaction of the director that the premium rates to be charged for such restricted coverage will develop or may reasonably be expected to develop a loss ratio not less than that contemplated for standard coverage at the premium rates described in these sections.

14. PRIMA FACIE RATES.

01. Credit Life Insurance Prima Facie Rates.

a. The Director will post on the Department's website the prima facie rates for credit life insurance that are to be used.

b. If the benefits provided are other than those described in Paragraph 014.0l.a., premium rates for such benefits will be actuarially consistent with the rates provided in Paragraph 014.0l.a.

c. If the policy provisions are other than those that correspond to the use of rates provided for in this subsection, those other provisions will not be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule.

02. Credit Disability Insurance Prima Facie Rates.

a. The Director will post on the Department's website the credit disability insurance prima facie rates that are to be used.

b. If the benefits provided are other than those described in Paragraph 014.02.a., rates for such benefits need to be actuarially consistent with rates provided in Paragraph 014.02.a.

c. The outstanding balance rate for credit disability insurance may be either a term-specified rate or may be a single composite term outstanding balance rate applicable to all loans.

d. If the policy provisions are other than those that correspond to the use of rate provided for in this Subsection, those other provisions are not to be unfair, just, inequitable, misleading, or deceptive; encourage misrepresentations of the coverage; or be contrary to statute or administrative rule.

15. CREDIT LIFE INSURANCE.

Premium rates in conformance with Section 014 apply to policies providing credit life insurance to be issued with or without evidence of insurability, to be offered to all debtors, and containing:

01. Exclusions. No exclusions other than suicide within six (6) months of the incurred indebtedness; and

02. Age Restrictions. Either no age restrictions or age restrictions making ineligible for coverage debtors sixty-five (65) or over at the time the indebtedness is incurred or debtors having attained age seventy (70) or over on the maturity date of the indebtedness.

03. Open-End Credit Plan. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance, classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age sixty-five (65).

04. Closed-End Credit Plans. On insurance written in connection with closed-end credit plans and open-end credit plans where the amount of insurance is based on or limited to the outstanding unpaid balance, no provision excluding or denying a claim for death resulting from a pre-existing condition except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six (6) months preceding the effective date of coverage and which caused or substantially contributed to the death of the insured debtor within six

(6) months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account is the date on which the advance or charge is posted to the plan account. Other more restrictive provisions may be used subject to appropriate rate adjustment approved by the director.

05. Other Provisions. If the policy provisions are other than those that correspond to the use of rates provided for in Section 014, those other provisions are not to be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule.

16. CREDIT DISABILITY INSURANCE.

Premium rates in conformance with Section 014 apply to policies providing credit disability insurance to be issued with or without evidence of insurability, to be offered to all eligible debtors, and containing:

01. Pre-existing Conditions. No provision excluding or denying a claim for disability resulting from preexisting conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six (6)

months preceding the effective date of the debtor's coverage and which caused loss within the six (6) months following the effective date of coverage.

02. Other Exclusions or Restrictions. No other provision which excludes or restricts liability in the event of disability caused in a specific manner except that it may contain provisions excluding or restricting coverage in the event of normal pregnancy and intentionally self-inflicted injuries or disability arising out of the commission of felony acts.

03. Actively-at-Work Requirement. No actively-at-work requirement more restrictive than one (1) requiring that the debtor be actively at work at a full-time gainful occupation on the effective date of coverage. "Full time" means a regular work week of not less than thirty (30) hours. A debtor is actively at work if absent from work due solely to regular day off, holiday or paid vacation.

04. Age Restrictions. No age restrictions, or only age restrictions making ineligible for coverage debtors sixty-five (65) or over at the time the indebtedness is incurred or debtors who will have attained age sixty-six (66) or over on the maturity date of the indebtedness.

05. Daily Benefit. A daily benefit equal in amount to one thirtieth (1/30) of the monthly benefit payable under the policy for the indebtedness.

06. Definition of Disability. A definition of "disability" which provides that during the first twelve (12) months of disability the insured is unable to perform the substantial and material duties of his occupation at the time the disability occurred, and thereafter the duties of any occupation for which the insured is reasonably fitted by education, training or experience. This does not apply to lump sum disability coverage.

07. Open-End Credit Plan. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age sixty-five (65).

08. Other Provisions. If the policy provisions are other than those that correspond to the use of rates provided for in Section 014, those other provisions are not to be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule.

09. Effective Date of Coverage. For the purposes of Subsections 016.01 and 016.03, the effective date of coverage for each part of the insurance attributable to a different advance or charge to an open-end credit plan account is the date on which the advance or charge is posted to the plan account.

17. REFUND FORMULAS.

01. Filing and Approval by the Director. Any refund formula that is at least as favorable to the insured debtor as the "sum of the digits" formula, or the "Rule of 78," for single premium decreasing or disability plans or pro-rata for other plans, will be deemed acceptable.

02. Termination. In the event of termination, no charge for credit insurance may be made for the first fifteen (15) days of a loan month and a full month may be charged for sixteen (16) days or more of a loan month.

03. Minimum Refund. No refund of five dollar ($5) or less need be made.

18. EXPERIENCE REPORTS AND ADJUSTMENT OF PRIMA FACIE RATES.

01. Report of Credit Life and Credit Disability Business Written. Each insurer doing credit insurance business in this state will annually file with the Director and the NAIC Support and Services Office a report of credit life and credit disability business written on a calendar year basis. Such report will utilize the Credit Insurance Supplement-Annual Statement Blank as approved by the National Association of Insurance Commissioners. Such filing will be made in accordance with and no later than the due date in the Instructions to the Annual Statement.

02. Review of Loss Ratio Standards. On a triennial basis beginning in 1995, the director will review the loss ratio standards set forth in Section 013 and the prima facie rates set forth in Section 014 and determine therefrom the rate of expected claims on a statewide basis, compare such rate of expected claims with the rate of actual claims for the preceding three years determined from the incurred claims and earned premiums at prima facie rates reported in the Annual Statement Supplement, and may, if deemed necessary, revise the actual statewide prima facie rates to be used by insurers during the next three (3) years. Such rates will reflect the difference between (a) actual claims based on experience; and (b) expected claims based on the loss ratio standards set forth in Section 013 applied to the prima facie rates set forth in Section 014.

19. USE OF RATES DIRECT BUSINESS ONLY.

01. Use of Prima Facie Rates. An insurer that files rates or has rates on file not in excess of the prima facie rates shown in Section 014, to the extent adjusted pursuant to Section 018, may use those rates without further proof of their reasonableness.

02. Use of Rates Higher Than Prima Facie Rates. An insurer may file for approval of and use rates higher than the prima facie rates established pursuant to Section 018, to the extent adjusted, if it can be expected that the use of such higher rates will result in a ratio of claims incurred to premiums earned (assuming the use of such higher rates) not less than fifty percent (50%) for those accounts to which such higher rates apply and that such upward deviations will not result on a statewide basis for that insurer of a ratio of claims incurred to premiums earned of less than the expected loss ratio underlying the current prima facie rate developed or adjusted pursuant to Section 018. If rates higher than the prima facie rates shown in

Section 014, to the extent adjusted pursuant to Section 018, are filed for approval, the filing will specify the accounts to which such rates apply. Such rates may be:

a. Applied uniformly to all accounts of the insurer; or

b. Applied on an equitable basis approved by the Director to only one (1) or more accounts of the insurer for which the experience has been less favorable than expected; or

c. Applied according to a case-rating procedure on file with the director.

03. Approval Period of Deviated Rates.

a. A deviated rate will be in effect for a period of time not longer than the experience period used to establish such rate (i.e. one (1) year, two (2) years or three (3) years). An insurer may file for a new rate before the end of a rate period, but not more often than once during any twelve-month (12) period.

b. Notwithstanding Subsection 019.01, if an account changes insurers, that rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on such account, if sooner.

04. Use of Rates Lower Than Filed Rates. An insurer may at any time use a rate for an account lower than its filed rate without prior notice, justification and approval by the director.

05. Terms and Definitions Applicable to This Section.

a. "Experience" means "earned premiums" and "incurred claims" during the experience period.

b. "Experience Period" means the most recent period of time for which experience is reported, but not for a period longer than three (3) full years.

c. "Incurred Claims" means total claims paid during the experience period, adjusted for the change in claim reserve.

20. SUPERVISION OF CREDIT INSURANCE OPERATIONS.

01. Responsibilities of Insurer. Each insurer transacting credit insurance in this state is responsible for the settlement, adjustment and payment of all claims and is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business with such creditors, to assure compliance with the insurance laws of this state and the rules promulgated by the Director. Such review needs to include, but not be limited to, a verification of the accuracy of premium payments or other identifiable charges, premium refunds, and claims incurred.

02. Maintenance of Records. Records of such reviews will be maintained for four (4) years for review by the director.

21. PRODUCER'S LICENSE NEEDED.

01. Life and Disability Insurance License or Limited License. Except as provided in this section, to solicit credit life and credit disability insurance, producer is: licensed to sell life and disability insurance; or issued an appropriate "Limited License".

02. Administration of Group Policy. Under Section41-1005(2)(b), Idaho Code, the issuance of group certificates of credit life insurance and credit disability insurance and the performance of other ministerial duties in connection with group insurance policy administration does not need the person doing such acts to be licensed as a producer provided that no commission is paid for such services. A group policyholder may be reimbursed its expense of administering a group policy without being licensed as a producer, and such reimbursement will not be considered a commission provided it is reasonably computed to equate to the actual administrative expenses. It will be presumed that an amount of reimbursement not exceeding ten percent (10%) of the net written prima facie premium for the group policy is reasonably computed to equate to the administrative expenses of the group policyholder. Amounts exceeding ten percent (10%) of the net written prima facie premium will be presumed to exceed actual administrative expenses unless prior approval to pay such greater amount is secured pursuant to the insurer demonstrating to the director's satisfaction that such higher amount does not exceed the policyholder's actual administrative expenses. For purposes of this subsection, "prima facie premium" means premiums at the rates set forth in Section 014 without adjustment pursuant to Section 018.

22. DISCLOSURE.

When a premium or identifiable charge is payable by a debtor for credit insurance coverage offered by a creditor, at the time such insurance is applied for, disclosures will be made to the principal debtor and copies given and retained, in accordance with State and Federal law. The creditor will also disclose the optional nature of the coverage, premium or identifiable charge separately by type of coverage, eligibility requirements, and policy limitations and exclusions. These disclosures need to be made prominently above the space for the signature indicating election to obtain such coverage. These disclosures may be made in conjunction with either (1) the Federal Truth-in-Lending disclosure, (2) a Notice of Proposed Insurance, or (3) the insurance policy or certificate.

23. -999. (RESERVED)

IDAPA 18.06.02 – PRODUCERS HANDLING OF FIDUCIARY FUNDS

00. LEGAL AUTHORITY.

Title 41, Chapter 2 and 10, Sections41-211,41-1024, and41-1025, Idaho Code.

01. TITLE AND SCOPE.

01. Title. IDAPA 18.06.02, "Producers Handling of Fiduciary Funds."

02. Scope. This rule will affect "producers," including bail agents who handle funds held in a fiduciary capacity.

02. -009. (RESERVED)

10. DEFINITIONS.

01. Cash Collateral. All funds received as collateral by a producer in connection with a bail bond transaction in the form of cash, check, money order, other negotiable instrument, debit or credit card payment, or other electronic funds transfer, given as security to obtain a bail bond, as referenced in Section41-1043, Idaho Code.

02. Fiduciary Fund Account. A financial account established to hold fiduciary funds as provided in Section 016.

03. Fiduciary Funds. All premiums, return premiums, premium taxes, funds as collateral, and fees received by a producer. Fiduciary funds include:

a. All funds paid to a producer for selling, soliciting or negotiating policies of insurance except for those fees recognized by statute as earned by the producer upon receipt which are payable to the producer and not the insurance company, pursuant to Section41-1030, Idaho Code.

b. All funds received by a producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or to the producer's employer.

c. All funds provided to a producer by an insurance company or its agents that are to be paid to a policyholder or claimant pursuant to a contract of insurance.

d. All checks or other negotiable instruments collected by the producer and made payable to the insurer.

e. Cash collateral.

04. Receive. To collect or take actual or constructive possession of fiduciary funds. Receiving, includes but is not limited to, taking possession of money, checks, or other negotiable instruments. If fiduciary funds are in the form of a credit or offset on an account or other liability for the benefit of the consumer, without the producer actually taking possession of the funds, then constructive receipt is presumed to have occurred on the due date to the insurer.

11. -013. (RESERVED)

14. FIDUCIARY FUND ACCOUNT.

01. Payable to an Insurer. Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to an insurer as described in Subsection 010.03 are to be remitted to the insurer within the time period set forth in the insurer's terms and conditions, or if not specified, then within twenty-one (21) days of receipt.

02. Payable to a Policyholder. Fiduciary funds that are in the form of a check or another negotiable instrument made payable to a policyholder or claimant as described in Subsection 010.02.c. are to be remitted to the policyholder or claimant within fourteen (14) days of receipt or as specified by the terms of the policy of insurance, the insurer, or applicable law.

03. All Other Fiduciary Funds. All other fiduciary funds received by the producer, except as described under Subsections 014.01 and 014.02 are to be deposited into a fiduciary fund account according to the following schedule:

a. If in the form of cash, within seven (7) days of receipt, except that, when a producer holds fiduciary funds in the form of cash that exceed two thousand dollars ($2,000), such funds will be deposited within three (3) business days.

b. If in the form of checks, money orders, other negotiable instruments, debit or credit card payments, or other electronic funds transfer, received or collected by the producer, within seven (7) days of receipt, except that the producer may remit such funds to the following:

i. Another licensed producer or licensed business entity, subject to Subsection 014.03.b.; or

ii. A person designated by the insurer who has the obligation to remit the fiduciary funds to the insurer subject to Subsection 014.03.b.

04. Document the Receipt of Fiduciary Funds. A producer who receives fiduciary funds will document the receipt of those funds in sufficient detail to determine, at a minimum, the date received, the name of the payee, and the amount received. If the producer receives cash, including cash collateral, the producer will give the payer a detailed receipt at the time of payment. The receipt needs to indicate that cash was received, the date received, the amount received, the payer's name, the payee's name, the purpose of payment, and any other information important to the transaction. The producer will maintain the receipt for a period of at least five (5) years.

15. DEPOSIT OF OTHER FUNDS IN ACCOUNT.

A producer may deposit other additional funds for the sole purpose of:

01. Reserves for Return Premiums. Establishing reserves for payment of return premiums.

02. Funds to Pay Bank Charges. Advancing funds sufficient to pay bank charges.

03. Contingencies. For any contingencies that may arise in the business of receiving and transmitting premium or return premium funds or cash collateral (any such deposit is hereinafter referred to as "voluntary deposit").

16. TYPES OF ACCOUNTS PERMITTED.

01. Accounts in Federally Insured Financial Institutions. A producer will maintain the fiduciary funds only in checking accounts, demand accounts, savings accounts or other accounts in a federally insured financial institution.

02. Exceed the Federally Insured Limits. If such funds held exceed the federally insured limits, then in addition to Subsection 016.01, those funds that exceed the federally insured limits may be deposited into the following:

a. An investment account that invests monies in United States government bonds, United States Treasury certificates or in

federally guaranteed obligations;

b. Money market mutual funds registered with the SEC which are rated AAA by Moody's or AAA by S&P.

03. Separate Fiduciary Funds Account. Nothing in this rule obligates a producer to maintain and hold fiduciary funds in his, her, or its, own separate fiduciary funds account. Each producer is responsible for compliance with the provisions of this rule even if fiduciary funds are maintained in a fiduciary funds account established by another affiliated producer.

17. ACCOUNT DESIGNATION.

01. Designation of a Fiduciary Fund. A fiduciary fund account is so designated on the records of the financial institution. The account has a separate account number, a separate check register and its own checks.

02. Trust Fund Account. The phrase, "Trust Fund Account" is displayed on the face of each check drawn on a fiduciary fund account or other similar designation as permitted by the financial institution to identify the checks as being from a fiduciary fund account.

18. INTEREST EARNINGS.

A fiduciary fund account may be interest-bearing or an investment account in accordance with Section 016. The producer will maintain records establishing the existence and amount of interest accrued.

19. PERMISSIBLE DISTRIBUTION OF FIDUCIARY FUNDS.

Distributions from a fiduciary fund account are to only be made for the following purposes, and in the manner stated:

01. Remit Premiums. To remit premiums to an insurer or an insurer's designee pursuant to a contract of insurance;

02. Return Premiums. To return premiums to an insured or other person or entity entitled to the premiums;

03. Remit Surplus Lines Taxes and Stamping Fees. To remit surplus lines taxes and stamping fees collected to the appropriate state;

04. Reimburse Voluntary Deposits. To reimburse voluntary deposits made by the producer to the extent that the funds in the fiduciary account exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous voluntary deposit.

05. Transfer or Withdraw Accrued Interest. To transfer or withdraw accrued interest to the extent that fiduciary fund account funds exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous interest deposit by the financial institution.

06. Transfer or Withdraw Actual Commissions. To transfer or withdraw actual commissions and those earned fees recognized as earned by the producer, upon receipt, which are payable to the producer, only if the commissions and fees can be matched and identified with funds previously deposited in the fiduciary account.

07. Pay Charges Imposed. To pay charges imposed by the financial institution that directly relate to the operation and maintenance of the fiduciary funds account.

08. Transfer Funds. To transfer funds from one (1) fiduciary fund account to another fiduciary fund account.

09. Return Cash Collateral. To return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, has been discharged.

10. Convert Cash Collateral. To convert cash collateral where the defendant or other responsible party fails to satisfy the obligation of the bail bond and the bail or obligation was not exonerated by the court but instead executed by the court, provided such conversion is compliant with the contract between the producer and the person who deposited the cash collateral.

20. -021. (RESERVED)

22. TIMELY DISBURSEMENT OF FIDUCIARY FUNDS.

In addition to the requirements of Section 014, after receiving fiduciary funds, a producer:

01. Remits Premiums. Remits premiums directly to an insurer or an insurer's designee within the time period set forth in the insurer's terms and conditions, or if not specified, within fourteen (14) days of receipt;

02. Returns Money Received. Returns to the payer the money received as a premium deposit which is retained by the producer or returned to the producer by the insurer to the payer by the earlier of:

a. Fourteen (14) days from the date the premium is received by the producer from the insurer, or

b. Fourteen (14) days from the date the insurer notifies the insurance applicant that coverage has been denied if the producer retained the premium deposit.

03. Refund Received from the Insurer. Issues a refund received from the insurer within fourteen (14) days by disbursing money to the insured or other party entitled thereto by notifying the insured that the refund is being applied to an outstanding amount owed or to be owed by the insured. If the producer is applying the refund to an outstanding amount owed by the insured, the producer obtains the insured's permission and provide the insured a detailed description of the amount owed to which the refund is being applied.

04. Dispute of Entitlement of Funds. If there is a dispute as to entitlement of funds under Subsections 022.01 or 022.03, a producer notifies the parties of the dispute, seeks to resolve it, and documents the steps taken to resolve it.

05. Funds Held for More Than Ninety Days. If fiduciary funds within the scope of Subsections 022.01 or 022.03 are held for more than ninety (90) days, the producer investigates to determine the entitlement to fiduciary funds and pays those

fiduciary funds when due to the appropriate person in accordance with this section.

06. Return Cash Collateral. Returns cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, is discharged.

23. 999. (RESERVED)

IDAPA 18.06.04 Continuing Education

00. LEGAL AUTHORITY.

Title 41, Chapters 2, 10, 11, and 58, Sections41-211,41-1013,41-1108,41-5813, and41-5820, Idaho Code.

01. SCOPE.

This rule prescribes a minimum education in approved subjects that impacts all resident licensees practicing insurance, except for producers licensed to sell only "limited lines insurance," and requires them to periodically complete, procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met.

02. -009. (RESERVED)

10. DEFINITIONS.

01. Licensee. An individual holding a license as a producer, bail, adjuster, or public adjuster pursuant to Title 41, Chapters 10, 11, or 58, Idaho Code.

11. (RESERVED)

12. BASIC REQUIREMENTS.

01. Proof of Completion. As a condition for the continuation of a license, a licensee must complete a total of 24 hours of continuing education credits, including a minimum of 3 ethics credits on or before the licensing renewal date every two (2) years. Proof of satisfactory completion of approved subjects or courses will be downloaded to licensing records by the system vendor in a format acceptable to the Director.

a. No more than four (4) hours of continuing education credit from courses approved for adjusters or public adjusters can apply toward the continuation of a producer license.

02. Completion Within Two Years. Each course to be applied toward satisfaction of the continuing education requirement is to be completed within the two (2) year period immediately preceding renewal of the license. Courses cannot have been duplicated in the same renewal period. The date of completion for a self-study course is the date of successful completion of exam.

13. EXCEPTIONS/EXTENSIONS.

01. Exceptions and Extensions. The following exceptions and extensions may be made to the continuing education rules:

a. Licensees on extended active duty with the Armed Forces of the United States for the period of such duty and all other exceptions allowed under Section41-1008(4), Idaho Code.

b. Persons which hold a temporary license as provided in Section41-1015, Idaho Code.

c. The Continuing Education Advisory Committee or the Director may approve an exception or extension for an extra ordinary situation that is requested by a licensee, in writing, setting forth the basis for the exception or extension. and received prior to the renewal date by the Director or Committee.

14. CONTINUING EDUCATION ADVISORY COMMITTEE.

01. Continuing Education Advisory Committee. An eleven (11) member Continuing Education Advisory Committee ("Committee") comprised of representatives from each segment of the insurance industry, is appointed by the Director. Committee members will serve a term of three (3) years.

02. Duties of the Committee. The Committee performs the following duties at the discretion of the Director:

a. Approve or disapprove courses as per the standards of this rule and assign the number of continuing education hours to be awarded.

b. Consider applications for exceptions and extensions as permitted under Section 013; and

c. Consider other matters as the Director may assign.

03. Quorum. Those present at any meeting of the Committee are a quorum for purposes of acting to perform the duties of the Committee pursuant to this rule. Matters before the Committee may be decided by a majority of those members present. In the event of a tie vote, the Chairman votes to break the tie.

15. PROGRAM REQUIREMENTS.

All continuing education programs need to be submitted to the Committee in accordance with Section 021 on forms promulgated by the Director. Any course provider that resides in and has had their continuing education program(s) approved by, a state in which the insurance department has signed a separate reciprocity agreement with the Idaho Department, need not have their continuing education program(s) reviewed and approved by the Committee. However, all such courses need to be filed with the Department in a format approved by the Director and course application fees paid.

16. PROGRAMS WHICH QUALIFY.

01. Requirements of Acceptable Program. A specific program will qualify as an acceptable continuing education program if it is a formal program of learning which contributes directly to the professional competence of a licensee. It will be left to each

individual licensee to determine the course of study to be pursued. All programs need to meet the standards outlined in Section 018.

02. Subjects Which Qualify.

a. The following general subjects are acceptable for producers.

i. Insurance, fixed and indexed annuities, and risk management.
ii. Insurance laws and rules.
iii. Mathematics, statistics, and probability.
iv. Economics.
v. Business law.
vi. Finance.
vii. Taxes, trusts, estate planning.
viii. Business environment, management, or organization.
ix. Securities.

b. The following general subjects are acceptable for adjusters and public adjusters.

i. Insurance.
ii. Insurance laws and rules.
iii. Mathematics, statistics, and probability.
iv. Economics.
v. Business law.
vi. Restoration.
vii. Communications.
viii. Arbitration.
ix. Mitigation.
x. Glass replacement and/or repair.

c. Areas other than those listed above may be acceptable if the licensee can demonstrate that they contribute to professional competence and meet the standards set forth in this rule. The responsibility for substantiating that a particular program meets the requirements of this rule rests solely upon the licensee.

17. PROGRAMS WHICH DO NOT QUALIFY.

01. Any Course Used to Prepare for Taking an Insurance Licensing Examination.
02. Committee Service of Professional Organizations.
03. Computer Science Courses.
04. Motivation, Psychology, or Selling Skills Courses.
05. Reviews, Quizzes and/or Examinations.
06. Any Program Not in Accordance with This Rule.

18. STANDARDS FOR CONTINUING EDUCATION PROGRAMS.

To qualify for credit, the following standards need to be met by all continuing education programs:

01. Program Development.

a. The program provides significant intellectual or practical content to enhance and improve the insurance knowledge and professional competence of participants.
b. The program is developed by persons who are qualified in the subject matter and instructional design.
c. The program content is current or up to date.

02. Program Presentation.

a. Instructors are qualified, both with respect to program content and teaching methods. Instructors will be considered qualified if, through formal training or experience, they have obtained sufficient knowledge to instruct the course competently.
b. The number of participants and physical facilities is consistent with the teaching method specified.
c. All programs will include some means for evaluating quality.

19. MEASUREMENT OF CREDIT.

01. Credits Measured in Full Hours. Professional education courses are credited for continuing education purposes in full hours only. The number of hours is equivalent to the actual number of contact hours which need to include at least fifty (50) minutes of instruction or participation. No credit will be given for partial attendance.
02. Internet Courses. Internet self-study courses will be credited one (1) hour of continuing education for every fifty (50) minutes of study material, excluding exams. Credit will be given in accordance with Section 021.
03. Webinar Courses. Webinars will be credited as classroom instruction or participation. In the event one (1) course encompasses multiple webinars and self-study is necessary between webinars, the self-study material need to be submitted to the Committee to be evaluated for additional credit in accordance with Section 021.

20. CONTROLS AND REPORTING.

01. Licensee to Retain Original Certificate as Evidence. The original certificate of completion received for each educational program or course is retained by the licensee to evidence completion during the two (2) year renewal period. The certificate of completion is in a format provided to the Department.

02. Sign-In and Sign-Out Sheets. Sign-in and sign-out sheets are to be used and monitored to ensure attendance for the full length of the seminar. No certificate of completion is to be given to anyone arriving late or leaving prior to the conclusion of the seminar. Failure to comply with these requirements will result in loss of certification of the provider in accordance with Section 023.

21. APPROVED PROGRAMS OF STUDY CERTIFICATION BY DIRECTOR.

01. Requirements of Course Approval. All courses are approved by the Committee. If a course is not approved in advance of presentation, an application for credit may be submitted to the Committee within sixty (60) days of completion of the course.

02. Nonrefundable Application Fee. Each course application is accompanied by a nonrefundable application fee (as set forth in IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges").

03. Course Approval Procedures. Any person intending to provide courses applies in a format prescribed by the Department and provides the following supporting documentation:

a. A specific outline and/or course material;
b. Time schedule;
c. Method of presentation;
d. Qualifications of instructor; and
e. Other information supporting the request for approval.

04. Method to Determine Completion. The submission includes a statement of the method used to determine the satisfactory completion of the course. Methods may be an examination, or certification by the provider of the agent's program attendance or completion, or other methods approved by the Director.

05. Certification of Program. Certification of a program is effective for two (2) years or until any material changes are made in the program, after which it may be resubmitted to the Committee for approval.

22. PROOF OF COMPLETION.

An authorized representative of the sponsoring organization will, within thirty (30) days of completion of the course, provide a certificate of completion to each individual who satisfactorily completed the course and certify to the Department electronically a list of all such individuals.

23. APPROVED SUBJECTS LOSS OF CERTIFICATION.

01. Program Suspension. The certification of a program may be suspended by the Director if it has been determined that:

a. The program teaching method or program content no longer meets the standards of this rule, or have been significantly changed without notice to the Director for recertification;
b. The program certified to the Director that an individual completed the program, when in fact the individual had not done so;
c. Individuals who have satisfactorily completed the program of study were not so certified by the program;
d. The instructor or sponsoring organization is not qualified per the standards of this rule or lacks education or experience in the subject matter of the proposed course;
e. The instructor, sponsoring organization, or any company or affiliate of a sponsoring organization has had a license revoked or suspended in any jurisdiction. This includes any firm or organization where a revoked or suspended individual has a substantial ownership interest, or other control in a firm or organization; or
f. There is other good and just cause why certification should be suspended.

02. Reinstatement of a Suspended Certification. Reinstatement of a suspended certification will be made upon proof satisfactory to the Committee or the Director, that the conditions responsible for the suspension have been corrected.

24. CREDIT FOR INDIVIDUAL STUDY PROGRAMS.

01. Requirements for Credit of Independent Study Programs. All approved correspondence courses or independent study programs needs to include an examination which requires a score of seventy percent (70%) or better to earn a certificate of completion. For each approved course, the sponsoring organization will maintain multiple tests (two (2) or more) sufficient to maintain the integrity of the testing process. A written explanation of test security and administration methods will accompany the course examination materials. Each unit and/or chapter of a course will contain review questions that can be answered with a score of seventy percent (70%) or better before access to the following unit/chapter is allowed.

02. Completed Tests. The examinations are administered, graded, and the results recorded by the organization to which approval was originally granted. Completed tests are retained by the sponsoring organization and will not be returned to any licensee.

03. Prior Approval Needed for Correspondence Courses. All correspondence courses need be submitted for approval and approved prior to being offered to licensees for continuing education credit.

25. CREDIT FOR SERVICE AS LECTURER, DISCUSSION LEADER, OR SPEAKER.

Only one (l) hour of continuing education credit will be awarded for each hour completed as an instructor or discussion leader

26. -999. (RESERVED)