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DEPARTMENT OF COMMERCE AND LABOR
FIRST FLOOR, ADMINISTRATION BUILDING, CAPITOL HILL
SAIPAN, MP 96950

SPECIAL REPORT TO THE LEGISLATURE PURSUANT TO SECTION 7113

AND

FIFTH ANNUAL REPORT OF THE INSURANCE COMMISSIONER FOR CALENDAR YEAR ENDING DECEMBER 31,1992

JOAQUIN S. TORRES
Insurance Commissioner

Prepared by Banking and Insurance Section

MESSAGE FROM THE INSURANCE COMMISSIONER...

It is my pleasure to present the Fifth Annual Report of the Insurance Commissioner for the year ended December 31, 1992. Made and published pursuant to 4 CMC Section 7112 of the Commonwealth Insurance Act of 1983 (enacted as Public Law 3-107 and herein referred to as "Insurance Act"), the annual report is the accomplished result of the dedicated staff of the Banking and Insurance Section, Office of the Director, Department of Commerce and Labor. An entire copy or portions of the report can be furnished to interested persons at cost upon request.

Although not widely known, the Director of Commerce and Labor is likewise Director of Banking and Insurance Commissioner, pursuant to the Commonwealth Banking Code of 1984 (Public Law 3-104) and the Insurance Act, respectively. Thus, to assist the Director with the administration and enforcement of the Commonwealth's banking and insurance laws, the Banking and Insurance Section was created internally by the first Commissioner, former Director Jesus R. Sablan. The Section is not sanctioned by statute nor could it purport to exercise legal, binding authority unless expressly delegated by the Director.

One of the Section's delegated tasks is to compile and analyze data required to produce the annual reports of the Director of Banking and Insurance Commissioner. The production of the Commissioner's report can be seriously impaired, however, due to non-compliance of insurers and other licensees whom are required but fail to file acceptable reports with the Commissioner.

A proposed deterrent to remedy non-compliance as just described is discussed along with other equally important recommendations found in the annual report under Recommended Legislative Action Pursuant To Section 7112. In addition to the annual report, a **"Special Report To The Legislature"** is made pursuant to 4 CMC Section 7113. The purpose of the special report is to apprise legislators of the administrative, personnel, and budgetary needs of the Commissioner, in addition to proposed amendments cited under Recommended Legislative Action Pursuant To Section 7113.

Because of changing needs and desires, man-made laws should be regarded as constantly evolving. Insurance laws are no exception. Current law, for example, does not specifically require domestic insurers to establish and maintain a separate reserve account(s) for the payment of claims or other liabilities. Consequently, in the eyes of the law there is little security on a domestic insurer's financial capability with respect to its obligations.

Bearing in mind that the Insurance Act was amended only once since becoming law, we must be cognizant of interactive economic, social, political, and a myriad of other, not only local, but also regional and international forces and trends that may signal inevitable changes in the status quo. We are, therefore, compelled to review periodically the relevancy of existing laws, including insurance laws, within the context of a changing local economy, society and, until recently, environment.

At some point in the young history of the Commonwealth, it was felt that a system was needed to regulate insurance. The Third Commonwealth Legislature became aware of this and, in exercising its constitutional mandate, reacted accordingly by passing the Insurance Act. The stated intent behind the Insurance Act is "To establish an insurance regulatory mechanism, creating the Office of Insurance Commissioner, and for other purposes."

However, a periodic evaluation of such mechanism is essential to determine its role and applicability to the Commonwealth. Based on the evaluation's conclusions, legislative or policy recommendations can be developed and presented to the legislature and other decision-makers for consideration. If accepted and implemented even with some modification, such recommendations are intended to yield an insurance regulatory mechanism that is adequately supported and more functionally responsive to the public.

Hence, the reports presented herein. Let the Fifth Annual Report of the Insurance Commissioner and Special Report to the Legislature be the catalyst for change, to inspire change in the provisions of applicable law to enable effective enforcement and execution of the Insurance Act.

Again, may I acknowledge the staff of the Banking and Insurance Section for their efforts to produce a truly commendable report. In addition, I would like to acknowledge appreciation to the National Association of Insurance Commissioners for allowing us to reproduce in this report NAIC published material.

Please direct any questions, comments, or concerns regarding the reports to the address below, or call the listed telephone/Fax numbers. Thank you.

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SPECIAL REPORT

TO THE LEGISLATURE

Pursuant To 4 CMC Section 7113
December 1, 1993

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Comments On Submission

This special report to the legislature is made pursuant to **4 CMC Section** 7113, Initial Implementation; Transition, with requirements which read in part:

> Subsection 7113(b). No later than 15 months from the effective date of this division, the Commissioner shall prepare a special report to the legislature which,...shall assess the administrative, personnel and budgetary needs of the Commissioner...
>
> Subsection 7113(c). The special report shall address specific application of this division to the Commonwealth and recommend such amendments as the Commissioner may deem appropriate to regulate:
>
> (1) Capital funds required for insurers;
> (2) Limits of risks for classes of insurance;
> (3) Requirements for organization of domestic insurers;
> (4) Insurance contract requirements for all classes of insurance;
> (5) Requirements for mergers, rehabilitation, and liquidation; and
> (6) Insurance rates for certain classes of tariff insurance.

Subsection 7113(b) requires the submission of the special report to occur no later than 15 months after February 24, 1984, the effective date of the Insurance Act. However, no record exists that such report was submitted. What appears in the records of the Commissioner is an original draft of the special report. The draft is dated May 28, 1985, and there is no indication that it, or any other, was submitted in final form to the legislature. See Draft Original, A SPECIAL REPORT.. beginning on page 14.

Thus, the Commissioner insists that a report is highly warranted to alert the legislature about his concerns and recommended reforms with respect to Section 7113. As per its legal effect, the 15 month restriction in Subsection 7113(b) no longer should be of practicable significance and, therefore, rendered irrelevant as should Subsections 7113(a) and (d).

The special report is divided into two sections, Part A and Part B. Part A focuses on Subsection 7113(b) -- an assessment of the Office of the Insurance Commissioner, particularly its administration, personnel, and budget. Part B addresses recommendations on topics specific to Subsection 7113(c). Where applicable, discussion in said draft is incorporated in the report.

Part A. Office of the Insurance Commissioner

Background

The position of Insurance Commissioner was created pursuant to 4 CMC Section 7104, Insurance Commissioner Established, which reads in part:

> The Insurance Commissioner of the Commonwealth shall be the Director of Banking until such time as the legislature, at the recommendation of the Insurance Commissioner pursuant to Section 7112, creates a separate office or position...

However, it should be noted too that the incumbent of both offices concurrently serves in a more primary capacity as Director, Department of Commerce and Labor. Initially, the Chief of Business and Trade assumed the role of assistant to the Commissioner. Later, that role was transferred to the insurance officer, a new position that began at the start of FY 1986.

In FY 1987, the position of Special Assistant for Insurance (SAI) became established and superseded the insurance officer. The SAI is expressly delegated certain insurance regulatory authority by the Commissioner pursuant to Section 7108 of the Insurance Act.

Presently, the SAI and an administrative specialist are under the immediate supervision of the Deputy Director of Banking. The three comprise the staff of the Banking and Insurance Section (Section) whose primary function is to provide enforcement support to the Director. At other times, the Section's staff may be charged with other departmental tasks as assigned by the Director.

The Section emerged at the discretionary authority of former Director Jesus R. Sablan, and likewise, is subject to dismissal by the Director. The Section continues to function as an integral part of the Office of the Director and relies completely on the latter for administrative, personnel, and budgetary support.

As such, the Section is limited virtually to only those resources available to the Office of the Director. When adequate resources are scarce, limited, or otherwise not available, the Section's effectiveness is compromised and may result in inadequate supervision of insurers, banks, brokers, etc.

In the eight years of the Insurance Act's existence, much remains to be considered for the purpose of enhancing the function and capabilities of the Office of the Insurance Commissioner. To enable a better understanding of needed reforms to that office, a brief summary of its administration, personnel, and budget is discussed and followed by the Commissioner's recommendations. The recommendations of each section are interrelated.

I. Administration

The Department of Commerce and Labor continues to advocate increased funding for the department's overall budget. However, because of continuously reduced funding for personnel, equipment, training, and other major necessities, the department is not able to properly administer and enforce its mandated laws, particularly insurance and banking laws. The Insurance Commissioner's eight-year, constant struggle under the department's administration is a clear indication that the present arrangement is ineffectual, and a better solution must be sought.

The Office of the Insurance Commissioner is not a separate office as already mentioned. See Background. However, 4 CMC Section 7104 allows the legislature to create a separate office or position pursuant to the Commissioner's recommendation.

Recommendation:

To ensure the needs and protect the integrity of the Office of the Insurance Commissioner, the Commissioner believes an expedient, definitive modification to Section 7104 is necessary to transfer and delete all references to the Office of the Insurance Commissioner from the Department of Commerce and Labor to a separate, semi-autonomous commission. The recommended purpose of this commission is to encourage and promote safety and diversity in financial and insurance activities in the Commonwealth through equable, sound regulation of such activities. See also NAIC Policy Statement on Financial Regulatory Standards beginning on page 37.

This commission shall be established via legislation and may be named the "Commonwealth Financial Regulatory Commission," or as appropriate to identify with the recommended purpose for which it is proposed to be established. In addition, the legislation shall create a five member Board of Commissioners to oversee the Commission.

Board Commissioners shall be appointed by the governor at the advice and consent of the Senate. The Insurance/Banking Commissioner, or his designee, and the legal counsel (See Section II. Personnel.) shall be ex-officio members of the Board. They will have no voting power nor be allowed to serve as officers of the Board.

However, their attendance shall be required at all official Board meetings, except when the Board deliberates to hire or terminate a Commission official (See Board's authority below). In contrast, the Chief of Administration or his designee shall be designated the Board's recording secretary and shall be present at all official meetings.

Board Commissioners shall elect among themselves a chairperson and vice-chairperson. Both shall serve in such capacity for one year subject to their removal, resignation, or death. Monetary compensation, if any, to Board Commissioners for official meetings, travel, and etc., shall be commensurate with members of other semi-autonomous boards.

Except for initial members, two members of the Board shall serve a two-year term while the remaining three shall serve a four- year term. The expiration of initial members' terms will be such that subsequent terms will produce at least one vacancy in the Board every year. A member may be reappointed to serve another two or four years but, in no event, shall a member be allowed to serve more than six years cumulative.

It is recommended that the governor shall be given flexibility with respect to prospective appointees' qualifications. However, no less than three members shall be required to possess at least two years of middle or upper level, managerial experience in financial, insurance, or other comparable management.

The Board shall have authority to:

1) Establish, adopt, or amend the commission's administrative policies, rules and regulations in accordance and consistent with the law establishing such commission;

2) Establish, adopt, or amend qualifications for the position of Insurance/Banking Commissioner and deputies, and legal counsel, if any;

3) Hire or terminate any Commission official (Insurance/Banking Commissioner, any deputy, and legal counsel);

4) Make, review, amend, reject or endorse proposed amendments to the banking and insurance laws prior to submission to the legislature;

5) Make, review, amend, reject or endorse annually the commission's proposed fiscal budget, subject to commission's fiscal policies and applicable laws;

6) Exercise reasonable, discretionary, and other authority either expressed or implied pursuant to statute; and

7) Delegate to the Insurance/Banking Commissioner authority pursuant to items 4 through 6 as deemed necessary.

The legislation establishing the Commission shall allow for the creation of functional divisions within the Commission. The legislature, upon recommendation by the Board of Commissioners, effectuate such legislation to add, reorganize, delete, fund, or otherwise effect changes in the Commission's organizational structure. See Exhibit I on page 30.

In addition, the above legislation shall give concurrent effect to the creation of three initial divisions, namely: (1) The Division of Banking; (2) The Division of Insurance; and (3) The Division of Administration. Initially, the Commission shall regulate:

1. Insurance pursuant to 4 CMC Division 7 or the Commonwealth Insurance Act of 1983 and amendments thereto; and

2. Banking and related entities pursuant to 4 CMC Division 6 or the Commonwealth Banking Code of 1984, amendments, rules and regulations thereto.

Note: See also Recommendations to the Legislature Pursuant to Section 7112 in the Fifth Annual Report of the Insurance Commissioner. For banking amendments, see the Fifth Annual Report of the Director of Banking.

II. Personnel

As already mentioned, there is only one full-time staff to assist the Insurance Commissioner since passage of the Insurance Act. This is a deficient and very unacceptable situation.

It is presumptuous to consider that one or two persons alone are sufficient to administer all functions of the Commissioner as intended pursuant to statute. Moreover, since FY 1989 attempts to secure legislative funding for additional insurance personnel consistently have been unsuccessful .

A perusal of the Commissioner's duties and obligations under the Insurance Act implies that he or she cannot but rely on a staff of qualified individuals capable of providing administrative and enforcement support. Because of the nature of insurance regulation, the Commissioner understandably is adamantly concerned about hiring and maintaining an absolute minimum staff level with minimum qualifications, in terms of work experience, special expertise, and educational/professional background.

Recommendation:

Exhibit II on page 31 depicts a proposed organizational chart of the Division of Insurance of the proposed Commonwealth Financial Regulatory Commission. The chart is a perception of the Commission's recommended staff requirements based on current and anticipated needs.

The Insurance/Banking Commissioner, the deputy, and general counsel shall serve at the pleasure of the Board of Commissioners. All other positions may be classified under the Civil Service System.

Compensation to the Insurance/Banking Commissioner, the deputy, and general counsel shall be set by the Board. Remuneration and other employee benefits to all other Commission employees shall be in accordance with existing statutes, rules and regulations relative to government employment. See also III. Budget.

All active employees of the Commission shall become contributing members of the Northern Mariana Islands Retirement Fund. In addition, the Commission shall provide employer's, matching contributions to the Fund.

Staff competency and capability shall be among the Commission's highest priorities. The Commission will require all insurance staff to undergo requisite training/educational programs to obtain an established minimum level of proficiency in accordance with job requirements. Specific language in the law shall address the issue of training funds. Such language shall specify that the required amount of funds for training be placed in a special account established exclusively for such purpose.

At the end of every fiscal year, any remainder in the account less than one thousand dollars shall accrue to the account. Amounts exceeding one thousand dollars shall revert to the general fund subject to the replenishment of the special account.

The amount of training funds shall be derived as a percentage of license and other fees collected by the Commission in the year preceding. The percentage applied shall be determined based on justifiable, training needs.

Training and educational programs of the National Association of Insurance Commissioners, as well as those of the Civil Service and other recommended course/training providers shall be applied systematically. See NAIC and other education programs beginning on page 43.

Furthermore, the Commission shall develop and implement a unique training program in cooperation with other state insurance supervisory authorities, whereby annually selected insurance staff of the Commission will undergo on-site, intensive familiarization of other state insurance departments' applicable regulatory procedures and capabilities. Cross-training of Commission's non-supervisory staff shall be encouraged where appropriate and to the extent that employee productivity is maximized.

III. Budget

Below is an average estimate of budget resources allocated to regulate insurance for FY 1991 and 1992:

Personnel	$41,700.00
Operations	1,900.00
Total	$43,600.00

Insurance budget estimate as a percentage of total premiums written and the total Commonwealth budget (executive branch) for years ending December 31, 1991 and 1992 and FY 1991 and 1992, respectively are:

Year	Insurance Budget Premiums Written	Insurance Budget Total Commonwealth Budget
1991	.0025	.000281
1992	.0026	.000275
	Compare with Exhibit III.1 on page 32.	Compare with Exhibit III.2 on page 33.

The percentages pale considerably in comparison to figures representative of the 50 U.S. states and insular possessions. One should resist disparaging comparison of CNMI figures to those found in Exhibits III.1 and III.2. There must be a means, after all, by which the CNMI can measure its performance relative to other jurisdictions.

While it can be argued that the Commonwealth's uniqueness due to its geography, economy, population characteristics and laws should not subject it to meaningful comparison with other entities, such arguments and attitudes often become an obstruction to and delay the problem-solving process to seek better alternatives and solutions. Notwithstanding, the comparisons are supportable with respect to methodology, apparent similarities, and uniformity in the regulation of insurance among the various jurisdictions, including the CNMI.

It is very likely that, in general, all budget proposals submitted to the legislature become victims of preferential prioritization. Similarly, it is very likely that insurer insolvency, varieties of fraud, unsubstantiated premium rates, false or unpaid claims, abusive insurance agents and brokers, and worthless insurance policies are just a few of many already existing problems that eventually will worsen and bring havoc to the Commonwealth should decision-makers choose to continue ignoring the Insurance Commissioner's plight and the intent of the Insurance Act.

Exhibit III.3 on page 34 shows an excerpt from the 1989 budget proposal for the Department of Commerce and Labor. This report intends to reiterate the same basic concerns as contained in the excerpt for obvious reasons cited above.

Recommendation:

The law to establish the Commonwealth Financial Regulatory Commission (See Section I. Administration) shall require that the Commission be accorded the financial resources sufficient to enable its operation. Such law shall contain specific language for the funding of the Division of Insurance's overall operation. The language shall provide for a reliable funding mechanism that defines a level of funding compatible with the requirements of the Division.

Such law shall require authorized insurers and surplus line agents/brokers to pay a "premium tax" at the equivalent existing rate, but in lieu of the tax currently imposed by Commonwealth tax laws. The premium tax due shall be based strictly on the amount of direct premiums written less any premium returns for the immediate calendar year preceding.

Funds derived from premium tax proceeds shall be deposited into an "Insurance Regulatory Trust Account", while any remainder amounts at fiscal year-end shall accrue to the benefit of the account. The trust account may include, as a separate account, the special account for insurance staff training.

The cumulative funds in the trust account shall fund 100 percent of the proportion of the Commission's approved fiscal budget for the Division of Insurance, with the exception of insurance staff training. However, excess funds from the special account for insurance staff training shall be used to cover directly any budget shortfall attributed to the trust account up to $70,000 per fiscal year.

The Board of Commissioners shall submit the Commission's fiscal budget proposal to the legislature not later than 30 days before the governor's required submission of the executive branch's proposed budget. Final approval of the Commission's budget shall be subject to applicable appropriations laws.

Exhibit III.4 beginning on page 35 illustrates a proposed budget for the Commission's insurance branch pursuant to the recommendations in Sections I and II. Revenues and expenses are estimated based on current, general data, proposed license and other fees, and salary trends.

A

SPECIAL REPORT

PREPARED BY THE

DEPARTMENT OF COMMERCE AND LABOR

FOR SUBMISSION

TO THE

COMMONWEALTH LEGISLATURE

AS REQUIRED BY SUBSECTION 13(b)

OF

THE COMMONWEALTH INSURANCE ACT OF 1983

MAY 28, 1985

SAIPAN, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
96950

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INTRODUCTION:

As required by Subsection 13(b) of the Commonwealth Insurance Act of 1983 (Public Law No. 3-107), the Insurance Comissioner or the Director of Commerce and Labor is mandated such a provision to prepare this special report for submission to the legislature. The Act was passed by the legislature with the intent to establish an insurance regulatory mechanism, creating the Office of the Insurance Commissioner, and for other purposes.

Subsection 13(b) sets forth that those topics outlined by Subsection 12(b) be included in this report also. In addition thereto, Subsection 13(b) of the Act further prescribes that the Insurance Commissioner shall assess the administrative, personnel and budgetary needs of his office to enable its full effective enforcement and execution of the Act, and Subsection 13(c) additionally requires that this report address specific application of the Act to the Commonwealth by which the Insurance Commissioner shall recommend such amendments he deems appropriate to regulate of those concerns pointed out therein.

This report ~~generally~~ covers a period of 15 months which extends from the effective date to May 24, 1985. The Act was sign into law on February 24, 1984. Therefore, since the Department of Commerce and Labor issues business licenses on a calendar year basis, all existing insurance business entities were licensed pursuant to Subsection 503(d) of Public Law No. 3-11 prior to that date. All renewal insurance licenses were issued effective January 1, 1984.

Subsequent to the signing of the Act by the Acting Governor, the Director of Commerce and Labor immediately acted in accordance with Section 34. As a result, the first six months from thereon were primarily used as a period of orientation and familiarization of the Act by the department, and especially for the various insurance agents who were operating in the Commonwealth. Given this situation, the Director decided to defer the enforcement and execution of Section 15 of the Act until calendar year 1985.

In short, it is the purpose of this report to communicate to the legislature what has basicly transpired since February 24, 1984. Similarly, this report stands to give an account of the department's reflection on the various elements it experienced within the last 15 months in the implementation of the Act.

COMMENTS RELATIVE TO SUBSECTIONS 12(b)(1) & 12(b)(3) OF THE ACT:

In reference to the condition of all insurers authorized to do business in the Commonwealth during the preceding year, it should be understood that this particular topic cannot be fully addressed at this time due to the fact that the necessary information for the compilation of such presentation were not adequately filed with the department. This situation is basicly true with the alien insurers. Some of the annual statements submitted were current as of December 31, 1984. These are considered current to date. However, some have managed to file annual statements that were prepared as of December 31, 1983. Most of these filing

of annual statements were done by foreign insurers who are predominantly organized under the corporate or insurance laws of a U.S. state.

The Act clearly states under Subsection 15(d)(1)(C) that each applicant insurer must file a current copy of its annual statement. This presents a problem for alien insurers that is very much similar to that requirement of having to file a copy of its report of examination. The legislature is requested to initiate an amendment that will address this particular issue.

Therefore, the Director of Commerce and Labor wishes to advise the leaderships of both houses that this particular topic will not be covered in this report but most likely be fully discussed in next year's regular annual report as mandated by Section 12 of the Act.

With respect to Subsection 12(b)(3), the leaderships of the legislature are hereby advised also that no set of rules and regulations has been promulgated by the department pursuant to Subsection 5(b) of the Act. With the exception of those provisions that will be enumerated later on herein, it is our view that the present context of the Act is adequate in provisions that it does not warrant the promulgation of rules and regulations at this time.

RECOMMENDED LEGISLATIVE ACTION PURSUANT TO SUBSECTION 12(b)(2) OF THE ACT:

It is the position of the Director at this time to have Section 4

of the Act amended so the office of the Insurance Commissioner be created as a separate one from the Director of Banking. The incumbent of that office is presently the Director of Commerce and Labor also. The Director suggests that the above amendment would organize the office of the Insurance Commissioner similar to a departmental division and be operated as such for the first three years, but the position of the Commissioner may not be equated to nor made equivalent in rank to that of a divisional chief. This distinction can easily be ascertained and justified when one peruses the powers and duties of the Commissioner under the Act.

The Commissioner may be appointed by the Governor. It could also be treated as a position within the Civil Service System. Given these choices, it is the recommendation of the Director that the legislature choose the first approach.

If the legislature decides that such a position be made a gubernatorial appointment, then it is suggested that the administrative budget of the Commissioner be established separately from the Department of Commerce and Labor. The Commissioner shall then be required to submit and justify his budget request annually to the legislature as required by existing and applicable law.

In terms of necessary qualifications, the applicant seeking the Insurance Commissionership should basicly possess at least five years of active experience in the field of insurance examination or has previously held such position in a satisfactory capacity.

The applicant should also be required to possess at least a baccalaureate degree in either the field of business or public administration. The Governor may be authorized by law to waive some of the above required credentials provided that the selected candidate possess other acceptable qualifications such as having ~~some past~~ some years of experience experience as an administrator ~~of~~ an enforcement or regulatory agency of the government related to business licensing. The candidate should be backed by at least two years of experience in such office. It is suggested that this position be compensated at least $32,000 per annum at the initial stage.

Given the foregoing amendment, Section 5 of the Act should be amended also in order to give the Commissioner the additional power to recruit and terminate his office personnel. This particular provision of the Act may be modified in such a way so that it spells out specificly what type of personnel may be hired by the incumbent.

COMMENTS RELATIVE TO SUBSECTION 12(b)(4) OF THE ACT:

In relation to issuance of licenses, the Department of Commerce and Labor presently reviews and process all insurance applications. ~~here at its main office in Saipan~~ Such activities are controlled at DCL main office on Saipan. This practice became necessary in order to avoid any misunderstanding that may result in the processing of the various types of licenses issuable under the Act. Also, it should be noted that the implementation of the Act is still in its transitional stage. The need for absolute centralization is essential for the first three years. This decision was made after careful

consideration was given on the circumstances affecting the present operation of the department with respect to personnel needs as well as training needs.

The Department of Commerce and Labor presently issues six types of insurance license. They are as follows: 1) Certificate of Authority (commonly known as the insurer or company license); 2) General Agent; 3) Subagent; 4) Solicitor; 5) Broker; and 6) Adjuster. With the exception of 5 and 6, license fees of the above types are specifically provided for by Section 503(d), P.L. No. 3-11. Such fees have been in existence since June 1, 1982. Under the same statute, the amount of license fee paid by a solicitor is the same as that paid by an adjuster. This fee is only $50.00 per calendar year authorized by Subsection 503 (d) (11), P.L. No. 3-11.

Other Areas of Concern

In its present form, the Act seems to impose among alien insurers a problem in satisfying the requirements of Subsections 15(d)(1)(E) and 15(d)(1)(I). Most of the existing alien insurers do not have a United States manager since they are not actually admitted to do business in that jurisdiction. However, Subsection 15(d)(1)(E) requires that a copy of the appointment and authority of its U.S. manager, as certified by its proper officer, be filed with its application for a certificate of authority to transact business in the Commonwealth.

With respect to Subsection 15(d)(1)(I), most alien insurers that were licensed prior to the enactment of the Act are not familiar with such ~~required document whereas it is a common known thing for foreign insurers~~ a requirement of an "Examination Report." s. A "report of examination" is a comprehensive report which basicly focuses its scope of inspection into the overall financial management practices of the insurer. It also focuses attention on other related affairs of an insurance company that directly affects its policyholders. Such examination is normally undertaken every three to four years, as it is commonly done in the United States. It is a checking device to assess the soundness of the insurer based on its financial records. The examination in most instances will focus attention also on the management practices of the insurer to find out whether such practices are in conformance to applicable insurance statutes or regulations. It is essentially a standardized format of examination set forth and approved in methodology by the National Association of Insurance Commissioners of America (NAIC).

As a solution to this particular problem, we suggest are that Subsection 15(d)(1)(I) be modified to include an added language whereby the Insurance Commissioner ~~is given the~~ shall have an authority to substitute the required report of examination with a "qualified auditor's report". Such type of report should essentially be required by law to conform to the format of the NAIC. It is therefore recommended that the legislature address this particular issue promptly since such an amendment will definitely alleviate the present difficulties faced by the alien insurers in renewing their licenses this year. It

should be noted that to date no alien insurer has been granted a certificate of authority under the Act due to this unfulfilled requirement on their part.

Another concern which deserves some attention here is the situation facing ~~a particular~~ an alien insurer. ~~This~~ An insurance company is owned and operated by ~~its home~~ a foreign government. The company was licensed under prior laws in effect prior to the enactment of the Act. This company is known as the Korea Automobile Fire & Marine Insurance Company, Ltd.. Its present agent in the Commonwealth is Moylan's Insurance Underwriters (Int'l.), Inc.. According to information filed with the department, this company is also licensed to do business in Guam. In fact. its business activities in Saipan was initially an extension of its Guam-based operation. A review of the company's application papers reveals that it was organized as a capital stock corporation having a total authorization level of $7,598,000 of which $3,913,000 is paid up as of November last year. Under the Act, this company is defined as an alien insurer. Along with the other alien insurers, this company is having difficulty complying with the requirements of Subsections 15(d)(1)(C), 15(d)(1)(E) and 15(d)(1)(I).

ASSESSMENT OF THE ADMINISTRATIVE, PERSONNEL, AND BUDGETARY NEEDS PURSUANT TO SUBSECTION 13(b) OF THE ACT:

Basicly, the office of the Insurance Commissioner should be equipped with the minimum number of neccessary personnel to enable such office to carry out the ~~full effective enforcement and execution~~ mandate of the Act.

The ~~incumbent~~ insurance commissioner should be authorized by law to recruit the following personnel in the initial stage:

1) An ~~assistant~~ Deputy commissioner;
2) A senior examiner;
3) A junior examiner;
4) An executive secretary; and
5) A statistical specialist.

It shall be the responsibility of the ~~assistant~~ deputy insurance commissioner to assist the Commissioner in the day-to-day administration of the office as it carries out the intent of the Act. The incumbent shall jointly be responsible with the Commissioner for the execution of budget plans, office regulations, administrative policies or decisions including the supervision of all personnel within that office. The incumbent shall become acting commissioner whenever a temporary vacation of the principal officer's position occurs. It is suggested that this position be compensated at least with a base salary of $30,000 per annum in the initial stage.

The senior examiner shall assist the Commissioner in exercising his powers and duties as set forth by Section 5 of the Act. The senior examiner shall be in charge of all examination undertaken by the Commissioner's office pursuant to Subsections 5(c), 14(a), and 14(d) of the Act. The incumbent shall assist the Commissioner in the preparation of such examination reports made pursuant to Subsection 14(f) of the Act. The incumbent shall jointly work with the junior

examiner in the performance of the above duties and responsibilities. In the temporary absence of the principal officer and his assistant, the senior examiner shall serve in an acting capacity for the commissionership. It is suggested that this position be paid at least a base salary of $30,000 per annum in the initial stage.

The position of a junior examiner shall be created as an adjutant to the senior examiner. Such a position can either be filled on a part-time or full-time basis. It shall be the responsibility of the incumbent to assist the senior examiner and jointly work with him in performing all assigned duties and responsibilities as mandated by the appropriate provisions of the Act. Whenever the position of the senior examiner is temporarily vacated, the incumbent shall serve such position in an acting capacity. It is suggested that this position be compensated in the initial stage at the rate of at least $28,000 per annum if it is filled on a full-time basis.

As required by any executive office, the Commissioner should be equipped with an executive secretary. This position is established with the responsibility of the incumbent to handle all secretarial and clerical functions of the office including the establishment of its recordkeeping system. It is suggested that this position be compensated at the base rate of at least $16,000 per annum in the initial stage.

A statistical specialist should be recruited to handle the statistical needs of the Insurance Commissioner's office. Such a position

is established with the responsibility of the incumbent to handle all data collections, compilations, analyses, and other necessary tasks of the office as assigned by the Commissioner. It is suggested that this position be initially compensated at the base rate of at least $18,000 per annum.

Given the above recommendations, exhibit "A" is presented below as an illustration of the budgetary needs of the office of the Insurance Commissioner.

RECOMMENDED BUDGET PLAN (ESTIMMATED YEAR 1) EXHIBIT "A"

PERSONNEL:

1)	Insurance Commissioner	$32,000
2)	Assistant Commissioner	30,000
3)	Senior Examiner	30,000
4)	Junior Examiner	28,000
5)	Executive Secretary	16,000
6)	Statistical Specialist	18,000
	Subtotal	154,000
	Benefits (soc. sec. @5.11%) Add	7,869
	Total	161,869

ALL OTHERS:

A.	General Travel	10,000
B.	Automobile (1 new)	7,000
C.	Equipment (desks, chairs, file cabinets, etc.)	5,700
D.	Basic Supplies	2,000
E.	Communication (telephone, postage, telex, postage)	2,000
F.	Printing & Reproduction (report publications, forms, license certificates, etc.)	1,000
G.	Miscellaneous (subscriptions, membership fees related to Commissioner's office)	500
GRAND TOTAL		190,069
	round off	+ 31
RECOMMENDED GRAND TOTAL		190,100

COMMENTS RELATIVE TO SUBSECTION 13(c) OF THE ACT:

With respect to Subsection 13(c) of the Act, it is worthwhile to note at this point that the enabling legislation has been in effect only for a period of 15 months. It became law without any ~~provision of~~ funding for ~~food funding~~ personnel. The Director of Commerce and Labor requested in fiscal year 1984 a certain amount of funding for the position of insurance officer. This position was intended to function as an assistant to the present commissioner similar to that position outlined above as the assistant commissioner.

This request for funding ~~was~~ in made in order to ~~execute~~ carry the intent of Section 34 ~~of the Act as efficiently as possible~~. Apparently, the legislative bill that appropriately addresses this concern is still undergoing review of both houses of the legislature. Under this condition, the Director of Commerce and Labor was left with only one choice which was to absorb the new added duties and responsibilities provided for by the Act. This meant that the normal workloads of the Director, his secretary, and a divisional chief were consequently increased in order to accommodate the transitional needs of the Act. Therefore, execution of the Act was basicly limited to Sections 15, 17, 20, 21, 22, and 27. With the exception of Sections 15, 17, and 21 full execution of the foregoing provisions was confronted with certain difficulties that were either connected or associated with the given reality of the level of sophistication that seems to prevalent in our insurance industry here in the Commonwealth. Perhaps another reason has something to do with the

fact that this particular type of statute is truly new and complicated to our insurance operators here in the Commonwealth. But this situation is gradually becoming simplified in the sense that we are now seeing associations such as the Northern Marianas Property and Casualty Association get organized for the purpose of promoting their interests. Recently, this particular group has been meeting with the responsible staff of this department in an attempt to share concerns and ideas that pertain mostly to the implementation of the Act. With respect to Section 27, the NMPCA is now aware its force and effect as it applies to their practices. An understanding between such an entity and this department has been reached about the application of such provision.

The problem is further compounded ~~also~~ by the fact that the Department's existing level of funding is not sufficient to ~~accommodate~~ meet the mandates of the Act, ~~in its entirety~~. It should be reiterated that this situation has prevented the recruitment of neccessary personnel as demanded by the administrative needs of the Act.

For the above reason, it is only fair that the Director of Commerce and Labor recommend to the legislature that an amendment to Sub-section 13(c) of the Act be made so that authorization be given to the department to promulgate the necessary rules and regulations that will address whatever issues or needs that may arise pertaining such provision in the near future. This recommendation should be considered should the legislature decide to defer action on creating a separate office of the Insurance Commissioner. Otherwise, the legislature is free to decide at this time on this issues based on its findings

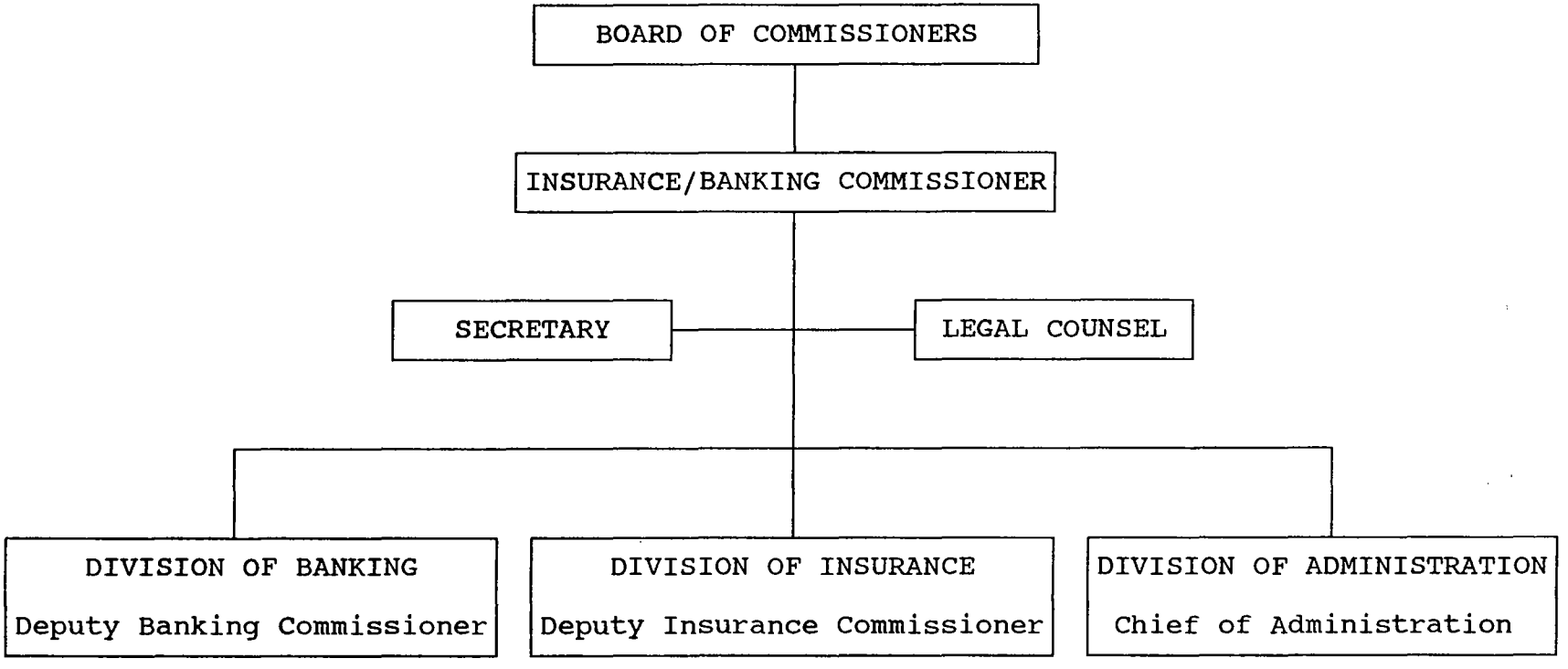
and how its contemporary viewpoint affects the issue at hand as it is deliberated with such body. Should this be the case, we feel obligated to caution the legislature of the fact that the office of the Insurance Commissioner should be given the opportunity to get fully organized and functioning as recommended earlier. Upon reaching this level of operation, the legislature can then be assured of ascertaining reliable data which is necessary in setting forth the requirements that will address the needs of the insurance industry as they relate to Subsection 13(c) of the Act.

CONCLUSION:

In conclusion, it is the purpose of this report to carry out the intent of Subsection 13(b) of the Act. The statements or information delivered by the foregoing parapagraphs are given as expression of concerns, of recommendations, and generally of reflections on the part of this department. The main point here ~~is~~ is to communicate our experience that took place within the last 15 months. It is our opinion that the legislature will be receptive to this report. Thus, the information provided herein is aimed at gearing, if not influencing, the legislative body in the right direction in terms of addressing the present needs of the Act in its initial stage of implementation.

EXHIBIT I

COMMONWEALTH FINANCIAL REGULATORY COMMISSION
ORGANIZATIONAL CHART



COMMONWEALTH REGISTER VOLUME 16 NUMBER 01 JANUARY 15, 1994 PAGE 11375

EXHIBIT II

DIVISION OF INSURANCE
ORGANIZATIONAL CHART

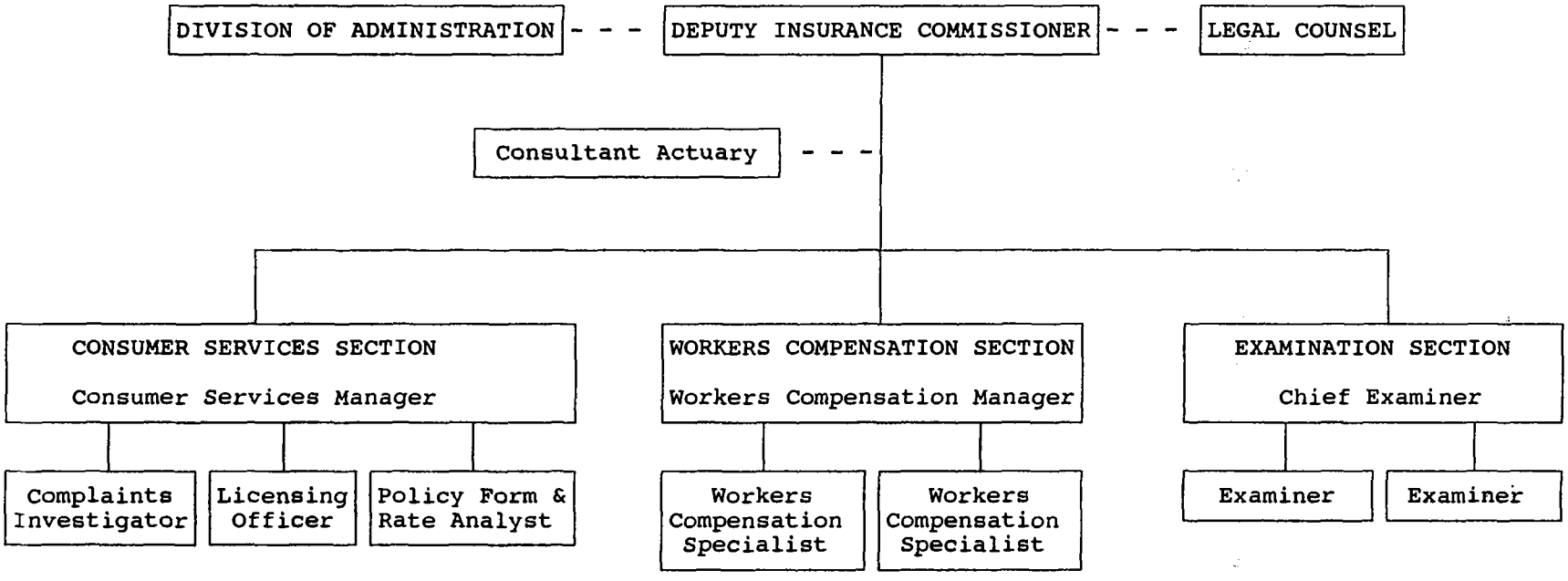


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TABLE 11

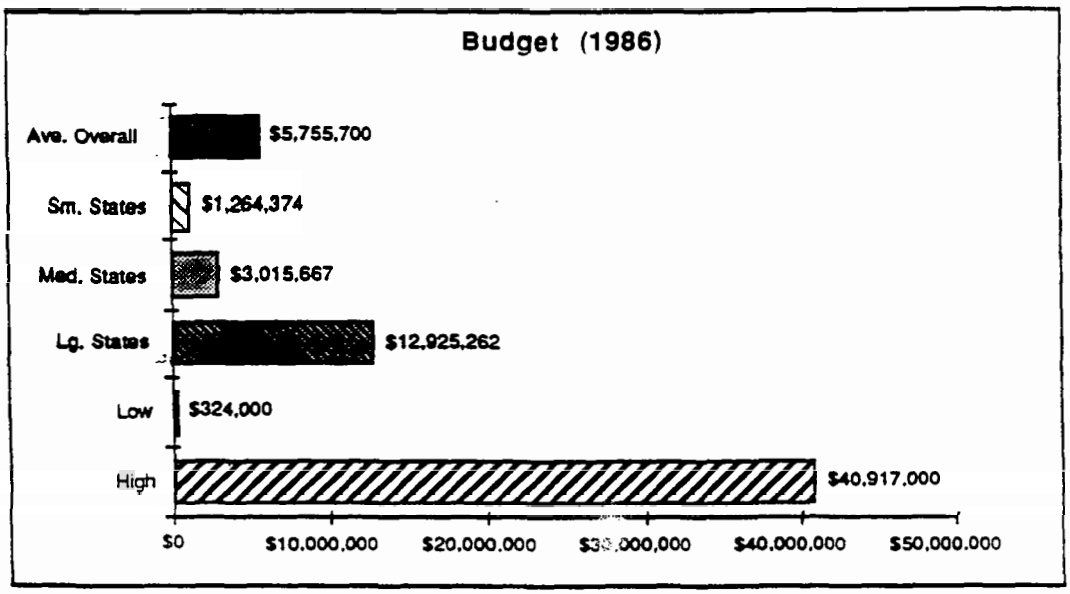
RELATIONSHIP OF BUDGET, REVENUES, AND PREMIUMS 1988-1991

STATE	BUDGET AS PCT OF REVENUES				BUDGET AS PCT OF PREMIUMS			
	1991	1990	1989	1988	1991	1990	1989	1988
ALABAMA	1.61	1.39	1.98	1.17	0.04	0.04	0.05	0.05
ALASKA	9.88	7.86	6.46	5.13	0.27	0.17	0.17	0.14
AMERICAN SAMOA	N/A	N/A	N/A	N/A	N/A	3.21	N/A	N/A
ARIZONA	2.93	2.58	2.46	2.37	0.04	0.04	0.04	0.04
ARKANSAS	3.98	4.89	4.02	3.92	0.08	0.07	0.08	0.09
[redacted]NIA	7.17	5.37	5.20	2.85	[redacted]	[redacted]	0.11	[redacted]
[redacted]ADO	4.14	3.99	3.34	3.23	0.04	0.03	0.03	[redacted]
[redacted]ECTICUT	2.17	2.09	2.38	2.41	0.03	0.03	0.05	[redacted]
[redacted]WARE	9.13	9.80	10.77	9.35	0.11	0.11	0.18	[redacted]
DISTRICT OF COLUMBIA	4.27	4.18	6.51	5.25	0.07	0.09	0.13	[redacted]
FLORIDA	11.12	12.00	13.00	11.89	0.15	0.16	0.15	0.13
GEORGIA	4.51	4.28	2.41	2.48	0.07	0.06	0.04	0.04
GUAM	6.00	0.59	N/A	N/A	0.24	0.24	N/A	N/A
HAWAII	2.55	3.39	2.59	2.08	0.06	0.07	0.09	0.08
IDAHO	9.98	9.50	7.71	7.36	0.19	0.18	0.21	0.21
[redacted]OIS	6.46	6.52	5.71	5.88	0.05	0.06	0.06	[redacted]
[redacted]ANA	2.51	2.66	2.95	2.81	0.03	0.02	0.04	[redacted]
IOWA	4.44	4.22	4.19	3.96	0.06	0.07	0.07	[redacted]
[redacted]SAS	4.79	5.01	4.50	4.42	0.09	0.10	0.10	[redacted]
[redacted]TUCKY	2.87	2.61	3.27	3.36	0.10	0.09	0.10	[redacted]
LOUISIANA	4.48	3.16	3.22	2.70	0.09	0.11	0.11	0.12
MAINE	9.41	7.52	8.04	7.31	0.17	0.16	0.13	0.12
MARYLAND	5.33	5.03	5.63	4.91	0.08	0.06	0.14	0.10
MASSACHUSETTS	1.76	1.88	1.78	2.03	0.02	0.05	0.05	0.05
MICHIGAN	3.32	3.45	4.95	4.83	0.03	0.03	0.05	0.05
[redacted]NESOTA	3.59	3.72	2.93	2.77	0.05	0.06	0.05	[redacted]
[redacted]PPI	3.12	2.77	2.63	2.90	0.09	0.08	0.08	[redacted]
[redacted]OURI	1.56	1.50	1.52	1.35	0.02	0.02	0.02	[redacted]
[redacted]ANA	3.31	3.91	2.91	2.12	0.07	0.08	0.07	[redacted]
[redacted]RASKA	10.46	6.83	6.18	6.07	0.12	0.09	0.09	[redacted]
NEVADA	8.19	10.22	2.51	2.43	0.28	0.32	0.08	0.07
NEW HAMPSHIRE	5.68	4.34	4.55	3.39	0.12	0.09	0.10	0.07
NEW JERSEY	13.16	4.93	5.09	6.72	0.11	0.10	0.09	0.08
NEW MEXICO	4.16	4.56	3.92	3.80	0.10	0.10	0.11	0.11
NEW YORK	10.09	9.87	8.90	9.37	0.11	0.09	0.09	0.09
NORTH CAROLINA	11.22	10.34	9.16	8.66	0.19	0.18	0.19	0.20
NORTH DAKOTA	6.95	5.41	3.52	5.19	0.13	0.15	0.10	0.10
OHIO	4.11	4.01	3.57	2.75	0.07	0.07	0.06	[redacted]
[redacted]OMA	4.42	3.70	3.47	2.89	0.10	0.09	0.08	[redacted]
[redacted]GON	8.68	8.36	6.32	5.88	0.07	0.08	0.08	[redacted]
PENNSYLVANIA	3.64	3.53	3.67	3.44	0.04	0.04	0.05	0.05
PUERTO RICO	12.99	N/A	N/A	N/A	0.12	0.11	N/A	N/A
RHODE ISLAND	4.09	4.05	4.55	5.27	0.06	0.06	0.12	0.13
SOUTH CAROLINA	6.39	5.87	4.56	4.43	0.11	0.10	0.10	0.10
SOUTH DAKOTA	2.58	2.64	2.58	2.73	0.07	0.06	0.06	0.06
TENNESSEE	2.59	2.09	2.27	2.14	0.05	0.04	0.05	0.05
TEXAS	8.85	8.87	8.80	8.04	0.16	0.16	0.16	0.18
U.S. VIRGIN ISLANDS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
UTAH	4.44	4.62	3.90	4.21	0.08	0.08	0.08	0.09
VERMONT	5.52	6.24	8.26	8.03	0.13	0.11	0.20	0.17
VIRGINIA	7.03	4.73	4.28	3.51	0.11	0.09	0.09	0.06
WASHINGTON	6.05	5.88	5.61	5.54	0.07	0.07	0.06	0.07
WEST VIRGINIA	3.02	3.07	3.02	2.60	0.08	0.06	0.06	0.06
WISCONSIN	5.53	6.03	5.76	5.29	0.03	0.04	0.05	0.05
WYOMING	17.74	8.12	7.92	9.42	0.37	0.16	0.16	0.16
ALL STATES COMBINED	6.64	5.45	5.16	4.64	0.09	0.08	0.09	0.08

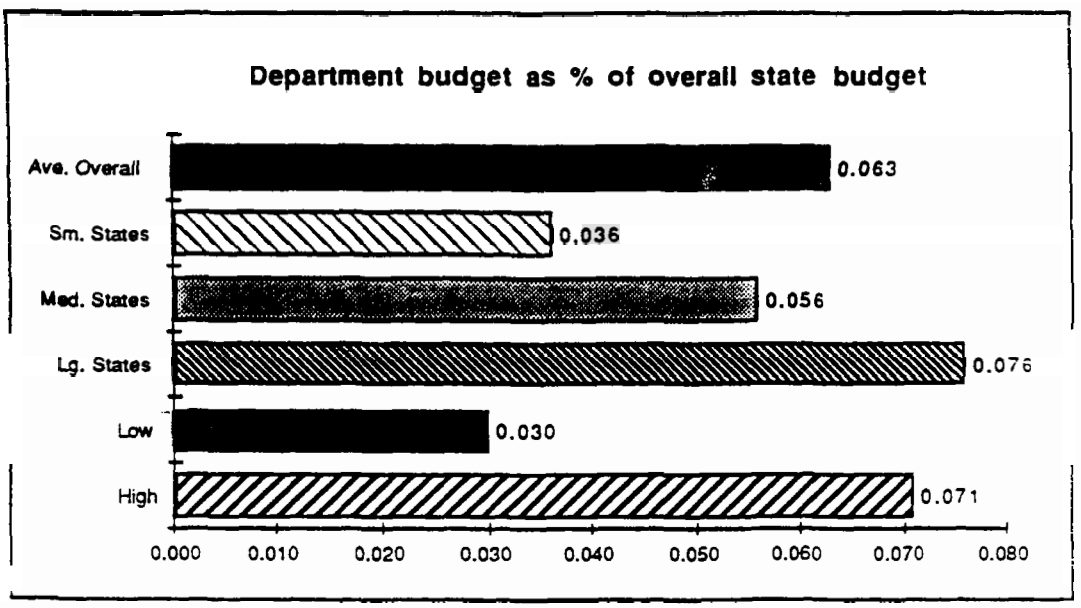
Source: 1991 NAIC Insurance Department Resources Report.

24 N/A - Not Available

EXHIBIT III.2



On the surface, the budgets may look adequate, especially for the more populous states, but a closer examination reveals a shortfall from many perspectives. The most dramatic comes from the percentage the insurance departments budgets represent of overall state budget.



A Study of State Insurance Department Operations Page 9
Source: Consumer Insurance Interest Group, April 1988.

EXHIBIT III.3

The following is an excerpt from the 1989 DC&L FY '89 Budget* which is still very true today and is incorporated here as part of this proposal.

Office of Banking and Insurance:

To understand the goals and objectives of the Bank and Insurance Examiners, one must know its purposes.

What are the purposes of bank or insurance examinations? Although many answers to this question could be given, several fundamental reasons can be identified.

The first relates to the maintenance of public confidence in the integrity of the banking system and on the individual banks. Such confidence is clearly essential because the system's customers serve as the source of funding, without which banks would be unable to meet their most fundamental objective of providing financial services. The existence of unhealthy or deteriorating conditions, which may threaten this integrity, should be disclosed through the examiner's evaluation of the bank's capital adequacy, asset quality, management, liquidity position, and earnings capacity.

Second, the periodic on-premise examination provides the best means of determining the bank's adherence to laws and regulations. Compliance with statutory and regulatory requirements should be given high priority by the Banking Director and the legislators.

Third, the examination process can help prevent problems situations from remaining uncorrected.

Finally, the examination supplies the Banking Director with an understanding of the nature, relative seriousness and ultimate cause of a bank's problems, and thus provides a factual foundation to soundly base corrective measures, recommendations and instructions. The examination thus plays a very key role in the supervisory process itself.

There are six (6) banks and thirty-five (35) insurance companies now operating in Saipan which are regulated by the Banking Code and the Insurance Code, respectively.

In order to properly implement both the Banking and Insurance Laws, we must start training our people for these positions. The Federal Deposit Insurance Corporation (FDIC) has an excellent training center in Arlington, Virginia, which trains Federal and State examiners. We have written to the FDIC whether we could participate on their FDIC/State Examiner Training Program. The FDIC/State Examiner Training Program is attached for your reference.

Estimated Cost Factors: For Assistant Examiner School I (3 weeks)

1. Per diem.....$112.00 X 23 days (2 days travel time) = $2,576.00
2. Lodging.....$55.00 X 21 days = $1,155.00
3. Tuition.....$250.00 = $ 250.00
4. Transportation.....$1,253.00 = $1,253.00

Total Cost.....$5,234.00

This investment will preclude us from hiring off-island in the future.

For the reasons of complexity and the magnitude of the responsibilities mandated by the Banking Act (P.L. 3-104), Insurance Act (P.L. 3-107) and the Foreign Currency Exchange Regulations (Commonwealth Register Vol. 9 No.4, April 15, 1987), we are here seeking for a favorable approval of this Committee to our request for the positions of Administrative Assistant and an Administrative Specialist. These new positions are essential administrative support to assist the Director of Banking in his delegation of authority given to the Deputy Director for Banking and the Special Assistant for the Insurance Commissioner. For the past three years, this office has made tremendous sacrifices in its efforts to serve the community of the financial sector. This sector has experienced tremendous growth and expansion since 1985.

Furthermore, we respectfully request this Committee to help us train our staffs to attend FDIC training in banking and NAIC training in insurance. This need to train capable staff is crucial, necessary and worthy investment as we have attempted to clarify above.

*NOTE: SOURCE 1989 FY ANNUAL BUDGET PROPOSAL PREPARED BY THE DIRECTOR OF COMMERCE AND LABOR IN 1989, MR JESUS R. SABLAN

EXHIBIT III.4

DIVISION OF INSURANCE

Proposed Salary Schedule:

Deputy Insurance Commissioner	$ 48,000
Chief Examiner	40,000
Manager, Consumer Services	40,000
Manager, Workers Compensation	40,000
Examiner (2 @ $25,000)	50,000
Workers Compensation Specialist (2 @ $25,000)	50,000
Complaints Investigator	25,000
Licensing Officer	25,000
Policy Form & Rate Analyst	25,000
Employer Factor (tax, insurance, & retirement)	43,000
Total Salaries	$386,000

Estimated Annual Revenue:

Premium Tax[1]					$500,000
License Fees[2]:					
Alien Insurers	7 X	$3,000 =	$21,000		
Domestic Insurers	12 X	1,500 =	18,000		
Foreign Insurers	26 X	3,000 =	78,000		
General Agents	48 X	350 =	16,800		
Sub-Agents	69 X	250 =	17,250		
Brokers	28 X	500 =	14,000		
Adjusters	8 X	200 =	1,600		
Solicitors	12 X	200 =	2,400		
Surplus Lines	4 X	750 =	3,000		172,050
Other Revenue:					
- Fines and Penalties					1,000
- Filing and Processing Fees: (All license applicants)					
Insurers	45 X	$25 =	$1,125		
All others	169 X	10 =	1,690		2,815
- Miscellaneous (late filing, amendment, certification, reproduction, other)					1,000
Total Revenue					$676,865

[1] Based on average of 1991 and 1992 Direct Premiums written less returns.

[2] See Annual Report, Recommendations to the Legislature Pursuant to Section 7112.

EXHIBIT III.4 cont'd.

Estimated Annual Expenses:

Personnel:		
- Salaries[1]	$386,000	
- Training[2]	30,000	416,000
Operations:		
- Division's Contribution to Commission's Overhead and Salaries, except Division of Banking, at 50% of projected amount of $365,200. To include:		
1) Personnel	$150,000	
2) Office Furniture & Equipment (amort.)	4,000	
3) Utilities	8,600	
4) Communications	6,000	
5) Maintenance	4,000	
6) Vehicle (2 ea.,Amort.)	5,500	
7) Publishing	2,500	
8) Miscellaneous	2,000	
- Vehicles (2 ea.,Amort.)	5,500	
- Office Furniture & Equipment (Amort.)	8,000	
- Supplies & Sundries	2,000	
- Repairs & Maintenance	2,000	200,100
Other Expenses:		
- Publication Subscribtions	$ 1,500	
- Membership Dues (NAIC, etc.)	7,000	
- Travel (non-training)	10,000	
- Sponsorship (seminars, etc.)	2,000	
- Miscellaneous (consultant fees, etc.)	2,000	22,500
Total Expenses		$638,600

[1] See Division of Insurance, Proposed Salary Schedule.

[2] Training expenses are charged to a special account of funds derived from license fees. Training scenario: 6 staff to attend NAIC training at cost of $5,000 each.

NAIC POLICY STATEMENT ON FINANCIAL REGULATION STANDARDS

Introduction

The safety and soundness of insurance companies operating in the United States is a prime objective of state insurance regulators. In many respects non-domiciliary states rely and depend to a great extent on domiciliary insurance departments to effectively monitor and regulate their domestic companies. To ensure that these concerns and objectives are met, an effective financial surveillance and regulation structure and system is needed. While everyone can agree that this is critical, to date no one has yet defined what constitutes an effective structure and system for financial surveillance and regulation. While the NAIC has done a great deal to foster uniformity and sound regulation through various model laws and regulations and standardized financial reporting formats and instructions as well as the development of a variety of manuals and other tools to assist state insurance departments, a comprehensive pronouncement on all functions and procedures relating to financial regulation has not been done. The objective of the NAIC Committee on Financial Regulation Standards is to establish standards for the NAIC and state insurance departments in this important area.

It is believed that establishing standards for financial regulation will have the following positive results:

(1) Strengthen state insurance departments through self-evaluation and improvement to meet the prescribed standards.

(2) Demonstrate to, and obtain from, state administrations and legislative bodies the support and resources needed to maintain an effective system of financial surveillance and regulation.

(3) Create a national standard for financial regulation which will improve and strengthen the state regulatory system of insurance and the safety and soundness of insurance companies.

(4) A standard established by the NAIC will, if attained, ensure that each jurisdiction is monitoring and regulating domestic companies operating in other jurisdictions on an admitted or non-admitted basis or as a risk retention group.

(5) Improve the efficiency of state regulation by eliminating duplicative procedures and activities and unnecessary state-by state variations.

The standards recognize the realities of the diverse circumstances of state insurance departments. Standards for financial regulation have been divided into three major categories—(1) laws and regulations; (2) regulatory practices and procedures; and (3) organizational and personnel practices.

A. Laws and Regulations

1. *Examination Authority*

The department should have authority to examine companies whenever it is deemed necessary. Such authority should include complete access to the company's books and records and, if necessary, the records of any affiliated company, agent, and/or managing general agent. Such authority should extend not only to inspect books and records but also to examine officers, employees and agents of the company under oath when deemed necessary with respect to transactions directly or indirectly related to the company under examination.

Editor's Note: At the December 1990 NAIC national meeting, the Association voted to make the newly adopted Model Law on Examinations part of the financial regulation standards. States have two years from that time to incorporate the model into their laws.

2. *Capital and Surplus Requirement*

The department should have the ability to require that insurers have and maintain a minimum level of capital and surplus to transact business. The department should have the authority to require additional capital and surplus based upon the type, volume and nature of insurance business transacted.

3. *NAIC Accounting Practices and Procedures*

The department should require that all companies reporting to the department file the appropriate NAIC annual statement blank which should be prepared in accordance with the NAIC's instructions handbook and follow those accounting procedures and practices prescribed by the NAIC's Accounting Practices and Procedures Manual.

4. *Corrective Action*

State law should contain the NAIC's Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition or a substantially similar provision which authorizes the department to order a company to take necessary corrective action or cease and desist certain practices which, if not corrected, could place the company in a hazardous financial condition.

5. *Valuation of Investments*

The department should require that securities owned by insurance companies be valued in accordance with those standards promulgated by the NAIC's Valuation of Securities Office. Other invested assets should be required to be valued in accordance with the procedures promulgated by the NAIC's Financial Condition (EX4) Subcommittee.

6. *Holding Company Systems*

State law should contain the NAIC Model Insurance Holding Company System Regulatory Act or an Act substantially similar and the department should have adopted the NAIC's model regulation relating to this law.

7. *Risk Limitation*

State law should prescribe the maximum net amount of risk to be retained by a property and liability company for an individual risk based upon the company's capital and surplus which should be no larger than 10% of the company's capital and surplus.

8. *Investment Regulations*

State statute should require a diversified investment portfolio for all domestic insurers both as to type and issue and include a requirement for liquidity. Foreign companies should be required to substantially comply with these provisions.

9. *Admitted Assets*

State statute should describe those assets which may be admitted, authorized or allowed as assets in the statutory financial statement of insurers.

10. *Liabilities and Reserves*

State statute should prescribe minimum standards for the establishment of liabilities and reserves resulting from insurance contracts issued by an insurer; including life reserves, active life reserves and unearned premium reserves, and liabilities for claims and losses unpaid and incurred but not reported claims.

11. *Reinsurance Ceded*

State law should contain the NAIC Model Law on Credit for Reinsurance and the Model Regulation for Life Reinsurance Agreements or substantially similar laws.

12. *CPA Audits*

State statute or regulation should contain a requirement for annual audits of domestic insurance companies by independent certified public accountants, such as contained in the NAIC's Model Rule Requiring Annual Audited Financial Reports.

13. *Actuarial Opinion*

State statute or regulation should contain a requirement for an opinion on life and health policy and claim reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist on an annual basis for all domestic insurance companies.

14. *Receivership*

State law should set forth a receivership scheme for the administration, by the insurance commissioner, of insurance companies found to be insolvent as set forth in the NAIC's Insurers Supervision, Rehabilitation and Liquidation Model Act.

15. *Guaranty Funds*

State law should provide for a statutory mechanism, such as that contained in the NAIC's model acts on the subject, to ensure the payment of policyholders obligations subject to appropriate restrictions and limitations when a company is deemed insolvent.

16. *Other*

(a) State statute should contain a provision similar to the NAIC model act requiring domestic insurance companies to participate in the NAIC Insurance Regulatory Information System (IRIS).

(b) State law should contain a provision similar to the NAIC's Model Risk Retention Act for the regulation of risk retention groups and purchasing groups.

(c) State statute should contain the NAIC's model law for Business Transacted with Producer Controlled Property/Casualty Insurer Act or a similar provision.

Editor's Note: At the June 1991 meeting, a new model was adopted to replace the original Producer Controlled Insurer Model Act. States have two years from that time to include the model in their laws.

Editor's Note: At the December 1990 NAIC national meeting, the Association voted to add two more models to the standards. These are the Managing General Agents Act and the Reinsurance Intermediaries Model Act. States have two years from that time to incorporate the model into their laws. Descriptive paragraphs about these two models will be included in the future.

B. Regulatory Practices and Procedures

1. *Financial Analysis*

(a) The department should have a sufficient staff of financial analysts with the capacity to effectively review the financial statements as well as other information and data to discern potential and actual financial problems of domestic insurance companies.

(b) The department should have an intra-department communication and reporting system that assures that all relevant information and data received by the department which may assist in the financial analysis process is directed to the financial analysis staff.

(c) The internal financial analysis process should provide for levels of review and reporting.

(d) The financial analysis procedure should be priority-based to ensure that potential problem companies are reviewed promptly. Such a prioritization scheme should utilize the NAIC's Insurance Regulatory Information System and/or a state's own system.

2. *Financial Examinations*

(a) The department should have the resources to examine all domestic companies on a periodic basis which is commensurate with the financial strengths and position of the insurer.

(b) The department's examination staff should consist of a variety of specialists with training and/or experience in the following areas or otherwise have available qualified specialists which will permit the department to effectively examine any insurer: computer audit specialist, reinsurance specialist, life and health company examiners, property and liability company examiners, life and health actuarial examiners, property and liability actuarial examiners and property and liability claims examiners.

(c) The department's procedures for examinations shall provide for supervisory review within the department of examination work papers and reports to ensure that the examination procedures and findings are appropriate and complete and that the examination was conducted in an efficient and timely manner.

(d) The department's policy and procedures for examinations should follow those that are set forth in the NAIC's Examiners Handbook.

(e) In scheduling financial examinations the department should follow those procedures set forth in the NAIC's Examiners Handbook and this schedule system should provide for the periodic examination of all domestic companies on a timely basis. This system should accord priority to companies which are having adverse financial trends or otherwise demonstrate a need for examination such as determinations of the NAIC IRIS Examiner Team.

(f) The department's procedures require that all examination reports which contain material adverse findings be promptly presented to the commissioner or his designee for a determination and implementation of appropriate regulatory action.

(g) The department's reports of examination should be prepared in accordance with the format adopted by the NAIC and should be sent to other states in which the company transacts business in a timely fashion.

3. *Other*

When a domestic company is identified as troubled this should be communicated to other insurance departments in jurisdictions in which the carrier transacts business. When a foreign company is identified as troubled this should be communicated to the domiciliary insurance department of the carrier.

Note: A troubled company is defined as an insurance company that has not maintained a financial position, or whose operations are moving toward a financial result that would indicate that its policyholders and claimants are subject to potential risk or that the specified statutory minimum capital and surplus requirements may not be maintained.

Drafting Note: When the NAIC's Troubled Insurance Company Manual is completed and adopted, a statement should be incorporated into this Policy Statement requiring states to generally follow and observe the procedures set forth in the manual.

C. Organizational and Personnel Practices

1. The department should have a policy which requires the professional development of staff through job-related college courses, professional programs and/or other training programs which are funded by the department.

2. All financial regulation and surveillance activities are the responsibility of an individual who shall report to the commissioner or his designee.

3. The department's staff and contractual staff involved in financial regulation and surveillance should all be periodically evaluated by the department to ensure that job duties and responsibilities are being discharged in a satisfactory manner.

4. The department should establish minimum educational and experience requirements for all professional employees and contractual staff positions in the financial surveillance and regulation area which are commensurate with the duties and responsibilities of the position.

5. The department's pay structure for those positions involved with financial surveillance and regulation should be competitively based to attract and retain qualified personnel.

6. The department's funding should be sufficient to allow for the financial surveillance and regulation staff's participation as appropriate in the meetings and training sessions of the NAIC and meetings relating to the review, coordination and the development and implementation of action for troubled insurers.

Legislative History (all references are to the Proceedings of the NAIC*)*

1989 Proc. II 13, 21, 33–36 (adopted).
1991 Proc. I 9, 15–16, 77 (voted to add three new models to standards).
1991 Proc. II (voted to add amended model to standards).

NAIC POLICY STATEMENT ON FINANCIAL REGULATION STANDARDS

To guide state legislatures and state insurance departments in the development of effective solvency regulation, the NAIC adopted these standards as minimum requirements for an effective regulatory regime.

In order to provide guidance to the states regarding these minimum standards and an incentive to put them in place, the NAIC adopted a formal certification program in June 1990. Under this plan, each state's insurance department will be reviewed by an independent review team whose job it is to assess that department's compliance with the NAIC's Financial Regulation Standards.

Following is a list of states that have completed the review process and been certified by the NAIC, followed by the date of state certifications.

Colorado (June 1992)

Florida (December 1990)

Illinois (June 1991)

Iowa (December 1991)

Kansas (December 1991)

Minnesota (June 1992)

New York (December 1990)

North Carolina (December 1991)

North Dakota (June 1992)

Ohio (December 1991)

South Carolina (June 1991)

Texas (September 1992)

Virginia (June 1992)

Wisconsin (December 1991)

REGULATORS-ONLY PROGRAMS

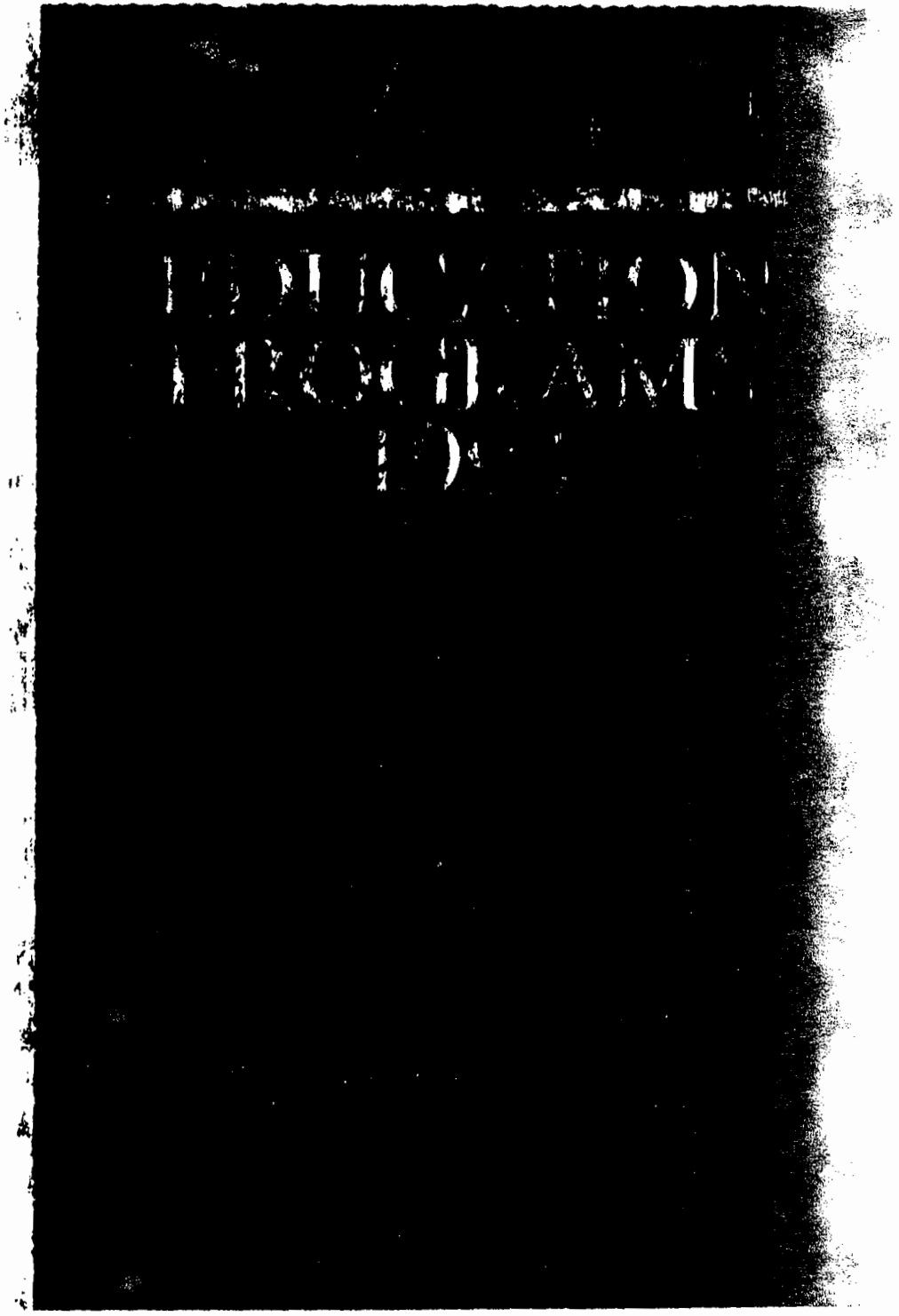
January 11-15	Financial Examiners Education Program
February 8-11	Regulating the Marketplace Program
May 3-6	Insurance Department Staff Education Program
July 12-16	Commissioners Education Program
July 29-30	Demystifying Derivatives: An Investment Seminar
August 9-13	Financial Examiners Education Program
October 4-7	Insurance Department Staff Education Program
November 1-4	Regulating for Solvency Program

PUBLIC PROGRAMS

February 18-19	Rehabilitators and Liquidators Workshop, Orlando
March 18-19	Health Issues Seminar, Kansas City
April 14-15	Reinsurance Seminar, Los Angeles
June 19	Health Insurance Counseling Seminar, Chicago
September 18	Health Access Seminar, Boston
TBA	Continuing Legal Education Seminar
TBA	Symposium

NAIC

National Association of Insurance Commissioners
Education and Training Department
120 West 12th Street, Suite 1100
Kansas City, MO 64105-1925
Phone (816) 374-7192 Fax (816) 471-7004



THE STAFF

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Education and Training Department
National Association of Insurance Commissioners
120 West 12th Street, Suite 1100, Kansas City, MO 64105-1925

Telephone: 816-374-7192 Fax: 816-471-7004
Fax: 816-374-7234 (After March 15, 1993)

THE DEPARTMENT

The Education and Training Department, created in 1989, develops and delivers quality programs, workshops, seminars and other educational activities to meet NAIC members' needs for education and training opportunities. Programs deal with information on insurance issues and regulation for commissioners, professional regulatory staffs and others concerned about insurance regulation. The Department provides regulators-only programs as well as seminars and workshops open to the public.

Regulators from each of the NAIC's 55 members participate in the programs. In addition, international regulators from Asia, the Caribbean, Europe and Africa attend NAIC-sponsored programs. Participants are from all levels of insurance regulation and represent all aspects of the field.

Instructors in the programs are volunteers drawn from many facets of insurance and its regulation. They are experienced state regulators, insurance educators, insurance consultants, and others with the requisite expertise.

REGULATORS-ONLY PROGRAMS

These programs are open only to insurance regulators. NAIC members have priority, but regulators from other countries are welcome as space allows. The sessions are generally held in the Training Center in the NAIC's Kansas City headquarters.

Commissioners Education Program

The Commissioners Education Program has been offered since 1985. Recently the program was completely revised and updated. Designed for new commissioners, directors, superintendents and other senior staff members, this program orients the attendees to the field of insurance and insurance regulation. It provides an overview of the various aspects of life, property/casualty, and accident/health insurance and a detailed review of their regulation. Regulatory responsibilities are explored in relation to current regulatory policies and issues. This four-and-one-half day program accommodates 35 attendees and is offered annually. It is scheduled July 12-16.

Insurance Department Staff Education Program

Offered for the first time in 1989, this program is designed for non-financial insurance department staff new to insurance regulation. It includes a basic orientation to the insurance industry and a detailed review of its regulation, with specific emphasis on individual areas of operations within the insurance department. This semi-annual program lasts three-and-one-half days, accommodates 40 participants and is offered May 3-6 and October 4-7.

Financial Examiners Education Program

This prize-winning program was developed in cooperation with the Society of Financial Examiners, based on the results of a 1989 needs assessment. The American Society of Association Executives selected the program for its national Excellence in Education award in 1990.

The program is designed to give the beginning financial examiner an orientation to financial insurance regulation. The participant is given an overview of state regulation, as well as the basic information and resources important to financial examination. Topics include assets and liabilities, SAP and GAAP, the annual statement, insurance principles, reinsurance, examinations and insolvencies. This is a four-and-one-half day program, limited to 40 participants. Sessions are scheduled January 11-15 and August 9-13.

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Regulating for Solvency

Initiated as a result of a membership survey and the requirements of the NAIC Solvency Agenda, this program for middle and senior-level financial regulators with at least four years of experience was offered first in 1992. It examines current financial issues in depth and includes such topics as automated examination techniques, investment analysis, asset valuation and interest maintenance reserves, risk-based capital, the accreditation process, reinsurance, and identifying and managing troubled companies. It is a three-and-one-half day program, limited to 40 participants. It is scheduled November 1-4.

Regulating the Marketplace

This program, developed jointly by the National Association of Insurance Commissioners and Insurance Regulatory Examiners Society was offered for the first time in 1992. A program for middle and senior-level regulators engaged in market conduct activities, it focuses on market conduct and compliance exams, agent and company licensing, consumer services and complaint handling, unfair trade and claims settlement practices, and form and rate review. It is a three-and-one-half day program, limited to 40 participants and is scheduled February 8-11.

Demystifying Derivatives: An Investment Seminar

Tailored for the National Association of Insurance Commissioners by the Swiss Bank Corporation, this non-technical derivatives program is designed to develop an understanding of these products, their uses and abuses. The ideas behind derivatives—swaps, caps, collars, linked issues, exotic options—and the basic concepts of risk, forwards, call and put options are explained. Regulatory concerns and issues are addressed and questions regulators should ask are identified. This two-day seminar is open to 40 regulators and is scheduled July 29-30.

Public Seminars And Workshops

Besides offering programs for regulators, the Education Department delivers seminars and workshops that are open to all interested people. These deal with topics of immediate concern to the insurance world and address current issues or changes that have occurred in regulations or legislation.

Reinsurance Seminar

This two-day workshop is designed to expand knowledge of reinsurance for those with minimal information and experience. Topics address both life and property/casualty reinsurance. This seminar, co-sponsored by the Reinsurance Association of America and the Society of Financial Examiners Education Foundation, was awarded an Excellence in Education Achievement award by the American Society of Association Executives in December, 1992. Offered annually, this year the workshop is scheduled April 14-15 in Los Angeles.

Rehabilitators and Liquidators Workshop

The Rehabilitators and Liquidators Workshop, co-sponsored by the NAIC and the Society of Insurance Receivers, offers panel discussions of such subjects as long-tail claims, managing general agents, claims systems, guaranty funds, emerging issues and rehabilitation. The first day features separate tracks for new receivers and those with experience in insolvency matters. The second day agenda offers presentations for all participants on important topics such as fraud, reinsurance and problems in closing a liquidation. Deputy receivers, insurance department staff, attorneys, accountants and others involved in receiverships should attend. This two-day workshop will be held February 18-19 in Orlando, Florida.

Health Issues Seminar

This seminar addresses technical issues related to Medicare supplement loss ratios and refunds, long-term care nonforfeiture benefits and related issues, small group reform compliance issues and community rating. It includes a panel on state/national health reform emphasizing long-term care insurance. State rate and form analysts and other technicians involved in compliance on a day-to-day basis and insurer marketing, compliance and public relations personnel should attend. This one-and-one-half day seminar is scheduled March 18-19 in Kansas City.

Health Insurance Counseling Seminar

This seminar focuses on reports from states that are HCFA grant recipients and related counseling issues. A one-day program, it will be held June 19 in Chicago, prior to the NAIC summer national meeting.

Health Access Seminar

Planned to review procedures in the availability model acts and accompanying regulation, it is scheduled for September 18 in Boston, prior to the NAIC zone meeting.

Continuing Legal Education Seminar

The NAIC sponsors seminars for insurance department attorneys. These sessions have qualified for continuing legal education in most jurisdictions. The one-day seminars are designed to highlight issues of interest to this audience, although attorneys from insurance companies, law firms and government agencies are invited to attend. One is scheduled annually.

Symposia

Occasional symposia are scheduled to address significant insurance topics. The NAIC has sponsored a Workers' Compensation Symposium in 1992 and a Solvency Symposium in 1990.

Occasional Workshops On Timely Topics

As new issues and concerns arise, occasional workshops and seminars are developed to meet members' needs.

Other Activities

Consulting

The Education and Training Department staff is available to consult with zones or members to assist in setting up workshops locally. In 1991, at the request of the Western Zone, the staff modified the Financial Examiners Education Program for zone members and coordinated its delivery. In 1992, two programs were modified for state presentation and Regulating for Solvency was adapted for presentation in the Northeastern and Western Zones.

Research

To meet the needs of NAIC members, the Department prepares, implements and analyzes member surveys and needs assessments. The results of this research assist the staff to identify current topic and program priorities and guide the development of new seminars, workshops and programs.

Continuing Education

The Department provides continuing education forms and attendance certificates upon request to participants in NAIC education and training programs. The activities have qualified for continuing education credit in many jurisdictions, although we do not submit programs in advance for approval.

NAIC

National Association of Insurance Commissioners
Education and Training Department
120 West 12th Street, Suite 1100
Kansas City, MO 64105-1925

National Association Of Insurance Commissioners Education Programs, 1993

Please send me descriptive brochure(s) for: (Please check your choices.)

Regulators-Only Programs

- Financial Examiners Program
- Regulating for Solvency
- Insurance Department Staff Education Program
- Regulating the Marketplace
- Commissioners Education Program
- Demystifying Derivatives Seminar

Public Programs

- Reinsurance Seminar
- Rehabilitators and Liquidators Workshop
- Health Seminars
- Continuing Legal Education Seminar
- Symposium
- Other programs as they develop

Name

Title

State/Organization

Street Address

City State Zip

Phone Fax

Please return to: NAIC, 120 West 12th Street, Suite 1100, Kansas City, MO 64105-1925
ATTN: Education and Training Department

NEWS

The Life Underwriter Training Council

7625 Wisconsin Ave.. Bethesda, MD 20814 • Tel. (301) 913 - LUTC

Contact: Paul Baebler, LUTCF
Associate Director, Promotion
(301) 913-5882

FOR IMMEDIATE RELEASE

FIVE SKILLS-BUILDING COURSES OFFERED THIS SPRING BY THE LIFE UNDERWRITER TRAINING COUNCIL

Bethesda, Md. -- For its 1993 spring semester, The Life Underwriter Training Council will offer five important skills-building courses designed to give life underwriters a competitive advantage within their industry.

These 13-week courses, which begin the week of Feb. 8, are open to persons licensed to sell life and health insurance, as well as individuals in the field and home office with sales support responsibilities.

Weekly classes are sponsored and conducted by local life underwriters associations affiliated with The National Association of Life Underwriters (NALU). Leading successful agents who are members of these associations serve as moderators for the classes.

• The ***Advanced Business Planning Course*** focuses on insurance planning techniques which can assist the owners of small businesses, including buy-sell agreements, qualified retirement plans, cafeteria plans and methods for transferring viable business enterprises to the next generation. The course is part of the newly introduced Advanced Sales Series, which also includes the Personal Estate & Retirement Planning Course, offered during the current fall semester.

• The ***Fundamentals of Financial Services Course*** has been completely restructured and now is available to students with or without NASD registration. This course enhances communication and data-collecting skills, and assists agents in understanding clients' financial objectives. It improves awareness of registered investments for non-registered students and provides implementation capabilities for registered students.

- more -

• The ***Professional Growth Course*** has undergone three years of successful pilot testing. It has evolved into a dynamic course which focuses on relationship marketing and market development as it guides students toward good businessperson skills. The course includes a unique and practical software package, *PGC Goals*.

• The ***Disability Income Course***, a favorite for those interested in improving their knowledge and skills within this attractive market, has been offered by LUTC for more than two decades. This year's updated edition features education and skills training on topics such as income replacement, applicable tax laws, disability income buyout coverage, residual coverage and split dollar opportunities.

• The ***Multiline Skills Course*** provides property & casualty underwriters, as well as life underwriters, with education and training to offer clients quality service and training through a total needs approach. The course helps students improve sales efficiency, increase productivity and build added professionalism.

An independent, nonprofit education and training organization, LUTC also offers classes each fall in Personal Insurance, Business Insurance, Disability Income, Professional Growth and an additional Advanced Sales Series Course in Personal Estate and Retirement Planning.

Each year, between 35,000 and 40,000 students enroll in more than 2,500 LUTC classes nationwide. LUTC Courses provide continuing education (CE) credits in states with requirements. Courses also earn credit toward the professional designation Life Underwriter Training Council Fellow (LUTCF) which is jointly conferred by LUTC and NALU.

# # #

November 1992

PART B. RECOMMENDATIONS TO THE LEGISLATURE PURSUANT TO SECTION 7113

(1) Capital funds required of Insurers

(i) 4 CMC Section 7306(h). Capital: other than life insurer.

It is recommended that the above subsection be amended to require the minimum, paid-in capital stock for a non-life domestic insurer to be increased to $200,000 and a paid-in surplus of $100,000 for the transaction of any one class of insurance. For each additional class of insurance to be transacted, except life insurance, there shall be an additional paid-in capital of $50,000 and surplus of $25,000.

However, an insurer having a paid-in capital stock of $500,000 and surplus of $250,000 may be authorized to transact all classes of insurance, except life insurance. One tenth or more of an insurer's statutory surplus shall be held on deposit with the Insurance Commissioner in the form of cash or acceptable securities for the benefit and protection of CNMI policyholders as long as the insurer has any outstanding obligation arising out of insurance transacted in the Commonwealth.

(ii) 4 CMC Section 7306(k). Life insurer: capital.

It is recommended that the above subsection be amended to require the minimum paid-in capital required under this section to be increased to $500,000 and a paid-in surplus of $250,000. One tenth or more of a life insurer's surplus shall be held on deposit with the Insurance Commissioner in the form of cash or acceptable securities for the benefit and protection of CNMI policyholders as long as the insurer has any outstanding obligation arising out of insurance transacted in the Commonwealth.

In addition to life insurance, an insurer may be authorized to transact disability insurance provided there shall be an additional paid-in capital of $200,000 and surplus of $100,000. A life insurer shall not transact any other class of insurance other than disability.

(iii) 4 CMC Section 7307. Foreign Insurers.

It is recommended that a new subsection be added to this section to require foreign insurers to have at all times paid-in capital of $1,000,000 or more and paid-in surplus not less than $500,000. One tenth or more of a foreign insurer's surplus shall be held on deposit with the Insurance Commissioner in the form of cash or acceptable securities for the benefit and protection of CNMI policyholders so long as the insurer has any outstanding obligation arising out of insurance transacted in the Commonwealth. Deposit requirements equivalent to the above shall so be applicable to non-stock insurers.

(iv) 4 CMC Section 7308. Alien Insurers.

It is recommended that a new subsection be added to this section to require alien insurers to have at all times paid-in capital in an amount equivalent to $5,000,000 and a paid-in surplus of not less than the equivalent of $2,500,000. One tenth or more of an alien insurer's paid-in surplus shall be held on deposit with the Insurance Commissioner in the form of cash or acceptable securities for the benefit and protection of CNMI policyholders so long as the insurer has any outstanding obligation arising out of insurance transacted in the Commonwealth.

(v) Deposits with the Commissioner pursuant to (i), (ii), (iii), and (iv) shall be subject to the following:

1. Designation of Depositary

The Commissioner shall assign all deposits to the Treasurer of the Commonwealth. Upon the request of the insurer the Commissioner may designate to the Treasurer any solvent financial institution having trust powers domiciled in the Commonwealth, as the Commissioner's depositary to receive and hold any such deposit.

Any such deposit so held shall be at the expense of the insurer. The CNMI government shall be responsible for the safekeeping and return of all funds or securities so required by the Insurance Act.

2. Rights of the Insurer

So long as the insurer remains solvent and complies with the provisions of the Insurance Act it may:

A. Demand, receive, sue for and recover the income from cash or securities deposited in accordance with the Insurance Act;

B. Exchange and substitute for the deposited cash or securities or any part thereof, cash or eligible securities of equivalent or greater value; and

C. Inspect, at reasonable times, any deposit made in accordance with the Insurance Act.

3. Treatment of Deposit

Any deposit made to the Commonwealth Insurance Commissioner under the Insurance Act shall be released and returned:

A. To the insurer upon extinguishment by reinsurance or otherwise of all liability of the insurer for the security of which the deposit is held; or

B. To the insurer to the extent such deposit is in excess of the amount required; or

C. Upon proper order of a court of competent jurisdiction to the receiver, conservator, rehabilitator, or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

4. Release of Deposit

No such release shall be made except upon application to and the written order of the Commissioner. The Commissioner shall have no personal liability for any such release of any such deposit or part thereof so made by him or her in good faith.

[Recommendations in subsection v are adapted from the Uniform Deposit Law, Model Regulation Service--October 1990, National Association of Insurance Commissioners.]

(2) Limits of risks for classes of insurance

4 CMC Section 7306. Domestic Insurers.

It is recommended that a new subsection be added to this section to impose limits of risks for classes of insurance on domestic insurers. Such insurer's retention of risk shall be limited to not more than ten percent (10%) of paid-in capital and surplus for any single risk, per class of insurance, per policy contract, after the deduction for any reinsurance taking effect simultaneously with the policy.

A corporate insurer may retain any net single risk in excess of ten percent (10%) of its paid-in capital and surplus provided that not earlier than five days before the effective date of retention of said risk, it shall have deposited with the Commissioner a collateral agreement and collateral security, both subject to the Commissioner's approval, in an amount not less than that proportion which exceeds the foregoing limitation.

[The above recommendation is adapted from Section 43110, the Insurance Law of Guam, Title XXXIX of the Government Code of Guam and Chapter IV, Title 14, Guam Codes Annotated.]

(3) Requirements for organization of domestic insurers

4 CMC Section 7306. Domestic Insurers.

(i) It is recommended that a new subsection be added to the above section to require that, as part of the organization of a new insurance company, all monies collected from the sale of stock other than that amount permitted for the promotional cost shall be held in escrow as designated by the Commissioner until such time as the company has been completely organized, has hired a sufficient number of qualified full-time employees, and has obtained a Certificate of Authority pursuant to Section 7301 of the Insurance Act.

(ii) It is recommended that another subsection shall be added to require that the usual home office records of every domestic insurer must be kept and maintained at all times within the Commonwealth.

(iii) It is further recommended that another subsection shall be added to provide that the Commissioner shall have the right to review, approve, or disapprove any management contract or exclusive agency contract that may have been made between the new insurance company and some individual, partnership or corporation. The Commissioner shall have the authority to promulgate or adopt such rules and regulations to define certain, definite standards by which to judge any such contract.

(4) Requirements for mergers, rehabilitation, and liquidation

Under study for their applicability to the Commonwealth are the NAIC's:

(a) Insurers Rehabilitation And Liquidation Model Act; and
(b) Administrative Supervision Model Act.

The findings of such study, if any, shall be reported in subsequent annual reports of the Insurance Commissioner, unless sooner published.

(5) Insurance rates for certain classes of tariff insurance

(i) 4 CMC Section 7504(a). Approval (Rates).

It is recommended that the above subsection shall be amended to require the Commissioner's approval of all rates, in addition to include rates for tariff lines (life insurance, motor vehicle insurance and workers compensation insurance) before they may be charged, advertised, publicized or otherwise represented.

(ii) It is further recommended that a thorough study and assessment be made pertaining to the necessity of revising rates for tariff lines from those currently in use in the Commonwealth by authorized insurers. A special task force shall undertake the project upon the endorsement of the Commissioner.

Members of such task force shall include representatives from the Office of the Insurance Commissioner, Northern Marianas Property and Casualty Insurance Association, authorized insurers and other private or public individuals, firms, associations, or corporations that may have a bonafide, participative interest in the undertaking of such study. Upon its final deliberations and conclusions, the task force shall prepare and present its report to the Commissioner whom shall approve or disapprove the task force's recommendations pursuant to Section 7504.

FIFTH ANNUAL REPORT

OF THE INSURANCE COMMISSIONER

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T A B L E O F C O N T E N T S

T A B L E O F C O N T E N T S

DESCRIPTION **PAGE**

RECOMMENDATIONS TO THE LEGISLATURE PURSUANT TO SECTION 7112

Since 1988, the year of the First Annual Report of the Insurance Commissioner, the Commonwealth insurance industry kept pace with the astronomical economic growth experienced in the CNMI, especially in Saipan. In fact, between 1988 and 1992, an additional 11 insurers were incorporated in the Commonwealth. The growth, however, began to show its vulnerability in 1992 when the CNMI's economy, previously thought to have been well-insulated by the strong economies of asia, went the way of the general recession that has afflicted nations' economies, including Japan, since the its advent in 1989.

With concerns of a lingering economic slowdown still uncertain, in addition to depreciated land values, apprehensions of foreign investors, political ineptitude, a government deficit and strained relationship with the U.S. Congress, worries about the affordability, availability, much less the regulation of insurance were perceived as minor, perhaps irrelevant, in comparison. In spite of such views, however, insurance is a potent economic reality, totally relevant and significant to the extent it impacts on society.

The recommendations to the legislature discussed below are intended to address the more crucial concerns about what the regulation of insurance should entail. Enforcement effectiveness and adequacy of these recommendations, should any eventually become law, will depend greatly on the extent that the recommendations in Part A of the Special Report to the Legislature Pursuant to 4 CMC Section 7113 are heeded.

For better clarity, the reader should consult the actual provision in the Insurance Act that relates to a particular recommendation. Applicable statutory provisions or other references are cited following each recommendation.

RECOMMENDATIONS:

1. Insurance licensees

For the purpose of protecting the insurance public by regulating those licensed to engage in the business of insurance, except as an insurer, IT IS RECOMMENDED to amend the Insurance Act by adopting a tailored version of the NAIC Agents and Brokers Licensing Model Act (See page 73, Exhibit A the actual model law.) and establishing minimum eligibility requirements for licensure of the two major categories of prospective licensees, i.e. CNMI resident verses non-resident. Such requirements may include but are not limited to the following:

For resident applicants.

A "resident" means any person who is a U.S. citizen, or of Northern Marianas descent who has met all applicable residency requirements and intends to reside permanently in the Commonwealth, or otherwise a person classified as a permanent resident of the Commonwealth.

(1) Must be at least 18 years of age;

(2) Must be a current registered voter;

(3) Must not have been convicted of a felony or a crime involving fraud within the last seven years as of the date of the application;

(4) Must be a high school graduate or equivalent;

(5) Must pass a written exam administered by the Commissioner;

(6) Must provide any additional information reasonably requested by the Commissioner in connection with the application and pay all required fees; and

(7) If applicant is not a natural person or sole proprietor, but a partnership, association, firm, corporation, or other such entity, the individual(s) designated in the application to act under the license being applied for shall be required to meet the requirements set forth in (1) through (6).

For non-resident applicants.

A "non-resident" means a person, regardless of citizenship, who does not meet the qualifications of resident and whose sole purpose for seeking an insurance license is for economic or other profit.

(1) Must be at least 18 years of age;

(2) Must provide proof of citizenship;

(3) Must have valid license to transact insurance where currently residing;

(4) Must not have been convicted of a felony or a crime involving fraud within the last seven years as of the date of the application;

(5) Must be a high school graduate or equivalent;

(6) Must pass a written exam administered by the Commissioner; and

(7) Must provide any additional information reasonably requested by the Commissioner in connection with the application and pay all required fees; and

(8) If applicant is not a natural person or sole proprietor, but a partnership, association, firm, corporation, or other such entity, the individual(s) designated in the application to act under the license being applied for shall be required to meet the requirements set forth in (1) through (7).

[See also 4 CMC Sections 7303(a)(4) and 7303(g)(1)(E)]

2. Loss reserves

For the purpose of protecting the insurance public by holding insurers more accountable for loss liabilities, IT IS RECOMMENDED to require all authorized insurers to establish and maintain loss reserves, or in the case of foreign and alien insurers to provide proof thereof, in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred in the Commonwealth, whether reported or unreported, which are unpaid and for which such insurer may be liable and to provide for the expenses of adjustment or settlement of losses and claims.

[See also (1) Exhibit B: Model Legislation to Modify Schedule "P", on page 103; and (2) 4 CMC Sections 7306, 7307 and 7308.]

3. Insurance license and other fees

For the purpose of protecting the insurance public by promoting the competency and enforcement effectiveness of insurance regulators, IT IS RECOMMENDED:

(a) To repeal all references to insurance fees from Public Law 3-11 (4 CMC Division 1);

(b) To amend the Insurance Act for the provision of such fees through the authority of the Commissioner to promulgate rules to regulate such fees;

(c) To notify of the Commissioner's intention to incorporate the Proposed Schedule of Fees below into such rules and regulations that he shall promulgate pursuant 3(b); and

(d) To use funds collected from such fees to train and educate staff in the regulation of insurance.

[See also Part A of the Special Report to the Legislature Pursuant to Section 7113.

Proposed Schedule of Fees:

I. Certificate of Authority, initial and renewal thereof:

(1) Alien insurer $3,000.00

(2) Domestic insurer 1,500.00

(3) Foreign insurer 3,000.00

II. Insurance licenses, initial and renewal thereof:

(1) General agent ..... $ 350.00

(2) Sub-agent 250.00

(3) Sub-agent (CNMI non-resident) 300.00

(4) Broker 500.00

(5) Broker (CNMI non-resident) 600.00

(6) Adjuster 200.00

(7) Adjuster (CNMI non-resident) 240.00

(8) Solicitor 200.00

(9) Solicitor (CNMI non-resident) 240.00

(10) Surplus Line 750.00

(11) Surplus Line (CNMI non-resident) 900.00

III. Filing and processing:

(1) Application to organize a domestic insurer ..... $ 250.00

(2) Initial applications only:

(a) Admission and certificate of authority:

(1) Alien insurer 500.00
(2) Domestic insurer 250.00
(3) Foreign insurer 500.00

(b) Insurance licenses (See II.):

(1) Resident 25.00
(2) Non-resident 50.00

(3) Amendment to certificate of authority or insurance license..... 10.00

(4) Reinstatement of:

(a) Certificate of authority $1,000.00
(b) Insurance license 100.00

(5) Annual statement 10.00

(6) Service of Process on Commissioner 10.00

(7) Late filing penalty for:

(a) Extension of certificate of authority, per day up to $1,200 maximum 20.00

(b) Renewal of insurance license or notice of intent not to renew insurance license, per day up to $200 maximum per year..... 1.00

(c) Annual statement per day up to $1,200 maximum 20.00

(d) Surplus lines annual report, per day up to $600 maximum 5.00

IV. Miscellaneous:

(1) Copies of documents or records on file with the Commissioner, per page ..... .50

(2) Certificate of the Commissioner under his seal authenticating any document or instrument (other than a license or certificate of authority 5.00

(3) Listing of insurance licensees, or insurers 5.00

(4) Annual Report of the Insurance Commissioner 25.00

(5) Copy of the Insurance Act 25.00

V. The Commissioner by rule may reasonably fix other fees in addition to the above.

4. Extension of certificate of authority

For the purpose of protecting the insurance public by defining the insurer's responsibility regarding the extension of its certificate of authority, IT IS RECOMMENDED to amend 4 CMC Section 7303(g)(1) to provide specific recourse against an insurer that fails to file a timely application for the extension of its certificate of authority, unless such insurer is found ineligible or otherwise barred from applying and is given adequate prior notice of such status.

This amendment provision shall require the immediate suspension of an insurer's certificate of authority if, on or before the established extension date, it fails to submit an application or request in writing for an extension of time not to exceed 60 working days in which to file such application. No further extensions shall be granted.

A written request for an extension of time in which to file shall be refused if such request is received after the extension date. An insurer is deemed to have ample opportunity before such date to prepare and submit such request. In addition to suspension, the insurer shall be penalized $20 each day beyond the extension date up to a $1,200 maximum, but that an insurer shall be liable for the $1,200 maximum should it fail to submit its application on or before the approved extended filing date.

If an insurer fails to file an application within 60 days after the extension date or on or before the approved extended filing date, whichever is later, the Commissioner, pursuant to Section 7201(k), shall give notice for a hearing why the insurer's certificate of authority should not be revoked. If the Commissioner so finds that the certificate of authority should be revoked, he shall prepare an order on hearing pursuant to Section 7201(p). The order on hearing may subject the insurer to such regulatory action as, be required to pay additional fines under Section 7301(m), withdraw from the CNMI, or be put on probation, the terms of which shall be specified in such order of the Commissioner.

If the Commissioner finds that the insurer's certificate of authority should not be revoked, he shall prepare an order on hearing which may subject the insurer to levied fines [See Section 7301(m).] or other regulatory actions pursuant to such order. The insurer is held completely responsible to meet all applicable requirements for the extension of its certificate of authority.

5. Annual financial statement: preparation

For the purpose of effecting uniform compliance regarding the preparation of the annual financial statement required pursuant to 4 CMC Sections 7306(o)(1), 7307(d) and 7308(d), and to improve the surveillance of the financial condition of insurers, IT IS RECOMMENDED by the promulgation of regulations to require every admitted insurer to subscribe and adhere to those instructions as published from time to time by the NAIC for the purpose of preparing the insurer's annual financial statement.

Current NAIC instructions for property and casualty insurers include a requirement for the preparation and submission of an annual audited financial report in addition to the annual financial statement. Such requirement, likewise, shall apply.

If the above regulation is adopted on or prior to June 1, then the preparation of annual financial statements as of December 31 of the year in which the regulation is adopted must comply with such regulations. If adoption occurs after June 1, then compliance thereto shall not be required until the following year's annual financial statement.

An insurer submitting a substantially deficient annual financial statement shall be so informed by the Commissioner. Such insurer shall bear all costs and penalties to resubmit a corrected annual financial statement.

6. Annual financial statement: submission

For the purpose of protecting the insurance public by defining the insurer's responsibility regarding the preparation and filing of the annual statement pursuant to 4 CMC Sections 7306(o)(1), 7307(d) and 7308(d), IT IS RECOMMENDED to amend the foregoing sections to provide specific recourse against an insurer that fails to submit its annual statement as prescribed herein.

With reference to the cited sections above, every admitted insurer shall, on or before April 1 of each year, file with the Commissioner an annual financial statement, verified under oath, setting forth its financial condition, transactions and affairs as of December 31 the year preceding. However, Sections 7307(d) and 7308(d) shall be amended such that a foreign or alien insurer with a financial year-end other than December 31 shall disclose to the Commissioner such fact in its initial application for admission and certificate of authority and, where admission is approved, the Commissioner shall establish the rules by which such insurer may satisfy filing requirements for the annual financial statement.

In addition, amendments to these sections shall require the immediate suspension of an insurer's certificate of authority if, on or before April 1 of each year, it fails to submit its annual statement or request in writing for an extension of time not to exceed 60 days in which to file such annual statement. No further extensions may be granted.

A written request for an extension of time in which to file shall be refused if such request is received after April 1. An insurer is deemed to have reasonably ample opportunity before April 1 to ascertain whether it is necessary to request for an extension of time in which to file.

In addition to suspension, an insurer shall be penalized $20 each day past April 1 up to a maximum of $1,200, but that an insurer shall be liable for the $1,200 maximum if it fails to submit its annual financial statement on or before the approved extended filing date.

If an insurer fails to file its annual financial statement within 60 working days after April 1 or on or before the approved extended filing date, whichever is later, the Commissioner, pursuant to Section 7201(k), shall give notice for a hearing why the insurer's certificate of authority should not be revoked.

If the Commissioner so finds that the certificate of authority should be revoked, he shall prepare an order on hearing pursuant to Section 7201(p). The order on hearing may subject the insurer to regulatory action such as to pay additional fines under Section 7301(m), withdraw from the CNMI, or be put on probation, the terms of which shall be specified in such order of the Commissioner.

If the Commissioner finds that the insurer's certificate of authority should not be revoked, he shall prepare an order on hearing which may subject the insurer to pay additional fines [See Section 7301(m).] or other regulatory actions pursuant to such order. The insurer is held completely responsible to meet all applicable requirements for the submission of its annual financial statement.

7. Examination of insurer

For the purpose of improving the surveillance of insurer solvency, IT IS RECOMMENDED to amend the Insurance Act by incorporating a modified version of the NAIC Model Law on Examinations. See Exhibit B and 4 CMC Section 7201(c) through (h). Exhibit C on page 105 is the actual NAIC model law.

8. Insurance guaranty association

For the purpose of establishing a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers, IT IS RECOMMENDED to amend the Insurance Act by incorporating a new chapter based on a modified version of the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act. See Exhibit D on page 115 the actual NAIC model law.

9. Sub-agent licensee

For the purpose of protecting the insurance public by restricting a sub-agent's license, IT IS RECOMMENDED to amend 4 CMC Section 7303(b) to add a new section to require a separate sub-agent license for each insurer whom the sub-agent under the sub-agent appointment is authorized to effectuate or countersign insurance contracts.

10. Workers Compensation Commission

For optimizing insurance regulatory activities through centralization under the Insurance Commissioner, IT IS RECOMMENDED to consider a plan to have the Office of the Insurance Commissioner assume the responsibilities of the Northern Marianas Retirement Fund with regards the administration of the Workers Compensation Commission. See also Part A of the Special Report to the Legislature Pursuant to Section 7113.

Certainly, amendments would be required to Public Laws 3-107, 6-33, and other laws that may be affected. Such a plan to assimilate the functions of the Workers Compensation Commission into one regulatory commission under the stewardship of the Commissioner, would yield more efficient use of government resources and provide a higher level of regulatory surveillance and enforcement effectiveness.

11. Surplus lines

For the protection of the insurance public by applying more stringent requirements for placement of surplus lines insurance, IT IS RECOMMENDED to amend the Insurance Act by adopting a modified version of the NAIC Model Surplus Lines Law. See page 133 Exhibit E the actual NAIC model.

The extent of adoption of the model law would either amend or repeal 4 CMC Section 7304 of the Insurance Act. This recommendation is likely more implementable, as are most of the recommendations herein, upon the implementation of Part A of the Special Report.

12. Unauthorized insurers

For the protection of the insurance public by advocating stricter penalties for the illegal transaction of insurance by unauthorized insurers, IT IS RECOMMENDED to amend 4 CMC Section 7505 of the Insurance Act by adopting certain modified sections of the NAIC Unauthorized Insurers Model Act. See page 149 Exhibit F the actual model law.

13. Title insurance

For the protection of people seeking title insurance in the Commonwealth by rightly recognizing that title insurance is a class of insurance and the legal transaction thereof constitutes a valid insurance transaction and, thus, should be subject to proper regulation, IT IS RECOMMENDED to amend the Insurance Act by incorporating a modified version of the NAIC Model Title Insurance Act. See page 161 Exhibit G the actual model.

14. Health maintenance organization

For the protection of people who are seeking to enroll in, or are current members of health maintenance organizations in the Commonwealth due to the non-regulated status of such organizations under the Insurance Act, IT IS RECOMMENDED to amend the Insurance Act by incorporating a locally tailored version of the NAIC Health Maintenance Organization Model Act. See page 181 the actual model law in Exhibit H.

The Commonwealth undoubtedly would benefit from such amendment as the Insurance Act does not provide for the regulation of health maintenance organizations. However, the amendment would be ill-advised and meaningless if the Commissioner has not given assurance that he has the necessary resources to enable effective enforcement of said amendment. Please see Part A of the Special Report.

15. Withdrawal from the CNMI

For the protection of policyholders with policies or claims pending at the time an insurer desires to withdraw from doing business in the Commonwealth, IT IS RECOMMENDED to amend the Insurance Act by adding a provision as follows:

Section _____. Withdrawal.

(a) An insurer who desires to withdraw from the CNMI must first make application to the Commissioner for an order granting permission to withdraw.

(b) Such application shall be accomplished by an affidavit of its principal officer and general agent, that:

(1) It desires to withdraw and to permanently discontinue the transaction of insurance business in the CNMI.

(2) All its outstanding policies have wither expired or have been reinsured, in which case it shall file an affidavit by the reinsurer stating that it has reinsured certain policies of the withdrawing company and setting forth in detail the policies it has reinsured; and that

(3) All existing claims arising out of insurance transacted in the CNMI have been paid in full.

(c) It shall cause publication of a notice of its intention to withdraw in a newspaper of general circulation in the CNMI once a week for four (4) consecutive weeks, and shall cause said newspaper to file affidavit of publication with the Commissioner.

(d) If any person shall object to such withdrawal within one (1) week from the date of last publication, and give good and sufficient cause therefore, the Commissioner may order that permission for such withdrawal be refused.

(e) If the insurer has complied with the provisions of this section and no objection has been made, or if objection is made but without good and sufficient cause, the Commissioner shall order permission to withdraw and the withdrawing insurer shall deliver to the Commissioner for cancellation its certificate of authority and current licenses of its agents, sub-agents, and solicitors.

EXHIBIT A

AGENTS AND BROKERS LICENSING MODEL ACT

Table of Contents

Section 1. Scope

This Chapter governs the qualifications and procedures for the licensing of insurance agents, insurance brokers, surplus lines brokers, insurance consultants and limited insurance representatives. These provisions shall apply to any and all lines of insurance and types of insurers including but not limited to life, health, property, liability, credit, title, fire or marine operating on a stock, mutual reciprocal, fraternal, hospital or medical service plan, as set forth in Chapter [insert applicable chapter]. For purposes of this Chapter, all references to insurance shall include annuities unless context otherwise requires.

Section 2. Definitions

As used in this Chapter, the following definitions apply:

A. Insurance Agent. An insurance agent is an individual, partnership, or corporation appointed by an insurer to solicit applications for a policy of insurance or to negotiate a policy of insurance on its behalf.

An individual, partnership, or corporation not duly licensed as an insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative who solicits a policy of insurance on behalf of an insurer shall be an insurance agent within the intent of this Chapter, and shall thereby become liable for all the duties, requirements, liabilities, and penalties to which an insurance agent of such company is subject, and such company by compensating such person through any of its officers, agents or employees for soliciting policies of insurance shall thereby accept and acknowledge such person as its agent in such transaction.

B. Insurance Broker. An insurance broker is any individual, partnership or corporation who, for compensation, not being a licensed agent for the company in which a policy of insurance is placed, acts or aids in any manner in negotiating contracts for insurance or placing risks or effecting insurance for a party other than himself or itself.

An individual, partnership or corporation not licensed as an insurance broker who solicits a policy of insurance on behalf of others or transmits for others an application for a policy of insurance to or

from an insurance company, or offers or assumes to act in the negotiations of such insurance, shall be an insurance broker within the intent of this Chapter, and shall thereby become liable for all the duties, requirements, liabilities and penalties to which such licensed brokers are subject.

C. Surplus Lines Insurance Broker. A surplus lines insurance broker is an individual, partnership or corporation who solicits, negotiates or procures a policy of insurance in an insurance company not licensed to transact business in this State which cannot be procured from insurers licensed to do business in this State. All transactions under such license shall be subject to Chapter [insert applicable chapter].

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

E. Consultant. A consultant is an individual, partnership or corporation who, for a fee, holds himself or itself out to the public as engaged in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages promised under any policy of insurance that could be issued in this State.

F. Person. A person shall mean any natural or artificial entity including, but not limited to, individuals, partnerships, associations, trusts or corporations.

Section 3. Duties

A. Agent: Limited Insurance Representative: Agent of Insurer. Every agent or limited insurance representative who solicits or negotiates an application for insurance of any kind shall, in any controversy between the insured or his beneficiary and the insurer be regarded as representing the insurer and not the insured or his beneficiary. This provision shall not affect the apparent authority of an agent.

B. Brokers: Agent of Insured. Every insurance broker or surplus lines insurance broker who solicits an application for insurance of any kind shall, in any controversy between the insured or his beneficiary and the insurer issuing any policy upon such application, be regarded as representing the insured or his beneficiary and not the insurer; except any company which directly or through its agents delivers in this State to any insurance broker a policy of insurance pursuant to the application or request of such broker, acting for an insured other than himself, shall be deemed to have authorized such broker to receive on its behalf payment of any premium which is due on such policy of insurance at the time of its issuance or delivery.

C. Any person that offers enrollment in more than one group contract of insurance shall, at a minimum, be licensed as a limited insurance representative. No firm shall be required to maintain more than one limited insurance representative license per location. This requirement shall not apply to employer/employee relationships, nor to any such enrollments.

Section 4. General License Requirements

A. License Required: Liability; Validity of Contract; Penalty.

(1) No person shall act as or hold himself out to be an insurance agent, insurance broker, surplus lines insurance broker, limited insurance representative or consultant unless duly licensed.

(2) No insurance agent, insurance broker, surplus lines insurance broker or limited insurance

representative shall make application for, procure, negotiate for or place for others, any policies for any lines of insurance as to which he is not then qualified and duly licensed.

(a) An insurance agent, insurance broker or surplus lines insurance broker may receive qualification for a license in one or more of the following lines:

1. Life insurance, annuity contracts, variable annuities and variable life insurance.
2. Sickness, accident and health.
3. Credit life insurance and credit accident and health.
4. Fire and allied lines.
5. Vehicle liability and vehicle physical damage insurance.
6. Comprehensive personal and general liability coverage.
7. Marine and transportation.
8. Workmen's compensation.
9. Credit and mortgage guarantee insurance.
10. Burglary and theft insurance.
11. Crop insurance.
12. Bail bonds.
13. Fidelity and surety insurance.
14. Homeowners' and farmowners' multiple peril insurance.
15. Commercial multiple peril insurance.
16. Property and/or casualty insurance sold in connection with a credit transaction.
17. Industrial fire (Optional).

(b) A limited insurance representative may receive qualification for a license without examination in one or more of the following lines:

1. Any ticket-selling agent of a common carrier who acts thereunder only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by such common carrier, or applicants selling limited travel accident insurance in transportation terminals.
2. Any other lines which the Commissioner finds by rule or regulation do not require the professional competency demanded for an agent's or broker's license.

(3) No insurance agent or limited insurance representative shall place a policy of insurance with any insurer as to which he does not then hold a license as an insurance agent or limited insurance representative under this Chapter.

B. Licensing of Organizations.

(1) A partnership or corporation may be licensed as an insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative. Every member of the partnership and every officer, director, stockholder and employee of the corporation personally engaged in this state in soliciting or negotiating policies of insurance shall be registered with the Commissioner as to its license, and each such member, officer, director, stockholder or employee shall also qualify as an individual licensee. An additional license fee shall be paid as to each individual registered as to the organization's license; provided, however, that this section shall not apply to a management association, partnership, or corporation, whose operations do not entail the solicitation of insurance from the public.

(2) The partnership or corporate licensee shall within ten working days notify the Commissioner of every change relative to the individuals registered with the corporate or partnership license.

C. Controlled Business.

(1) The Commissioner shall not grant, renew, continue or permit to continue any license if he finds that the license is being or will be used by the applicant or licensee for the purpose of writing controlled business. Controlled business shall mean:

(a) Insurance written on the interests of the licensee or those of his immediate family or of his employer; or

(b) Insurance covering himself or members of his immediate family or a corporation, association or partnership, or the officers, directors, substantial stockholders, partners, or employees of such a corporation, association or partnership, of which he or a member of his immediate family is an officer, director, substantial stockholder, partner associate, or employee; provided, however, that nothing in this section shall apply to insurance written in connection with credit transactions.

(2) Such a license shall be deemed to have been, or intended to be, used for the purpose of writing controlled business, if the Commissioner finds that during any twelve (12) month period the aggregate commissions earned from such controlled business has exceeded twenty-five percent (25%) of the aggregate commission earned on all business written by such applicant or licensee during the same period.

D. Commissions; Payment; Acceptance.

(1) No insurer, insurance agent, insurance broker, surplus lines insurance broker or limited insurance representative shall pay, directly or indirectly, any commission, brokerage or other valuable consideration to any person for services as an insurance agent, insurance broker, surplus lines insurance broker or limited insurance representative within this State, unless such person held at the time such services were performed a valid license for that line of insurance as required by the laws of this State for such services; nor shall any person other than a person duly licensed by this State as an insurance agent, insurance broker, surplus lines insurance broker or limited insurance representative at the time such services were performed accept any such commission, brokerage or other valuable consideration. Provided, however, any person duly licensed under this Chapter may pay his commissions or assign his commissions, or direct that his commissions be paid, to a partnership of which he is a member, employee or agent, or to a corporation of which he is an officer, employee or agent; and provided further that this section shall not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto under this section.

E. License Contents.

(1) The license shall state the name, resident address, and social security or IRS identification number of the licensee, date of issue, the renewal or expiration date, the line or lines of insurance covered by the license and such other information as the Commissioner deems proper for inclusion in the license.

(2) The license of an insurance agent or limited insurance representative shall specify the name of the particular insurer by which the licensee is appointed. An insurance agent or limited insurance representative may represent as many insurers as may appoint him in accordance with this Chapter.

F. Term of License.

All licenses issued pursuant to this Chapter shall continue in force not longer than twelve (12) months, but shall expire as of 12:01 a.m. o'clock on the first day of [insert month] next following date of issuance unless the licensee prior thereto has filed with the Commissioner, on forms prescribed and furnished by him, a request for renewal of such license for an ensuing twelve-month period. Such request must be accompanied by payment of the renewal fee as provided in Section 5D.

G. Exceptions to Licensing Requirements.

No license as an insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative shall be required of the following:

(1) Any regular salaried officer or employee of an insurance company, or of a licensed insurance agent, insurance broker, surplus lines insurance broker or limited insurance representative if such officer or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

(2) Persons who secure and furnish information for the purpose of group or wholesale life insurance or annuities; or group, blanket or franchise health insurance; or for enrolling individuals under such plans or issuing certificates thereunder or otherwise assisting in administering such plans, where no commission is paid for such service.

(3) Employers or their officers or employees, or the trustees of any employee trust plan, to the extent that such employers, officers, employees or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company, provided that such employers, officers, employees or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing such insurance.

(4) Employees of a creditor who enroll debtors under a group policy, provided such employees receive no commission.

(5) Persons representing fraternal organizations, who are excluded in accordance with the provisions of Section 12 of this Chapter.

(6) Limited insurance representative, if separately licensed under the insurance code of this state.

Section 5. License Requirements

The Commissioner shall not issue, continue or permit to continue any license of an insurance agent, insurance broker, surplus lines insurance broker or limited insurance representative except in compliance with the following:

A. Application. Application shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner.

B. Appointment by the company. The application for an insurance agent or limited insurance representative license shall be accompanied by a written appointment. Such appointment shall be made by an officer of the insurer designating the applicant as an insurance agent or limited insurance representative for such lines of insurance as the applicant will be authorized to write for said insurer. All appointments for any licensee shall be submitted on behalf of the appointing insurer, on a form prescribed by the Commissioner, and shall remain in force until the annual renewal date which shall be [insert date].

C. Age. Every applicant for an insurance agent or limited insurance representative licensed under this Chapter, except a partnership or corporation, must be eighteen (18) years or more of age.

D. Fees. All applications shall be accompanied by the applicable fees. An appointment shall terminate upon failure to pay the prescribed annual renewal fee.

(1) Initial Licensing

Residents— _____

Nonresidents— _____

(2) Annual renewal— _____

(3) Initial Exam— _____

Subsequent Exams— _____

(4) Initial appointment— _____

(5) Annual Renewal of Appointment— _____

The following fees are for brokers' licenses:

(6) Initial fee— _____

Residents— _____

Nonresidents— _____

(7) Annual renewal— _____

Residents— _____

Nonresidents— _____

The following fees are for surplus lines brokers:

(8) Initial fee— _____

(9) Annual renewal— _____

The following fees are for consultants:

(10) Initial fee— _____

(11) Annual renewal— _____

E. Resident-Nonresident Licenses. The Commissioner shall issue an insurance agent's license, insurance broker's license and a limited insurance representative's license to any duly qualified resident or nonresident, individual, partnership or corporation of the state as follows:

(1) Resident.

An applicant may qualify as a resident if he resides in this State or maintains his principal place of business in this State. Any license issued pursuant to any such application claiming residency for licensing purposes, as defined herein, in this State shall constitute an election of residency in this State and shall be void if the licensee while holding a resident license in this State, also holds or makes application for a license in, or thereafter claims to be a resident of any other state or other jurisdiction or ceased to be a resident of this State; provided, however, if the applicant is a resident of a community or trade area, the border of which is contiguous with the state line of this State, the applicant may qualify as a resident in such states and hold a license from each state.

(2) Nonresident.

(a) An applicant may qualify for a license under this Chapter as a nonresident only if he holds a like license in the United States, province of Canada or other foreign country. A license issued to a nonresident of this State shall grant the same rights and privileges afforded a resident licensee, except as provided in Subparagraph (f) of this paragraph.

(b) The Commissioner shall not issue a license to any nonresident applicant until he files with the Commissioner his designation of the Commissioner and his successors in office to be his true and lawful attorney, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of any interested person arising out of the applicant's insurance business in this State. Such designation shall constitute an agreement that such service of process is of the same legal force and validity as personal service of process in this State upon such person.

Such service of process upon any such licensee in any such action or proceeding in any court of competent jurisdiction of this State may be made by serving the Commissioner with appropriate copies thereof and the payment to him of a fee of [insert amount]. The Commissioner shall forward a copy of such process by registered or certified mail to the licensee at his last known address of record or principal place of business, and shall keep a record of all process so served upon him.

(c) Service of process upon any such licensee in any action or proceeding instituted by the Commissioner under this subsection shall be made by the Commissioner by mailing such process by registered or certified mail to the licensee at his last known address of record or principal place of business.

Such service of process is sufficient, provided notice of each service and a copy of the process are sent within ten (10) days thereafter to the licensee at his last known address of record or principal place of business by registered or certified mail return receipt requested.

If the Commissioner revokes or suspends any nonresident's license through a formal proceeding under this Chapter, he shall promptly notify the appropriate Commissioner of the licensee's residence of such action and of the particulars thereof.

(d) A nonresident of this State may be licensed without taking an otherwise required written examination if the Commissioner of the state of the applicant's residence certifies that the applicant has passed a similar written examination, or has been a continuous holder prior to the time such written examination was required, of a license like the license being applied for in this State.

(e) Notwithstanding other provisions of this Chapter, no new bond shall be required for a nonresident insurance broker if the Commissioner is satisfied that the existing bond covers his insurance business in this State.

(f) Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this State who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Chapter, the same such requirements shall be imposed upon such residents of such other state or jurisdiction.

(g) A nonresident who complies with the continuing education requirements of the individual's state of residence is exempt from the continuing education requirements for resident producers.

(3) Additional License Requirement—Surplus Lines Insurance Broker.

An applicant for a surplus lines insurance broker's license must be licensed in this State as a resident insurance agent or insurance broker qualified as to the line or lines to be written.

(4) Character.

An applicant for any license under this Chapter must be deemed by the Commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation.

(5) Experience Requirements—Insurance Brokers.

Each applicant for an insurance broker's license must have had not less than two (2) years' experience as an insurance agent or in comparable employment for an insurance company, agency or brokerage firm during the three (3) years immediately preceding the date of application. The application for an insurance broker's license must be accompanied by an affidavit from the employer or insurer to the effect that the applicant was so engaged in such required responsible insurance duties.

(6) Examination.

(a) After completion and filing of the application with the Commissioner, except as provided in Section 6 of this Chapter, the Commissioner shall subject each applicant for license as an insurance agent, insurance broker, surplus lines insurance broker, consultant or limited insurance representative to a written examination as to his competence to act as such licensee which he must personally take and pass to the satisfaction of the Commissioner.

(b) If the applicant is a partnership or corporation, the examination shall be so taken by each individual who is to be named in or registered as to the corporate or partnership license.

(c) Each examination for a license shall be approved for use by the Commissioner and shall reasonably test the applicant's knowledge as to the lines of insurance, policies and transactions to be handled under the license applied for, of the duties and responsibilities of such a licensee, and of the pertinent insurance laws of this State.

(d) All the lines of insurance which the applicant proposes to transact under the license applied for shall have a separate examination.

(e) Examination for licensing shall be at such reasonable times and places as are designated by the Commissioner and such times and places shall be made public sixty (60) days after the effective date of this law.

(f) The Commissioner shall give, conduct and grade all examinations in a fair and impartial manner and without discrimination as between individuals examined.

(g) The applicant must pass the examination with a grade determined by the Commissioner to indicate satisfactory knowledge and understanding of the line or lines of insurance for which the applicant seeks qualification. Within ten (10) days after the examination, the Commissioner shall inform the applicant and the appointing insurer, where applicable, as to whether or not the applicant has passed. Formal evidence of said licensing shall be issued by the Commissioner to the licensee within a reasonable time.

(h) An applicant who has failed to pass the first examination for the license applied for may take a second examination after a thirty (30) day waiting period. Examination fees for subsequent examinations shall not be waived.

(i) An applicant who has failed to pass the first two (2) examinations for the license applied for will not be permitted to take a subsequent examination until the expiration of six (6) months after the last previous examination.

(7) Denial of License.

(a) If the Commissioner finds that the applicant has not fully met the requirements for licensing, he shall refuse to issue the license and promptly notify the applicant and the appointing insurer, in writing, of such denial, stating the grounds therefore.

(b) If a license is refused, the Commissioner shall promptly refund the appointment fee tendered with the license application. All other fees accompanying the application for license as insurance agent, insurance broker, surplus lines insurance broker, consultant and limited insurance representative shall be deemed earned and shall not be refundable.

(8) Notification of Address Change.

Every licensed agent shall notify the Commissioner of any change in his residential or business address within thirty (30) days of the change.

Section 6. Exemption from Examination

The following shall be exempt from the requirement for a written examination:

A. Any applicant for a license covering the same line or lines of insurance for which the applicant was licensed under a like license in this State, other than a temporary license, within the twelve (12) months next preceding the date of application, unless such previous license was revoked, suspended, or continuation thereof was refused by the Commissioner.

B. An applicant who has been licensed under a like license in another state within twelve (12) months prior to his application for a license in this State, and who files with the Commissioner and the certificate of the public official having supervision of insurance in such other State as to the applicant's license and good standing in such state.

C. An applicant who has attained the designation of Chartered Life Underwriter shall only be required to take that portion of the examination for line 1 pertaining to rules, regulations and state laws.

D. An applicant who has attained the designation of Chartered Property and Casualty Underwriter shall only be required to take that portion of the examination for lines 4 through 17 pertaining to rules, regulations and state law.

Section 7. Consultants

A. No individual, partnership or corporation shall engage in the business of an insurance consultant until a license therefore has been issued to him by the Commissioner; provided, however, that no consultant license shall be required of the following:

(1) Attorneys licensed to practice law in this State acting in their professional capacity;

(2) A duly licensed insurance agent, insurance broker or surplus lines insurance broker;

(3) A trust officer of a bank acting in the normal course of his employment; or

(4) An actuary or a certified public accountant who provides information, recommendations, advice or services in his professional capacity.

B. An application for a license to act as an insurance consultant shall be made to the Commissioner on forms prescribed by the Commissioner. Within a reasonable time after receipt of a properly completed application form, the Commissioner shall hold a written examination for the applicant, and may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations and any other matter which he deems necessary or advisable to determine compliance with this Chapter or for the protection of the public.

C. In advance of rendering any service set forth in Section 2E, a written agreement on a form approved by the Commissioner shall be prepared by the consultant, and shall be signed by both the consultant and the client. The agreement shall outline the nature of the work to be performed by the consultant and shall state his fee for the work. The consultant shall retain a copy of the agreement for not less than two years after completion of the services. The copy shall be available to the Insurance Commissioner.

D. No person, firm, corporation or partnership may concurrently hold a consultant's license and an insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative's license in any line.

E. No licensed consultant may employ, be employed by, or be in partnership with nor receive any remuneration whatsoever, from any licensed insurance agent, insurance broker, surplus lines insurance broker, limited insurance representative or insurer arising out of his activities as a consultant.

F. Such license shall be valid for not longer than twelve (12) months and may be renewed annually and extended in the same manner as an insurance agent's license.

G. All requirements and standards relating to the denial, revocation or suspension of an insurance agent's license, including penalties, shall apply to the denial, revocation and suspension of an insurance consultant's license as nearly as practicable.

H. A consultant is obligated under his license, to serve with objectivity and complete loyalty the interests of his client alone; and to render to his client such information, counsel, and service as within the knowledge, understanding and opinion, in good faith, of the licensee, best serves the client's insurance needs and interests.

Section 8. License Denial, Non-Renewal, or Termination

A. Causes.

(1) The Commissioner may suspend, revoke or refuse to continue or renew or refuse to issue any license issued under this Chapter if, after notice to the licensee and to the insurer represented, and hearing, he finds as to the licensee any one or more of the following conditions:

(a) Any materially untrue statement in the license application;

(b) Any cause for which issuance of the license could have been refused had it then existed and been known to the Commissioner at the time of issuance;

(c) Violation of, or noncompliance with, any insurance laws, or for violation of any lawful rule, regulation or order of the Commissioner or of a Commissioner of another state;

(d) Obtaining or attempting to obtain any such license through misrepresentation or fraud;

(e) Improperly withholding, misappropriating, or converting to his own use any moneys belonging to policyholders, insurers, beneficiaries or others received in the course of his insurance business;

(f) Misrepresentation of the terms of any actual or proposed insurance contract;

(g) Conviction of a felony or misdemeanor involving moral turpitude;

(h) The licensee has been found guilty of any unfair trade practice or fraud defined in this Code;

(i) In the conduct of his affairs under the license, the licensee has used fraudulent, coercive, or dishonest practices, or has shown himself to be incompetent, untrustworthy or financially irresponsible;

(j) His license has been suspended or revoked in any other state, province, district or territory;

(k) Such licensee has forged another's name to an application for insurance;

(l) Such applicant has been found to have been cheating on an examination for an insurance license.

(2) In the event that the action by the Commissioner is to non-renew or to deny an application for a license, he shall notify the applicant or licensee and advise the applicant or licensee in writing of the reasons for the denial or non-renewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Commissioner within a reasonable time for a hearing before the Commissioner to determine the reasonableness of the Commissioner's action. Such hearing shall be held within thirty (30) days from the date of receipt of the written demand by the applicant and shall be held pursuant to [insert applicable section].

(3) The license of a partnership or corporation may be suspended, revoked, or refused if the Commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and such violation was not reported to the insurance department nor corrective action taken in relation thereto.

(4) In addition to or in lieu of any applicable denial, suspension or revocation of a license, any person violating this Chapter may, after hearing, be subject to a civil fine of not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000). Such fine ~~may be enforced~~ under Chapter [insert applicable section].

Section 9. Hearings

All hearings held pursuant to this Chapter shall be governed by [insert applicable section].

Section 10. Surrender of License, Loss or Destruction of License

A. The Commissioner shall promptly notify all appointing insurers, where applicable, and the licensee regarding any suspension, revocation or termination of license by the Commissioner.

B. Upon suspension, revocation or termination of the license of a resident of this State, the Commissioner shall notify the Support and Services Office of the NAIC and the Insurance Commissioner of each state for whom he has executed a certificate as provided for in accordance with Section 5E of this Chapter.

C. Upon suspension, revocation or termination of a license, the licensee shall forthwith deliver it to the Commissioner by personal delivery or by mail.

D. Any licensee who ceases to maintain his residency in this State as defined in Section 5E shall deliver his insurance license(s) to the Commissioner by personal delivery or by mail within thirty (30) days after terminating said residency.

E. The Commissioner may issue a duplicate license for any lost, stolen or destroyed license issued pursuant to this Chapter upon an affidavit of the licensee prescribed by the Commissioner concerning the facts of such loss, theft or destruction.

Section 11. Termination Reports

A. If an appointment is terminated, the insurer shall promptly give written notice of said termination and the effective date thereof to the Commissioner and to the licensee where reasonably possible. The Commissioner may require the insurer to demonstrate that the insurer has made a reasonable effort to give such notice to the licensee.

B. All such notices of termination shall be filed in due course on forms prescribed by the Commissioner stating the cause and circumstances of such termination.

C. In the event the termination is for any of the causes listed under Section 8 of this Chapter, the insurer shall so notify the Commissioner. Any information, document, record or statement provided pursuant to this section may be used by the Commissioner in any action taken pursuant to Section 8; however, such information shall be deemed privileged in any civil action between the reporting insurer and such terminated licensee.

Section 12. Representatives of Fraternal Benefit Societies

Representatives of fraternal benefit societies who solicit and negotiate insurance contracts shall be deemed insurance agents and subject to the same licensing requirements as insurance agents, provided that no insurance agent's license shall be required of:

A. Any officer, employee or secretary of any such society, or of any subordinate lodge or branch thereof who devotes substantially all of his time to activities other than the solicitation or negotiation of insurance contracts and who receives no commission or other compensation directly dependent upon the number or amount of contracts solicited or negotiated; or

B. Any agent or representative of a society who devotes, or intends to devote, less than fifty percent (50%) of his time to the solicitation and procurement of insurance contracts for such society. Any person who in the preceding calendar year has solicited and procured life insurance in excess of fifty thousand dollars ($50,000) face amount, or, in the case of any other kind or kinds of insurance which the society may write, on the persons of more than twenty-five (25) individuals and who has received or will receive a commission or other compensation therefore, shall be presumed to be devoting or intending to devote fifty percent (50%) of his time to the solicitation or procurement of insurance contracts for such society.

Section 13. Countersignature and Related Laws: Repeal

Notwithstanding the provisions of this chapter, or any other laws of this State, there shall be no requirement that a licensed resident agent or broker must countersign, solicit, transact, take, accept, deliver, record or process in any manner an application, policy, contract or any other form of insurance on behalf of a nonresident agent or broker and/or an authorized insurer; or share in the payment of commissions, if any, related to such business.

Section 14. Temporary Licensing

The Commissioner may issue a temporary license as an insurance agent or insurance broker for a period not to exceed ninety (90) days without requiring an examination if the Commissioner deems that such temporary license is necessary for the servicing of an insurance business in the following cases:

A. To the surviving spouse or next of kin, or to the administrator or executor or employee thereof, of a licensed insurance agent who becomes deceased, or to the spouse, next of kin, employee or legal guardian of a licensed insurance agent or insurance broker who becomes disabled;

B. To a member or employee of a partnership or officer or employee of a corporation, licensed as an insurance agent, upon the death or disability of an individual designated in or registered as to the license;

C. To the designee of a licensed insurance agent entering upon active service in the armed forces of the United States of America;

D. To a trainee employed to collect and service a weekly or monthly premium debit. During the temporary license period, his or her sales activities must be confined to weekly and monthly life, health and industrial fire plans; or

E. In any other circumstance where the Commissioner deems that the public interest will best be served by the issuance of such license.

Section 15. Rules and Regulations

The Commissioner of Insurance may adopt reasonable rules and regulations for the implementation and administration of the provisions of this Chapter.

Section 16. Conflict with Other Laws

All laws and parts of laws of this State inconsistent with this Chapter are hereby superseded with respect to matters covered by this Chapter.

Section 17. Severability of Provisions

If any provisions of this Chapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this Chapter which can be given effect without the invalid provision or application and for this purpose the provisions of this Chapter are severable.

Section 18. Effective Date

This Chapter shall take effect [insert date].

Legislative History (all references are to the Proceedings of the NAIC)

1973 Proc. II 18, 21, 370, 381-393 (adopted).
1974 Proc. I 12, 14, 272, 276, (amended).
1986 Proc. I 9-10, 22, 125, 132, 134 (amended).
1989 Proc. II 13, 22-23, 161, 166-167, 169-178, 191-193 (amended and reprinted).
1990 Proc. II 7, 13-14, 159-160, 192, 195 (amended).

AGENTS AND BROKERS LICENSING MODEL ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama		LA. CODE §§ 27-7-1 to 27-7-38 (1957/1988) (Property, Casualty, & Surety Ins. Reps.); §§ 27-8-1 to 27-8-28 (1971/1981) (Life and Disability Ins. Representatives).
Alaska		ALASKA STAT. §§ 21.27.010 to 21.27.520 (1966/1990).
Arizona		ARIZ. REV. STAT. ANN. §§ 20-281 to 20-318 (1954/1987).
Arkansas		ARK. STAT. ANN. §§ 23-64-101 to 23-64-229 (1959/1991).
California		CAL. INS. CODE §§ 1621 to 1758.5 (1959/1990) (Amendments eff. 1992).
Colorado	COLO. REV. STAT. §§ 10-2-201 to 10-2-221 (1977/1986).	
Connecticut		CONN. GEN. STAT. §§ 38a-702 to 38a-718 (1949/1986).
Delaware		DEL. CODE ANN. tit. 18 §§ 1701 to 1738 (1953/1965).
D.C.		D.C. CODE ANN. §§ 35-425 to 35-428 (1934/1985) (Life insurance); §§ 35-1301 to 35-1302 (1901/1985) (Agents other than life insurance); §§ 35-1534 to 35-1549 (1940/1985) (Fire, Casualty and Marine).
Florida		FLA. STAT. §§ 626.011 to 626.711 (1959/1990).

AGENTS AND BROKERS LICENSING MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Georgia		GA. CODE ANN. §§ 33-23-1 to 33-23-86 (1960/1989).
Guam		GUAM GOVT. CODE §§ 43250 to 43258 (1981).
Hawaii		HAWAII REV. STAT. §§ 431-9-101 to 431:9-240 (1988).
Idaho		IDAHO CODE §§ 41-1020 to 41-1079 (1973/1986).
Illinois	See page 218-10.	
Indiana		IND. CODE §§ 27-1-15.5-1 to 27-1-15.5-20 (1977/1987).
Iowa		IOWA CODE §§ 522.1 to 522.5 (1982).
Kansas		KAN. STAT. ANN. §§ 40-240; 40-241 to 40-246a (1927/1989).
Kentucky		KY. REV. STAT. §§ 304.9-010 to 304.9-460 (1970/1986).
Louisiana		LA. REV. STAT. ANN. §§ 22:1161 to 22:1182 (1958/1987) (Non-Life Agents); §§ 22:1111 to 22:1124 (1964/1984) (Life Agents).
Maine		ME. REV. STAT. ANN. tit. 24-A §§ 1501 to 1542 (1970/1989, <u>See also</u> §§ 1601 to 1857 (1970/1985).
Maryland		MD. ANN. CODE art. 48A §§ 165 to 179 (1951/1989).
Massachusetts		MASS. GEN. LAWS ch. 175 §§ 162 to 177 (1969/1989).

AGENTS AND BROKERS LICENSING MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Michigan		MICH. COMP. LAWS §§ 500.1200 to 500.1244 (1972/1989).
Minnesota		MINN. STAT. § 60A.17 (1969/1989).
Mississippi		MISS. CODE ANN. §§ 83-17-1 to 83-17-309 (1892/1985).
Missouri		MO. REV. STAT. §§ 375.012 to 375.146 (1939/1987).
Montana	See also page 218-10.	MONT. CODE ANN. §§ 33-17-101 to 33-17-1114 (1959/1989).
Nebraska		NEB. REV. STAT. §§ 44-4001 to 44-4044 (1985/1991).
Nevada		NEV. REV. STAT. §§ 683A.010 to 683A.490 (1971/1985).
New Hampshire		N.H. REV. STAT. ANN. §§ 402:15 to 402:26 (1913/1985).
New Jersey	See page 218-10.	
New Mexico		N.M. STAT. ANN. §§ 59A-11-1 to 59A-12-2 (1985/1986).
New York		N.Y. INS. LAW §§ 2101 to 2129 (1984/1986).
North Carolina	See page 218-10.	
North Dakota	N.D. CENT. CODE §§ 26.1-26-01 to 26.1-26-50 (1985).	
Ohio		OHIO REV. CODE ANN. §§ 3905.01 to 3905.99 (1917/1987) (Contains part of model).
Oklahoma	OKLA. STAT. tit. 36 §§ 1421 to 1433 (1980/1989).	

AGENTS AND BROKERS LICENSING MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Oregon		OR. REV. STAT. §§ 744.005 to 744.665 (1967/1989).
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 25-101 to 25-412 (1921/1980).
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 901 to 948 (1974/1986).
Rhode Island		R.I. GEN. LAWS §§ 27-3-1 to 27-3-48.5 (1956/1987).
South Carolina		S.C. CODE ANN. §§ 38-45-10 to 38-45-150 (1988/1989) (Insurance Brokers); §§ 38-43-10 to 38-43-470 (1988) (Insurance Agents); §§ 38-47-10 to 38-47-70 (1988) (Insurance Adjusters).
South Dakota		S.D. CODIFIED LAWS ANN. §§ 58-30-1 to 58-30-113 (1966/1990).
Tennessee	See page 218-10.	
Texas		TEX. INS. CODE ANN. art. 21.01 to 21.15-5 (1951/1991).
Utah		UTAH CODE ANN. §§ 31A-23-101 to 31A-23-406 (1986).
Vermont	VT. STAT. ANN. tit. 8 §§ 4791 to 4812 (1974/1985).	
Virgin Islands		V.I. CODE ANN. tit. 22 §§ 751 to 794 (1968).
Virginia		VA. CODE §§ 38.2-1800 to 38.2-1845 (1986/1991).
Washington		WASH. REV. CODE ANN. §§ 48.17.010 to 48.17.600 (1947/1985).

AGENTS AND BROKERS LICENSING MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
West Virginia		W. VA. CODE §§ 33-12-1 to 33-12-28 (1957/1990).
Wisconsin		WIS. STAT. §§ 628.01 to 628.12 (1975/1981); §§ 628.51 to 628.81 (1975/1981).
Wyoming		WYO. STAT § 26-9-101 to 26-9-139 (1921/1985). See also WYO. INS. REGS. ch. XVI (1987).

UNIFORM APPLICATION FOR INDIVIDUAL RESIDENT/NON-RESIDENT LICENSE

(Please PRINT or TYPE)

Please read carefully and complete all necessary information.

STATE FOR WHICH APPLICATION IS SOUGHT _____ ( ) Resident ( ) Non-Resident

PART I - IDENTIFICATION

A. Social Security No. _____
(Note: Your Social Security Number will only be used for purposes of computer identification in issuing your license. If you choose not to give this number, please check here. () This will not have any impact on the issuance of your license.)

B. Date of Birth ___ / ___ / ___

C. Full Legal Name of Applicant: _____
(Last) (First) (Middle Name)

D. Home Address: _____
(Street)

_____
(County) (City) (State) (Zip Code)

E. Business Address: _____
(Street) (PO Box)

_____
(City) (State) (Zip Code)

F. Home Phone No. (_____) _____ Business Phone No. (_____) _____

G. If residence address has changed during last 12 months, list former resident address for past year:

_____
(Street)

_____
(City) (State) (Zip Code)

PART II - LINES OF AUTHORITY REQUESTED (Check Appropriate Spaces)

( ) Life ( ) Accident & Health (Sickness, Disability)
( ) Property ( ) Casualty
( ) Other (please specify) _____

PART III - BACKGROUND INFORMATION

A. Do you now or have you ever held an insurance license in another state or province of Canada? If the license is still in force, attach a certification letter from the issuing state. If the license is cancelled, attach a letter of clearance from the issuing state.

B. Have you had an insurance license cancelled, refused, suspended, revoked or subject to any other disciplinary action? ( ) Yes ( ) No (If yes, provide full explanation on separate sheet of paper.)

C. Have you ever been convicted of or pled nolo contendere to any felony? ( ) Yes ( ) No If yes, attach certified copies of the final adjudication.

D. Are you an officer, director or employee of a lending institution (bank, savings and loan or other such institution which accepts deposits and lends money) or of a bank holding company or an affiliate of one of the above? ( ) Yes ( ) No
If yes, give name and address of institution. _____

_____

PART IV - APPLICANT'S CERTIFICATION

STATE OF _____

COUNTY OF _____

The undersigned, being first duly sworn, deposes and says that he has executed and read this application; that to the best of his knowledge and belief the statements made in the application and in any attachment are true and correct, and that he has read and understands the insurance laws of the State of _____, for which application is made.

_____
Signature of Applicant

SUBSCRIBED AND SWORN to before me on this _____ day of _____, 19 ____.

_____
Notary Public

Legislative history (all references are to the Proceedings of the NAIC).

1985 Proc. I 156-157 (text).
1985 Proc. II 11, 22, 184, 203, 226 (adopted).
1988 Proc. I 9, 18, 91, 102, 110-111 (amended).

STANDARD CERTIFICATION FORM

Editor's Note: The Standard Certification Form is to be used to verify the status of an agent who is seeking a non-resident license in another state.

State of _____
Department of Insurance
Licensing Unit

2. Date: 00/00/0000
Page: 1

1. (Address)_____

Re: Clearance For:

_____

I.D. 000-00-0000

_____

4. Doe, John A.

3. To: Whom it May Concern
1 Main Street
Anywhere, U.S.A 00000

(Address)_____
_____
_____

5. Official Records of the A._____ Department of Insurance indicate the above named has qualified by B. _____for the following lines of insurance:

C.	Life	on	00/00/0000
	Accident & Health	on	00/00/0000
	Variable Contract	on	00/00/0000
	Property	on	00/00/0000
	Casualty	on	00/00/0000
	Other	on	00/00/0000

6. No regulatory action has been taken against the licensee.

Following is the current licensing record for the above named:

A. 1. The last active licenses for the above named were cancelled on 00/00/0000.

B. 1. At the time of cancellation, the licensee held the following type(s) of license(s):

7. License(s):

A. Agent - Life
Accident & Health
Variable Contract
Property
Casualty
Other

B. Broker - Life
Accident & Health
Variable Contract
Property
Casualty
Other

C. 3. Individual has (not) met the pre-licensing requirements of the state.

4. Individual has (not) met the continuing education requirements of the state.

Testimony where of, I hereto set my hand at ____(City)____, this ____(Date)____ day of (month)_____, 19____.

_____
Director of Insurance

INSTRUCTIONS FOR COMPLETING THE CERTIFICATION FORM

Area 1

Should contain the name of the state, the name of the department, commission, division, section, unit, etc.. issuing the Certification and the address of the issuer of the Certification.

Area 2

Should contain the date the Certification is issued and a page number.

Area 3

Should contain the name and address of the person or entity to which the Certification is sent.

Area 4

Should identify the document and contain the identification number (Social Security number or tax identification number, if possible), name and address of the individual or entity whom the Certification is for.

Area 5

This area should contain:

A. The manner by which the individual qualified for licensure. Possibilities would include:

1. Passing the department's written examination;
2. Being licensed prior to qualification law;
3. By Certification from the State of (name of state);
4. Exemption from examination which is not required for Limited License;
5. Holding a Temporary License pending completion of examination;
6. Holding a (CLU) (CPCU) designation;
7. An optional plan approved by the state.

B. The line(s) of insurance for which the individual is qualified and the date of qualification for each. The general lines of insurance should be:

1. Life
2. Accident and Health
3. Variable Contract
4. Property
5. Casualty

Types of Limited Licenses should be categorized under one of these general lines and the Certification would, for example, read as follows:

Life -- Limited to Group Credit on 00/00/0000.
Casualty -- Limited to Crop-Hail on 00/00/0000.

Area 6

Should either state "No regulatory action has been taken against the licensee" or "Regulatory action has been taken against the licensee."

Area 7

This area should contain the following:

A. Should state either "Licensed as an agent" or "Not licensed as an agent." Where the individual is currently licensed, the expiration date of the license(s) should also appear.
Note:
If the state does not issue agent licenses, the Certification should state "Not licensed as an agent."

Should state either "Licensed as a broker" or "Not licensed as a broker." Where the individual is currently licensed, the expiration date of the license should also appear.
Note:
If the state does not issue broker licenses, the Certification should state "Not licensed as a broker."

B. For states which license firms, this area should state either "Authorized member of the following firm(s)" and list the firm name and identification (Social Security number or tax identification number if possible) or state "Not an authorized member of a firm." For states which do not license firms, this area should state "(state name) does not license firms."

C. States which recognized and license DBA's (trade or assumed names) should include them in this area. States which do not recognize or license DBA's should state "Do not recognize or license DBA's."

D. States which have pre-licensing requirements should state either "Individual has met the pre-licensing requirements of this state" or "Individual has not met the pre-licensing requirements of this state." States which do not have pre-licensing requirements or where such requirements are not applicable to the individual should state "Pre-licensing requirements not applicable."

E. States which have continuing education requirements should state either "Individual has met the continuing education requirements of this state" or "Individual has not met the continuing education requirements of this state." States which do not have continuing education requirements or where such requirements are not applicable to the individual should state "Continuing education requirements not applicable."

Area 8

This area is self-explanatory.

Legislative History (all references are to the Proceedings of the NAIC).

1984 Proc. II 9, 19, 191, 193, 195-197 (adopted).

STANDARD LETTER OF CLEARANCE

Editor's Note: The Standard Letter of Clearance is to be used in verifying the status of an agent's license in his or her state of domicile when the agent is seeking to be licensed as a registered agent in a new state.

State of _____
Department of Insurance
Licensing Unit

2. Date: 00/00/0000
Page: 1

1. _____(Address)_____
_____
_____

Re: Certification of Licensing Authority for:

3. To: Whom it May Concern
1 Main Street
Anywhere. U.S.

4. _____(Address)_____
_____
_____

5. The above names has qualified by A._____ for the following lines of insurance:

		DATE ISSUED	EXPIRATION DATE
B.	Life	00/00/0000	00/00/0000
	Accident & Health	00/00/0000	00/00/0000
	Variable Contract	00/00/0000	00/00/0000
	Property	00/00/0000	00/00/0000
	Casualty	00/00/0000	00/00/0000
	Other	00/00/0000	00/00/0000

6. No regulatory action has been taken against the licensee.

7. Following is the current licensing record for the above named:

A. 1. Not currently licensed as a broker.

B. 2. Authorized member of the following firm(s): I.D._____ Firm Name:_____

C. 3. Individual operating under the trade name(s): Name:_____

D. 4. Individual has (not) met the pre-licensing requirements of this state:

E. 5. Individual has (not) met the continuing education requirements of this state.

8. In testimony whereof. I _____. hereto set my hand at _____(City)_____. _____(State)_____ this _____(Date)_____ day of _____(Month)_____. 19_____.

_____
Director of Insurance

INSTRUCTIONS FOR COMPLETING THE CERTIFICATION

Area 1

Should contain the name of the state, the name of the department, commission, division, section, unit, etc., issuing the Clearance and the address of the issuer of the Clearance.

Area 2

Should contain the date the Clearance is issued and a page number.

Area 3

Should contain the name and address of the person or entity to which the Clearance is sent.

Area 4

Should identify the document and contain the identification number (Social Security number or tax identification number, if possible), name and address of the individual or entity whom the Clearance is for.

Area 5

This area should contain:

A. The name of the state issuing the Clearance.

B. The manner by which the individual qualified for licensure. Possibilities would include:

1. Passing the department's written examination;
2. Being licensed prior to qualification law;
3. By Certification from the State of (name of state);
4. Exemption from examination which is not required for Limited License;
5. Holding a Temporary License pending completion of examination;
6. Holding a (CLU) (CPCU) designation;
7. An optional plan approved by the state.

C. The line(s) of insurance for which the individual has qualified and the date of qualification for each. The general lines of insurance should be:

1. Life
2. Accident and Health
3. Variable Contract
4. Property
5. Casualty

Types of Limited Licenses should be categorized under one of these general lines and the Clearance would, for example, read as follows:

Life -- Limited to Group Credit on 00/00/0000.

Casualty -- Limted to Crop-Hail on 00/00/0000.

Area 6

Should either state "No regulatory action has been taken against the licensee" or "Regulatory action has been taken against the licensee."

Area 7

This area should include:

A. The date that the most recent license(s) held by the individual were cancelled.

B. If an individual held both an agent and broker license, both should be listed with the various types of insurance directly below each. If either is not applicable to the individual or the state does not issue either, it should be noted by the word "NONE." If the individual held a Limited License, it should be so identified.

C. States which have pre-licensing requirements should state either "Individual has met the pre-licensing requirements of this state" or "Individual has not met the pre-licensing requirements of this state." States which do not have pre-licensing requirements or where such requirements are not applicable to the individual should state "Pre-licensing requirements not applicable."

D. States which have continuing education requirements should state either "Individual has met the continuing education requirements of this state" or "Individual has not met the continuing education requirements of this state." States which do not have continuing education requirements or where such requirements are not applicable to the individual should state "Continuing education requirements not applicable."

Area 8

This area is self-explanatory.

Legislative History (all references are to the Proceedings of the NAIC).

1984 Proc. II 9, 19, 191, 193, 198-200 (adopted).

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EXHIBIT B

MODEL LEGISLATION TO MODIFY SCHEDULE "P"

Table of Contents

Section 1. Property and Liability Reserve Requirements.

Each insurance company transacting business in this State shall, at all times, maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported, which are unpaid and for which such company may be liable and to provide for the expenses of adjustment or settlement of losses and claims. Such reserves shall be computed in accordance with regulations made from time to time by the (Commissioner, Superintendent, Director), after due notice and hearing, upon reasonable consideration of the ascertained experience and the character of such kinds of business for the purpose of adequately protecting the insured and securing the solvency of such company.

Section 2. Inadequate Reserves.

Whenever the loss and loss expense experience of such company shows the reserves, calculated in accordance with such regulations, to be inadequate, the (Commissioner, Superintendent, Director) may require such company to maintain additional reserves.

Section 3. Minimum Reserve Requirements for Certain Lines.

The minimum reserve requirements prescribed by the (Commissioner, Superintendent, Director) in the regulations promulgated under authority of this section for unpaid losses and loss expenses incurred during each of the most recent three years for coverages included in the lines of business described in the annual statement as workmen's compensation, liability other than auto (B.I.), and auto liability (B.I.) shall not be less than the following: for workmen's compensation, 65% of premiums earned during each year less the amount already paid for losses and expenses incidental thereto incurred during said year; for liability other than auto (B.I.) and auto liability (B.I.), 60% of premiums earned during each year less the amount already paid for losses and expenses incidental thereto incurred during said year.

Section 4. Power of Commissioner.

The (Commissioner, Superintendent, Director) may, by regulation, prescribe the manner and form of reporting pertinent information concerning the reserves provided for herein.

Legislative History (all references are to the Proceedings of the NAIC).

1968 Proc. II 498, 501-502, 567 (adopted).

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EXHIBIT C

MODEL LAW ON EXAMINATIONS

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Prefatory Drafting Comment

This model act reflects a conceptual change with respect to the frequency and scope of on-site financial examinations of insurers. The Act authorizes the Commissioner to conduct examinations whenever it is deemed necessary and the Commissioner is given the flexibility to decide the scope of the examination. Since criteria for determining when a company should be examined and the scope of that examination and procedures to be employed is a complex matter, the Act requires the Commissioner to observe the direction set forth in the NAIC Examiner's Handbook with respect to these matters.

The objective of the Model Act is to direct Department resources to companies having or likely to have financial difficulty; however, all companies are required to be examined once every five years, although the scope and extent of that exam will be based on the particular attributes of the company to be examined.

The conceptual change reflected by this Model Law can be accomplished because over the last several years a variety of additional financial regulatory tools have been developed and implemented including annual independent CPA audits, opinions on insurance reserves by qualified actuaries, annual financial statement analyses and others which alleviate the necessity for comprehensive periodic examinations.

This Model Act will not diminish the Commissioner's authority to conduct examinations but rather will see that examinations are a more effective part of the Department financial regulation and surveillance program.

Section 1. Purpose

The purpose of this Act is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this State and all persons otherwise subject to the jurisdiction of the Commissioner. The provisions of the Act are intended to enable the Commissioner to adopt a flexible system of examinations which directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this State.

Section 2. Definitions

The following terms as used in this Act shall have the respective meanings hereinafter set forth:

A. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: The title of the chief insurance regulatory official should be used here and throughout the law.

B. "Company" means 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 Commissioner.

C. "Department" means the Department of Insurance of this State.

D. "Examiner" means any individual or firm having been authorized by the Commissioner to conduct an examination under this Act.

E. "Insurer" means [refer to appropriate definition in state insurance code].

F. "Person" means any individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

Section 3. Authority, Scope and Scheduling of Examinations

A. The Commissioner or any of his examiners may conduct an examination under this Act of any company as often as the Commissioner in his or her 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 Commissioner 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 Commissioner exercises discretion under this section.

B. For purposes of completing an examination of any company under this Act, the Commissioner may examine or investigate any person, or the business of any person, in so far as such examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the company.

Drafting Note: In order to force a person outside the state to cooperate with any examination, it may be necessary to obtain judicial enforcement of a subpoena.

C. In lieu of an examination under this Act of any foreign or alien insurer licensed in this State, the Commissioner 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 state until January 1, 1994. Thereafter, such reports may only be accepted if (1), 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 (2) the examination is performed under the supervision of an accredited Insurance Department or with the participation of one 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.

Section 4. Conduct of Examinations

A. Upon determining that an examination should be conducted, the Commissioner or the Commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

B. Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under Subsection A timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The

refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the Commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to Section [insert reference to cease and desist statute or other law having a post-order hearing mechanism].

C. The Commissioner or any of his examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. [*or* "Such subpoenas may be enforced pursuant to the provisions of Section _____ of this Code."]

D. When making an examination under this Act, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

E. Nothing contained in this Act shall be construed to limit the Commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this State. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

F. Nothing contained in this Act shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

Section 5. Examination Reports

A. General Description

All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

B. Filing of Examination Report

No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

C. Adoption of Report on Examination

Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the Commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order:

(1) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Commissioner, the Commissioner may order the company to take any action the Commissioner considers necessary and appropriate to cure such violation; or

(2) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to Subsection A above; or

(3) Calling for an investigatory hearing with no less than twenty (20) days notice to the company for purposes of obtaining additional documentation, data, information and testimony.

D. Orders and Procedures

(1) All orders entered pursuant to Subsection C(1) above shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed pursuant to the [insert name of State Administrative Review Law], and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) Any hearing conducted under Subsection C(3) above by the Commissioner or authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the Commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within twenty (20) days of the conclusion of any such hearing, the Commissioner shall enter an order pursuant to Subsection C(1) above.

(a) The Commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers which tend to substantiate any assertions set forth in any written submission or rebuttal. The Commissioner or his representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the Department, the company or other persons. The documents produced shall be included in the record and testimony taken by the Commissioner or his representative shall be under oath and preserved for the record.

Nothing contained in this section shall require the Department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(b) The hearing shall proceed with the Commissioner or his representative posing questions to the persons subpoenaed. Thereafter the company and the Department may present testimony relevant to the investigation. Cross examination shall be conducted only by the Commissioner or his representative. The company and the Department shall be permitted to make closing statements and may be represented by counsel of their choice.

E. Publication and Use

(1) Upon the adoption of the examination report under Subsection C(1) above, the Commissioner shall continue to hold the content of the examination report as private and confidential information for a period of [insert number] days except to the extent provided in Subsection B. Thereafter, the Commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

Drafting Note: The time period may correspond to the amount of time allowed for a party to seek administrative review under state law or it should at a minimum allow a company adequate time, not less than two (2) days following receipt of the adopted report to obtain an equitable stay if provided for under state law.

(2) Nothing contained in this Code shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Act.

(3) In the event the Commissioner determines that regulatory action is appropriate as a result of any examination, he or she may initiate any proceedings or actions as provided by law.

F. Confidentiality of Ancillary Information

All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this Act must be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person, except to the extent provided in Subsection E above. Access may also be granted to the National Association of Insurance Commissioners. Such parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

Drafting Note: As an alternative, states may make reference to their public records law as follows: "All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this Act may be held by the Commissioner as a record not required to be made public pursuant to [cite public records laws].

Section 6. Conflict of Interest

No examiner may be appointed by the Commissioner if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Act. This section shall not be construed to automatically preclude an examiner from being:

A. A policyholder or claimant under an insurance policy;

B. A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

C. An investment owner in shares of regulated diversified investment companies: or

D. A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

Notwithstanding the requirements of this section, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this Act.

Section 7. Cost of Examinations

Drafting Comment: The NAIC Model State Insurance Department Funding Bill or such funding mechanism as may be currently authorized by law should be incorporated here by reference. Any funding mechanism should assure that the manner in which examinations are funded does not influence the scheduling, scope or conduct of examination.

Section 8. Immunity from Liability

A. No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

B. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Act, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

C. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Subsection A.

D. A person identified in Subsection A shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Legislative History (all references are to the Proceedings of the NAIC*)*

1991 Proc. I 9, 14, 26, 27–31 (adopted).

This replaces an earlier model law entitled: Standard Law Relating to Procedures in Examining the Affairs of Insurance Companies

1956 Proc. II 328, 329–333 (adopted).

MODEL LAW ON EXAMINATIONS

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama		ALA. CODE §§ 27-2-20 to 27-2-27 (1971).
Alaska	ALASKA STAT. §§ 21.06.120 to 21.06.170 (1966/1992).	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-142, 20-156 to 20-160 (1954/1989).
Arkansas	ARK. STAT. ANN. §§ 23-61-201 to 23-61-302 (1959/1991).	
California	CAL. INS. CODE §§ 730 to 738 (1935/1992).	
Colorado	COLO. REV. STAT. §§ 10-1-201 to 10-1-207 (1992).	
Connecticut	CONN. GEN. STAT. § 38a-14 (1949/1992).	
Delaware		DEL. CODE ANN. tit. 18 §§ 322 to 333 (1956/1991).
D.C.		D.C. CODE ANN. § 35-418 (1934/1973) (Life); § 35-1513 (1940/1973) (P/C).
Florida		FLA. STAT. §§ 624.316 to 624.322 (1959/1990).
Georgia		GA. CODE ANN. §§ 33-2-11 to 33-2-16 (1960/1992).
Guam		GUAM GOV'T. CODE §§ 43028 to 43031 (1981).
Hawaii		HAWAII REV. STAT. §§ 431:2-301 to 431:2-308 (1988).
Idaho		IDAHO CODE §§ 41-219 to 41-230 (1961/1984).

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Illinois	SB 267 (1991).	
Indiana	IND. CODE §§ 27-1-3.1-1 to 27-1-3.1-18 (1991).	
Iowa	IOWA CODE §§ 507.1 to 507.17 (1965/1992).	
Kansas	KAN. STAT. ANN. §§ 40-222 (1991).	
Kentucky		KY. REV. STAT §§ 304.2-210 to 304.2-300 (1970/1982).
Louisiana	LA. REV. STAT. ANN. §§ 20:1301 to 20:1302 (1979/1992).	
Maine		ME. REV. STAT. ANN. tit. 24-A §§ 221 to 228 (1970/1992).
Maryland		MD. ANN. CODE art. 48A §§ 30 to 34 (1963/1981).
Massachusetts		MASS. GEN. LAWS ch. 175 § 4 (1941/1987).
Michigan		MICH. COMP. LAWS § 500.222 (1957/1959).
Minnesota	MINN. STAT § 60A.031 (1961/1992).	
Mississippi	HB 606 (1992)	MISS. CODE ANN. §§ 83-1-23 to 83-1-27 (1972/1984).
Missouri	MO. REV. STAT. §§ 374.202 to 374.207 (1992).	
Montana		MONT. CODE ANN. §§ 33-1-401 to 33-1-413 (1959/1979).
Nebraska	Bulletin CB-80 contains some standards from model; regulation pending (1992).	NEB. REV. STAT. §§ 44-105 to 44-111.01 (1957/1989).
Nevada		NEV. REV. STAT. §§ 679B.230 to 679B.300 (1971/1983)

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
New Hampshire	N.H. REV. STAT. ANN. § 400-A:37 (1979/1992).	
New Jersey		N.J. REV. STAT. §§ 17:23-4 to 17:23-7 (1958).
New Mexico		N.M. STAT. ANN. §§ 59A-4-4 to 59A-4-14 (1985/1991).
New York		N.Y. INS. LAW § 309 to 313 (1984).
North Carolina	N.C. GEN. STAT. §§ 58-2-131 58-2-133 (1991).	
North Dakota		N.D. CENT. CODE §§ 26.1-03-19 to 26.1-03-22 (1983/1989).
Ohio		OHIO REV. CODE ANN. §§ 3901.07 to 3901.071 (1978/1991).
Oklahoma	OKLA. STAT. tit. 36 §§ 309.1 to 309.7 (1991).	
Oregon		OR. REV. STAT. §§ 731.300 to 731.316 (1967/1981).
Pennsylvania	SB 1086 pending (1991).	PA. STAT. ANN. tit. 40 §§ 40-1-214 to 40-1-221 (1921/1947).
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 214 to 226.
Rhode Island	R.I. GEN. LAWS §§ 27-13.1-1 to 27-13.1-7 (1992).	R.I. GEN. LAWS §§ 27-1-11 to 27-1-12 (1896/1953); §§ 27-13-1 to 7-13-5 (1896/1982).
South Carolina	S.C. CODE ANN. §§ 38-13-10 to 38-10-60 (1992).	
South Dakota	SB 59 (1992).	S.D. CODIFIED LAWS ANN. §§ 58-3-1 to 58-3-15 (1966/1977).

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Tennessee		TENN. CODE ANN. § 56-1-401 (1932); §§ 56-1-408 to 56-1-413 (1895/1971).
Texas		TEX. INS. CODE ANN. art. 1.15 to 1.19 (1951/1985).
Utah		UTAH CODE ANN. §§ 31A-2-203 to 31A-2-205 (1985/1986); See also UTAH INS. REG. R590-150-1 to 590-150-4 pending (1992).
Vermont	VT. STAT. ANN. tit. 8 §§ 3563 to 3576 (1967/1992).	
Virgin Islands		V.I. CODE ANN. tit. 22 §§ 101 to 108 (1968).
Virginia	VA. CODE §§ 38.2-1317 to 38.2-1321.1 (1986/1992).	
Washington		WASH. REV. CODE ANN. §§ 48.03.010 to 48.03.070 (1947/1982).
West Virginia		W.VA. CODE § 33-2-9 (1957/1991).
Wisconsin		WIS. STAT. §§ 601.43 to 601.45 (1969/1985).
Wyoming		WYO. STAT. §§ 26-2-116 to 26-2-124 (1925/1992).

EXHIBIT D

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known as the [state] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

(1) life, annuity, health or disability insurance;

(2) mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;

(3) fidelity or surety bonds, or any other bonding obligations;

(4) credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction.

(5) insurance of warranties or service contracts;

(6) title insurance;

(7) ocean marine insurance;

(8) any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

(9) any insurance provided by or guaranteed by government.

Comment: This bill focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The bill further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these.

"Financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether such failure is the result of a financial default or insolvency and whether or not such obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;

2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;

3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;

4. Changes in the value of specific assets or commodities, or price levels in general.

"Credit insurance" as used here is intended to mean insurance on accounts receivable.

It is intended that the terms "disability insurance" and "accident and health insurance," and "health insurance" be synonymous. Each state will wish to examine its own statutes to determine which is the appropriate phrase. In addition, states that have not enacted the Life and Health Insurance Guaranty Association Model Act, and that allow property and casualty insurers to write health insurance, may wish to delete health insurance written by property and casualty insurers from the list of scope exclusions.

Section 4. Construction

This Act shall be liberally construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional

(1) "Account" means any one of the three accounts created by Section 6.]

Comment: This definition should be used by those states wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the comment after Section 6. If this definition is used, all subsequent sections should be renumbered.

(1) "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(2) "Association" means the [state] Insurance Guaranty Association created under Section 6.

(3) "Claimant" means any insured making a first party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(4) "Commissioner" means the Commissioner of Insurance of this State.

(5) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

(6) "Covered claim" means an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies issued by an insurer, if such insurer becomes an insolvent insurer after the effective date of this Act and:

(a) the claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or

(b) the property from which the claim arises is permanently located in this state.

"Covered claim" shall not include any amount awarded as punitive or exemplary damages; sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries or otherwise.

Comment: The subcommittee feels that the claims covered by the Association should include all claims, including unearned premiums, arising from the policies of the insolvent insurer. A state may wish to exclude unearned premiums, in which case "excluding" should be substituted for "including" in the first line. However, recovery from this state's Association should be limited to persons having sufficient contacts with the state. The subcommittee does not feel that coverage should be extended to elements of the insurance industry which know or reasonably can be expected to know the financial condition of various companies.

(7) "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom an order of liquidation with a finding of insolvency has been entered after the effective date of this Act by a court of competent jurisdiction in the insurer's

state of domicile or of this state under the provision(s) of Section ____ of ____, and which order of liquidation has not been stayed or been the subject of a writ of supersedes or other comparable order.

(8) "Member insurer" means any person who:

(a) writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and

(b) is licensed to transact insurance in this state (except at option of state).

Comment: A state may wish to exempt from the Act certain kinds of companies: such as farmer, county, township or assessment mutuals, fraternals or nonprofit service plans.

(9) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Act applies, less return premiums thereon and dividends paid or credit to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(10) "Person" means any individual, corporation, partnership, association or voluntary organization.

Comment: In some states it may be necessary to add reciprocals and insurance exchanges to this definition. Each state will wish to examine its own statutes to determine whether this definition and the others listed above should be deleted and to determine whether additional definitions are necessary.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [state] Insurance Guaranty Association. All insurers defined as member insurers in Section 5(8) 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 a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[***Alternate Section 6. Creation of the Association***

There is created a nonprofit unincorporated legal entity to be known as the (state) Insurance Guaranty Association. All insurers defined as member insurers in Section 5(8) 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 a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the Association shall be divided into three separate accounts: (a) the workmen's compensation insurance account; (b) the automobile insurance account; and (c) the account for all other insurance to which this Act applies.]

Comment: Although the Association is created here as a "nonprofit unincorporated legal entity," each state will wish to examine its law to determine whether some alteration in this terminology is desirable.

The alternate Section 6 should be used if a state, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Such separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8(1)(c) and 8(2)(f) and optional Section 5(1) should also be used.

Section 7. Board of Directors

(1) The board of directors of the Association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies on the board 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 Commissioner. If no members are selected within sixty days after the effective date of this Act, the Commissioner may appoint the initial members of the board of directors.

(2) In approving selections to the board, the Commissioner 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.

Comment: The number of members on the board of directors may be left open to some extent, as it is here, or it may be specified. The same holds true for the terms of office. A state may also wish to provide that a majority of the members of the board represent domestic insurers.

Section 8. Powers and Duties of the Association

(1) The Association shall:

(a) be obligated to pay covered claims existing prior to the determination of the insolvency arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if he does so within thirty days of the determination. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(i) the full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) an amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium;

(iii) an amount not exceeding $300,000 per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include any claim filed with the Guaranty Fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The Association shall pay only that amount of each unearned premium which is in excess of $100.

Comment: The obligation of the Association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is cancelled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the Association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no

corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to $10,000, against the Association. The deductible amount ($100) and the maximums ($10,000 for the return of unearned premium; $300,000 for all other covered claims) represent the subcommittee's concept of practical limitations, but each state will wish to evaluate these figures.

[Alternate Section 8(1)(a)

(1) The Association shall:

(a) be obligated to pay covered claims existing prior to the determination of the insolvency arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if he does so within thirty days of the determination. Such obligation shall extend to covered claims reported pursuant to an optional extended period to report claims sold to the insured by the liquidator. The obligation as to covered claims shall be satisfied by paying to the claimant an amount as follows:

(i) the full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) an amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium;

(iii) an amount not exceeding $300,000 per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provision of this Act, a covered claim shall not include any claim filed with the Guaranty Fund after the earlier of the final date for the filing of claims against the liquidator or receiver of an insolvent insurer or eighteen months after the order of liquidation. The Association shall pay only that amount of each unearned premium which is in excess of $100.]

Comment: The alternate Section 8(1)(a) should be used if the state includes a provision in its liquidation law giving the liquidator authority to sell a limited extended reporting period for claims-made policies.

(b) be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.

(c) assess insurers amounts necessary to pay the obligations of the Association under Section 8(1)(a) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers and for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment,

together with the other assets of the Association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it may deem reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments.

[*Alternate Section 8(1)(c)*

(c) Allocate claims paid and expenses incurred among the three accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the Association under Section 8(1)(a) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any one year on any account an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it deems reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.]

Comment: The maximum assessment per year may be varied from state to state depending on the size of the base. The figure used should produce sufficient funds to handle any possible insolvency, keeping in mind that the total amount may not be needed in one year. The two percent maximum used here would have produced in 1968 on a nationwide basis, from the kinds of insurance to which this Act applies, approximately $500,000,000.

(d) investigate claims brought against the Association and adjust, compromise, settle and pay covered claims to the extent of the Association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.

(e) notify such persons as the Commissioner directs under Section 10(2)(a).

Comment: The liquidation statutes of the state may describe the persons to be notified by the liquidator, but since this Association provides a distinctive service, the Commissioner may wish to require a separate notification by it.

(f) handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but such designation may be declined by a member insurer.

(g) reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association and shall pay the other expenses of the Association authorized by this Act.

(2) The Association may:

(a) employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(b) borrow funds necessary to effect the purposes of this Act in accord with the plan of operation;

(c) sue or be sued;

(d) negotiate and become a party to such contracts as are necessary to carry out the purpose of this Act;

(e) perform such other acts as are necessary or proper to effectuate the purpose of this Act;

(f) refund to the member insurers in proportion to the contribution of each member insurer to the Association that amount by which the assets of the Association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association exceed the liabilities of the Association as estimated by the board of directors for the coming year.

[Alternate Section 8(2)(f)

(f) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]

Comment: The subcommittee feels that the board of directors should determine the amount of the refunds to members when the assets of the Association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

Section 9. Plan of Operation

(1) (a) The Association shall submit to the Commissioner 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 approval in writing by the Commissioner.

(b) If the Association fails to submit a suitable plan of operation within ninety days following the effective date of this Act, or if at any time thereafter the Association fails to submit suitable amendments to the plan; the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

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

(3) The plan of operation shall:

(a) establish the procedures whereby all the powers and duties of the Association under Section 8 will be performed;

(b) establish procedures for handling assets of the Association;

(c) establish the amount and method of reimbursing members of the board of directors under Section 7;

(d) establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of claims shall be periodically submitted to the Association or similar organization in another state by the receiver or liquidator;

Comment: On the general subject of the relationship of the Association to the liquidator, the subcommittee takes the position that since this is a model state bill, it will be able to bind only two parties, the Association and the in-state liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-state liquidators and the requirements placed on in-state liquidators in relation to out-of-state associations.

(e) establish regular places and times for meetings of the board of directors;

(f) establish procedures for records to be kept of all financial transactions of the Association, its agents and the board of directors;

(g) provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within thirty days after the action or decision;

(h) establish the procedures whereby selections for the board of directors will be submitted to the Commissioner;

(i) 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 Section 8(1)(c) and 8(2)(b), 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 or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, 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 Act.

Comment: The subcommittee recognizes current discussion at both the regulatory and industry levels concerning the possible creation of a nonfederal interstate organization to perform various functions relating to the protection of policyholders and claimants from insurer insolvency. It is difficult at present to predict the type of interstate arrangement which may evolve. At the same time, the subcommittee would like to avoid the necessity of returning to each state legislature if a desirable, nonfederal interstate approach is developed. Consequently, this subsection, with appropriate standards and regulatory safeguard, provides a highly flexible transition device. The subsection operates on the theory of a revocable delegation of functions in the plan of operations if approved by the industry and the Commissioner. The board of directors would continue in existence in each state which would, among other things, provide the commissioner with a contact for his regulatory control. In addition, membership would continue to be mandatory state by state as recognized under this bill and no new legislation would be necessary. This approach would permit the gradual development (e.g. a partial delegation of powers) of an interstate system as opposed to an all or nothing choice. Finally, it should be noted that the Association may not delegate its powers to assess or borrow money. Assessment would continue to be made on a state by state basis in accordance with the provisions of the individual state statutes.

Section 10. Duties and Powers of the Commissioner

(1) The Commissioner shall:

(a) notify the Association of the existence of an insolvent insurer not later than three days after he receives notice of the determination of the insolvency. The Association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction;

(b) upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer.

(2) The Commissioner may:

(a) require that the Association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this Act. Such notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient;

(b) suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed five percent of the unpaid assessment per month, except that no fine shall be less than $100 per month;

(c) revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(3) Any final action or order of the Commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Comment: This subsection may be omitted if the insurance statutes of a state provide for judicial review of all actions or orders of the Commissioner.

Section 11. Effect of Paid Claims

(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 and except as provided in Subsection (2) below. 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 the insureds to the receiver, liquidator or statutory successor for unpaid assessments.

(2) The Association shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person pursuant to the Act:

(a) any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds $50 million and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act; and

Comment: The reference to "liability obligations" includes obligations under workers' compensation insurance coverages.

(b) any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act.

Comment: The term "net worth" would not apply to state and local governmental units which, in accounting parlance, have "fund balances" rather than net worth.

(3) The receiver, liquidator or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Association or a similar organization in another state. The court having jurisdiction shall grant 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.

Comment: The priority of claims against the assets of the insolvent insurer may be determined by the liquidation statutes. States which do not set such priorities by the statute may wish to revise the language in this subsection. It seems probable that the courts would treat claims by the Association on the basis of the underlying claim, as this subsection requires, even in the absence of this provision.

(4) 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.

Section 12. Nonduplication of Recovery

(1) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his right under such policy. Any amount payable on a covered claim under this Act shall be reduced by the amount of any recovery under such insurance policy.

(2) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first, from the Association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the Association of the location of the property, and if it is a workers' compensation claim, he shall seek recovery first from the Association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

Comment: This subsection does not prohibit recovery from more than one Association, but it does describe the Association to be approached first and then requires that any previous recoveries from like Associations must be set off against recoveries from this Association.

Section 13. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

(1) The board of directors may, upon majority vote:

(a) make recommendations to the Commissioner for the detection and prevention of insurer insolvencies; and

(b) respond to requests by the Commissioner to discuss and make recommendations regarding the status of any member insurer whose financial condition may be hazardous to policyholders or the public. Such recommendations shall not be considered public documents.

(2) The board of directors may, at the conclusion of any domestic insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the Association and submit such report to the Commissioner.

Section 14. Examination of the Association

The Association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

Section 15. Tax Exemption

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Section 16. Recognition of Assessments in Rates

The rates and premiums charged for insurance policies to which this Act applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association by the member insurer less any amounts returned to the member insurer by the Association and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

Comment: Although generally rates are prospective in nature, this section would permit recoupment of amounts assessed in the past.

Section 17. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act.

Section 18. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for six months and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state whichever is later, to permit proper defense by the Association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the Association either on its own behalf or on behalf of such insured may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and shall be permitted to defend such claim on the merits.

The liquidator, receiver, or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

General Comments: Each state may wish to consider the following when preparing this bill:

1. **The addition of an effective date section.**

2. **The addition of a section amending the state retaliatory law so that assessments by insurance guaranty associations or similar organizations are not considered in determining retaliatory taxation.**

3. The addition of a section amending the state liquidation statute to permit or require the liquidator to make periodic partial payments to the Association. This will serve to reduce the size and frequency of assessments.

4. The addition of a section specifically permitting or prohibiting advertisements by member insurers which include a reference to coverage of the insurance guaranty association.

Recommendations: Formula to Recoup Assessments

The task force, in making the following recommendation, considered among other subjects the lines of business affected how long a time period should the procedures apply the magnitude of the increment in the rate-making formula individual policyholder equity, and flexibility in the operation, surveillance and application of this recommendation.

It is recommended by the task force that the following formula be incorporated in the rate-making procedure of the various states:

1. Insurance companies in a state having a guaranty fund law may add .001 to "taxes, licenses and fees" in their rate-making or rate review formulas for lines of business subject to the guaranty fund law under the following conditions:

   (a) The state's guaranty fund total assessments paid and payable and accumulated through December 31 of the preceding year have exceeded $100,000 in that state for all accounts; and

   (b) The difference between (i) and (ii) below is less than one-half percent of the subject premium in the most recently available calendar year:

      (i) The amount generated by multiplying the sum of premiums subject to guaranty fund assessment by .001 for the period the .001 increment may be in effect.

      (ii) The amount of accumulated fund assessment paid or payable.

2. When the amount determined in 1(b) above exceeds one-half of one percent of premiums in the most recently available calendar year, the use of the .001 increment will not be permitted in future rate-making or rate review. If additional or subsequent assessments are made the use of the .001 increment may be reenacted subject to the criteria under 1(a) and 1(b) above.

3. In states where the assessment indicates the .001 increment is inadequate to recoup such assessments within a reasonable period of time, it is recommended by the task force that the increment be increased so that recoupment can be achieved in a reasonable period of time.

Legislative History (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984 Proc. I 6, 31, 196, 326, 352 (amended).
1986 Proc. II 410-411 (Amendments adopted later printed here).
1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA. CODE §§ 27-42-1 to 27-42-20 (1981) (Uses separate account option).	
Alaska	ALASKA STAT. §§ 21.80.010 to 21.80.190 (1970/1985) (Uses separate account option).	
Arizona	ARIZ. REV. STAT. ANN. §§ 20-661 to 20-680 (1977/1992).	
Arkansas		ARK. STAT. ANN. §§ 23-90-101 to 23-90-123 (1977/1987).
California		CAL. INS. CODE §§ 1063 to 1063.15 (1969/1992).
Colorado	COLO. REV. STAT. §§ 10-4-501 to 10-4-519 (1963/1989) (Uses separate account option.)	
Connecticut	CONN. GEN. STAT. §§ 38a-836 to 38a-853 (1971/1990) (Uses separate account option).	
Delaware	DEL. CODE ANN. tit.18 §§ 4201 to 4221 (1982/1991).	
D.C.	D. C. CODE ANN. §§ 35-1901 to 35-1917 (1973).	
Florida	FLA. STAT. §§ 631.50 to 631.70 (1982/1987).	
Georgia		GA. CODE §§ 33-36-1 to 33-36-19 (1970/1989).
Guam	NO ACTION TO DATE	
Hawaii	HAWAII REV. STAT. §§ 431:16-101 to 431:16-117 (1988).	
Idaho	IDAHO CODE §§ 41-3601 to 41-3621 (1970/1992) (Uses separate account option).	

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Illinois	ILL. REV. STAT. ch. I. C. §§ 532 to 553 (1977/1990) (Uses separate account option).	
Indiana	IND. CODE §§ 27-6-8-1 to 27-6-8-19 (1973/1988) (Uses separate account option.)	
Iowa	IOWA CODE §§ 515B.1 to 515B.26 (1970/1991).	
Kansas	KAN. STAT. ANN. §§ 40-2901 to 40-2919 (1970/1986).	
Kentucky	KY. REV. STAT. §§ 304.36-010 to 304.36-170 (1972/1990).	
Louisiana	LA. REV. STAT. ANN. §§ 22:1375 to 22:1394 (1970/1992).	
Maine	ME. REV. STAT. ANN. tit. 24-A §§ 4431 to 4452 (1969/1990) (Uses separate account option).	
Maryland	MD. ANN. CODE tit. 48A §§ 504 to 519 (1971/1988).	
Massachusetts	MASS. GEN. LAWS ch. 175D §§ 1 to 16 (1970/1989).	
Michigan		MICH. COMP. LAWS §§ 500.790 to 500.7949 (1969/1982).
Minnesota	MINN. STAT. §§ 60C.01 to 60C.20 (1971/1991) (Uses separate account option).	
Mississippi	MISS. CODE ANN. §§ 83-23-101 to 83-23-137 (1970/1992).	
Missouri	MO. REV. STAT. §§ 375.771 to 375.780 (1971/1991) (Uses separate account option).	
Montana	MONT. CODE ANN. §§ 33-10-101 to 33-10-117 (1971).	

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Nebraska	NEB. REV. STAT. §§ 44-2401 to 44-2418 (1971/1990) (Uses separate account option).	
Nevada	NEV. REV. STAT. §§ 687A.010 to 687A.160 (1971/1989).	
New Hampshire	N.H. REV. STAT. ANN. §§ 404-B:1 to 404-B:18 (1970) (Uses separate account option).	
New Jersey	N.J. STAT. ANN. §§ 17:30A-1 to 17:30A-20 (1974).	
New Mexico	N.M. STAT. ANN. §§ 59A-43-1 to 59A-43-18 (1985/1989). (Uses separate account option).	
New York		N.Y. INS. LAW §§ 7601 to 7614 (1984/1989).
North Carolina	N.C. GEN. STAT. §§ 58-48-1 to 58-48-130 (1971/1992) (Uses separate account option).	
North Dakota	N.D. CENT. CODE §§ 26.1-42-01 to 26.1-42-15 (1985/1991).	
Ohio	OHIO REV. CODE ANN. §§ 3955.01 to 3955.21 (1970) (Uses separate account option).	
Oklahoma	OKLA. STAT. tit. 36 §§ 2001 to 2019 (1980/1988) (Uses separate account option).	
Oregon	OR. REV. STAT. §§ 734.510 to 734.710 (1971/1977).	
Pennsylvania	PA. STAT. ANN. tit. 40 §§ 51-101 to 51-603 (1970).	
Puerto Rico	P.R. LAWS ANN. tit. 26 §§ 3801 to 3819 (1974/1980)	
Rhode Island	R. I. GEN. LAWS §§ 27-34-1 to 27-34-19 (1988/1991) (Uses separate account option.)	

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
South Carolina	S. C. CODE ANN. §§ 38-31-10 to 38-31-180 (1988/1991) (Uses separate account option).	
South Dakota		S. D. CODIFIED LAWS ANN. §§58-29A-1 to 58-29A-53 (1970/1990)(Uses separate accounts).
Tennessee	TENN. CODE ANN. §§ 56-12-101 to 56-12-119 (1971/1989).	
Texas	TEX. INS. CODE 21.28-C (1991) (Uses separate account option).	
Utah	UTAH CODE ANN. §§ 31A-28-201 to 31A-28-220 (1986/1991) (Uses separate account option).	See also INS. DEPT. REG. 71-3 (1971).
Vermont	VT. STAT. ANN. tit. 8 §§ 3611 to 3633 (1969/1979) (Uses separate account option).	
Virgin Islands	NO ACTION TO DATE	
Virginia	VA. CODE §§ 38.2-1600 to 38.2-1623 (1986/1987).	
Washington	WASH. REV. CODE §§ 48.32.010 to 48.32.930 (1971/1975-76) (Uses separate account option).	
West Virginia	W. VA. CODE §§ 33-26-1 to 33-26-19 (1970) (Uses separate account option).	
Wisconsin		WIS. STAT §§ 646.01 to 646.73 (1979/1988) ("Insurance Security Fund").
Wyoming	WYO. STAT §§ 26-31-101 to 26-31-117 (1971/1990).	

EXHIBIT E

MODEL SURPLUS LINES LAW

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as "The Surplus Lines Law."

Section 2. Purpose—Necessity for Regulation

This Act shall be liberally construed and applied to promote its underlying purposes which include:

A. Protecting persons seeking insurance in this state;

B. Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to this Act;

C. Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state; and

D. Protecting revenues of this state.

Section 3. Definitions

As used in this Act:

A. "Admitted insurer" means an insurer licensed to do an insurance business in this state.

B. "Capital", as used in the financial requirements of Section 5, means funds paid in for stock or other evidence of ownership.

C. "Commissioner" means the Commissioner of Insurance of this state.

D. "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under Section 5 of this Act.

E. "Export" means to place surplus lines insurance with a nonadmitted insurer.

F. "Kind of insurance" means one of the types of insurance required to be reported in the annual statement which must be filed with the Commissioner by licensed insurers.

G. "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this state. This definition shall include insurance exchanges as authorized under the laws of various states.

H. "Producing broker" means the individual broker or agent dealing directly with the party seeking insurance.

I. "Reciprocal State" means a state that has enacted provisions substantially similar to those contained in:

(1) Sections 17J, 18D, 19(A), 19(C), 19(D) and 21(E) herein;

(2) The allocation schedule and reporting form contained in The NAIC Model Regulation on Surplus Lines Taxation; and

Editor's Note: This model regulation does not yet exist, but is in the process of development.

(3) Section 6 of the NAIC Model Non-Admitted Insurance Act regarding taxation of premiums in independently procured insurance.

Note: This may result in a broker having to pay greater than 100% tax.

J. "Surplus", as used in the financial requirements of Section 5, means funds over and above liabilities and capital of the company for the protection of policyholders.

K. "Surplus lines insurance" means any insurance in this state of risks resident, located or to be performed in this state, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, wet marine and transportation insurance, insurance independently procured, and life and health insurance and annuities.

L. "Surplus lines licensee" means an individual (firm or corporation) licensed under Section 15 of this Act to place insurance on risks resident, located or to be performed in this state with nonadmitted insurers eligible to accept such insurance.

M. "Wet marine and transportation insurance" means:

(1) Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

(2) Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

(3) Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and

(4) Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto.

Section 4. Placement of Surplus Lines Insurance

Insurance may be procured through a surplus lines licensee from nonadmitted insurers if:

A. Each insurer is an eligible surplus lines insurer;

B. The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this state. Such full amount or kind of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular kind and class of insurance in this state; and

C. All other requirements of this Act are met.

Section 5. Eligible Surplus Lines Insurers Required

No surplus lines licensee shall place any coverage with a nonadmitted insurer, unless, at the time of placement, such nonadmitted insurer:

A. Has established satisfactory evidence of good repute and financial integrity; and

B. Qualifies under one of the following paragraphs:

(1) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals:

(a) (1) This state's minimum capital and surplus requirements under the laws of this state, or

(2) $15,000,000, whichever is greater; except that nonadmitted insurers already qualified under this Act shall have $10,000,000 by December 31, 1990; $12,500,000 by December 31, 1991; and $15,000,000 by December 31, 1992.

(b) The requirements of this paragraph may be satisfied by an insurer possessing less than the aforementioned capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $4,500,000.

(2) In the case of an "Insurance Exchange" created by the laws of individual states, maintains capital and surplus, or the substantial equivalent thereof, of not less than $50,000,000 in the aggregate. For Insurance Exchanges which maintain funds for the protection of all Insurance Exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than $3,000,000. In the event the Insurance Exchange does not maintain funds for the protection of all Insurance Exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of Section 5B(1).

C. (1) In addition, an insurer not domiciled in one of the United States, its territories or Canada must have in force in the United States an irrevocable trust account in a qualified U.S. financial institution, on behalf of U.S. policyholders of not less than $2,500,000 and consisting of cash, securities, letters of credit, or of investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this state. Such trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five (5) years; or

Drafting Note: The Commissioners may wish to establish the authority to set a higher level on a case by case basis.

(2) In the case of a Lloyd's plan or other similar unincorporated group of individual insurers, maintains a trust fund of not less than $50,000,000 as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and such trust shall likewise comply with the terms and conditions established in Paragraph (1) for alien insurers.

D. Has caused to be provided to the Commissioner a copy of its current annual statement certified by such insurer. Such statement shall be provided at the same time it is provided to the insurer's domicile, but in no event no more than six (6) months after the close of the period reported upon and which is either:

(1) Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

(2) Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile.

In the case of an Insurance Exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

Drafting Note: The following subsection is for use by those states which desire to adopt a "white list" for determining the eligibility of nonadmitted insurers to write surplus lines insurance.

E. In addition to meeting the requirements in Subsections A to C, an insurer shall be an eligible surplus lines insurer if it appears on the most recent list of eligible surplus lines insurers published by the Commissioner from time to time but at least semi-annually. Nothing in this section shall require the Commissioner to place or maintain the name of any nonadmitted insurer on the list of eligible surplus lines insurers.

Section 6. Other Nonadmitted Insurers

Drafting Note: This section is necessary only in states which have adopted Section 5E.

Only that portion of any risk eligible for export for which the full amount of coverage is not procurable from eligible surplus lines insurers may be placed with any other nonadmitted insurer which does not appear on the list of eligible surplus lines insurers published by the Commissioner pursuant to Section 5E but nonetheless meets the requirements set forth in Section 5A to C and any regulations of the Commissioner. The surplus lines licensee seeking to provide coverage through an unlisted nonadmitted insurer shall make a filing specifying the amount(s) and percentage(s) of each risk to be placed, and naming the nonadmitted insurer(s) with which placement is intended. Within {insert number} days after placing the coverage, the surplus lines licensee shall also send written notice to the insured or the producing broker that the insurance, or a portion thereof, has been placed with such nonadmitted insurer.

Section 7. Withdrawal of Eligibility from a Surplus Lines Insurer

If at any time the Commissioner has reason to believe that an eligible surplus lines insurer:

A. Is in unsound financial condition;

B. Is no longer eligible under Section 5;

C. Has willfully violated the laws of this state; or

D. Does not make reasonably prompt payment of just losses and claims in this state or elsewhere;

the Commissioner may declare it ineligible. The Commissioner shall promptly mail notice of all such declarations to each surplus lines licensee.

Section 8. Admitted Insurers—Waiver of Rate and Form Regulations

An admitted insurer may issue, through any agent, broker or other representative, in the manner permitted under the insurance law for other policies of the same kind, insurance covering the particular insured for the amount of or kind of insurance which is exportable under Section 4, without regard to rate and form requirements otherwise applicable, if the agent, broker or other representative placing such insurance complies with the filing requirements of Section 9A. Such insurance shall be subject to the premium tax applicable to such admitted insurer.

Section 9. Duty to File Evidence of Insurance and Affidavits

Within [insert number] days after the placing of any surplus lines insurance, each producing broker shall execute and each surplus lines licensee shall file;

A. A written report, which shall be kept confidential, regarding the insurance with the Commissioner, including the following:

(1) The name and address of the insured;

(2) The identify of the insurer or insurers;

(3) A description of the subject and location of the risk;

(4) The amount of premium charged for the insurance; and

(5) Such other pertinent information as the Commissioner may reasonably require; and

B. An affidavit on a standardized form furnished by the Commissioner, as to the diligent efforts to place the coverage with admitted insurers and the results thereof. The affidavit shall affirm that the insured was expressly advised in writing prior to placement of the insurance that:

(1) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and

(2) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Such affidavit shall be open to public inspection.

Section 10. Surplus Lines Advisory Organizations

A. An advisory surplus lines organization of surplus lines licensees may be formed to:

(1) Facilitate and encourage compliance by its members with the laws of this state and the rules and regulations of the Commissioner relative to surplus lines insurance;

(2) Provide means for the examination, which shall remain confidential, of all surplus lines coverage written by its members to determine whether such coverages comply with such laws and regulations;

(3) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market; and

(4) Receive and disseminate to its members information relative to surplus lines coverages.

B. Every such advisory organization shall file with the Commissioner:

(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation;

(2) A copy of its bylaws, rules and regulations governing its activities;

(3) A current list of its members;

(4) The name and address of a resident of this state upon whom notices or orders of the Commissioner or processes issued at his direction may be served; and

(5) An agreement that the Commissioner may examine such advisory organization in accordance with the provisions of this section.

C. The Commissioner shall, at least once in [insert number] years, make or cause to be made an examination of each such advisory organization. The reasonable cost of any such examination shall be paid by the advisory organization upon presentation to it by the Commissioner of a detailed account of each cost. The officers, managers, agents and employees of such advisory organization may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The Commissioner shall furnish two copies of the examination report to the advisory organization examined and shall notify such organization that it may, within twenty (20) days thereof, request a hearing on the report or on any facts or recommendations therein. If the Commissioner finds such advisory organization or any member thereof to be in violation of this Act, he may issue an order requiring the discontinuance of such violation.

Drafting Note: The following Subsection D should be included only if it is in accord with the existing law and public policy of the state.

D. By order of the Commissioner a surplus lines licensee may be compelled to join an advisory organization as a condition of continued licensure under this Act.

Section 11. Evidence of the Insurance—Changes—Penalties

A. Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing broker the policy, or if such policy is not then available, a certificate as described in Subsection D, cover note, binder or other evidence of insurance.

The certificate as described in Subsection D, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee's license number.

B. No surplus lines licensee shall issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any eligible surplus lines insurer, or a nonadmitted insurer pursuant to Section 6, unless he has authority from the insurer to cause the risk to be insured, or has received information from the insurer in the regular course of business that such insurance has been granted.

C. If, after delivery of any such evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing broker an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible thereunder.

D. As soon as reasonably possible after the placement of any such insurance, the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing broker to replace any evidence of insurance theretofore issued. Each certificate or policy of insurance shall contain or have attached thereto a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.

E. Any surplus lines licensee who fails to comply with the requirements of this section shall be subject to the penalties hereinafter provided.

F. Every evidence of insurance negotiated, placed or procured under the provisions of this Act issued by the surplus lines licensee shall bear the name of the licensee and the following legend in ten (10) point type: "This is evidence of insurance procured and developed under the [insert state] Surplus Lines Law. It is NOT covered by the [insert citation of guaranty fund statute]."

Section 12. Licensee's Duty to Notify Insured

No contract of insurance placed by a surplus lines licensee under this Act shall be binding upon the insured and no premium charged therefor shall be due and payable until the surplus lines licensee shall have notified the insured in writing, a copy of which shall be maintained by the licensee with the records of the contract and available for possible examination, that:

A. The insurer with which the licensee places the insurance is not licensed by this state and is not subject to its supervision; and

B. In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

Section 13. Valid Surplus Lines Insurance

Insurance contracts procured under this Act shall be valid and enforceable as to all parties.

Section 14. Effect of Payment to Surplus Lines Licensee

A payment of premium to a surplus lines licensee acting for a person other than himself in negotiating, continuing, or reviewing any policy of insurance under this Act shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

Section 15. Licensing of Surplus Lines Licensee

A. No agent or broker licensed by the state shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner.

B. The Commissioner shall issue a surplus lines license to any qualified holder of a current property and casualty broker's or general agent's license but only when the broker or agent has:

(1) Remitted the $[insert amount] annual fee to the Commissioner;

(2) Submitted a completed license application on a form supplied by the Commissioner;

(3) Passed a qualifying examination approved by the Commissioner, except that all holders of license prior to the effective date of this Act shall be deemed to have passed such an examination; and

(4) Filed with the Commissioner, and maintains during the term of the license, in force and unimpaired, a bond in favor of this state in the penal sum of [insert amount] dollars, aggregate liability, with corporate sureties approved by the Commissioner. The bond shall be conditioned that the surplus lines licensee will conduct business in accordance with the provisions of this Act and will promptly remit the taxes as provided by law. No bond shall be terminated unless at least thirty (30) days prior written notice is given to the licensee and Commissioner. If the Commissioner determines that a surplus lines licensee of a sister state is competent and trustworthy; he may, in his discretion, issue a nonresident surplus lines agent's license. A nonresident licensee shall be limited in his authority to servicing of business negotiated elsewhere and filing any appropriate taxes. A nonresident licensee shall not have authority to solicit business.

C. Corporations, including foreign corporations, shall be eligible to be resident surplus lines licensees, upon the following conditions:

(1) The corporate licensee shall list individuals within the corporation who have satisfied the requirements of this Act to become surplus lines licensees; and

(2) Only those individuals listed on the corporate license shall transact surplus lines business.

D. Each surplus lines license shall expire on December 31st of each year and shall be renewed before December 2nd of each year upon payment of the annual fee, and compliance with other provisions of this section. Any surplus lines licensee who fails to apply for renewal of the license before December 2nd shall pay a penalty of [insert amount] dollars and be subject to such other penalties as provided by law before his license will be renewed.

Section 16. Surplus Lines Licensees May Accept Business from Other Agents or Brokers

A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other agent or broker duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate such agent or broker therefor.

Section 17. Records of Surplus Lines Licensee

Each surplus lines licensee shall keep in his office in this state a full and true record of each surplus lines insurance contract placed by or through him, including a copy of the policy, certificate, cover note or other evidence of insurance showing such of the following items as may be applicable:

A. Amount of the insurance and perils insured;

B. Brief description of the property insured and its location;

C. Gross premium charged;

D. Any return premium paid;

E. Rate of premium charged upon the several items of property;

F. Effective date of the contract, and the terms thereof;

G. Name and address of the insured;

H. Name and address of the insurer;

I. Amount of tax and other sums to be collected from the insured; and

J. Allocation of taxes by state as referred to in Section 19.

K. Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.

The record of each contract shall be kept open at all reasonable times to examination by the Commissioner without notice for a period not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines licensee shall make available to the Commissioner any and all records that he deems necessary for examination.

Section 18. Reports—Summary of Exported Business

On or before the end of the month following each [insert month, quarter, year], each surplus lines licensee shall file with the Commissioner, on forms prescribed by the Commissioner, a verified report in duplicate of all surplus lines insurance transacted during the preceding period, showing:

A. Aggregate gross premiums written;

B. Aggregate return premiums;

C. Amount of aggregate tax remitted to this state; and

D. Amount of aggregate tax remitted to each other state for which an allocation is made pursuant to Section 19.

Drafting Note: States desiring to have taxes remitted annually may call for monthly detailed listing of business.

Section 19. Surplus Lines Tax

A. In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to Section 15 of this Act shall collect and pay to the Commissioner a sum equal to [insert number]% of the gross premiums charged, less any return premiums, for surplus lines insurance provided by such licensee pursuant to such license. Where the insurance covers property or risks located, resident or to be performed both in and out of this state, the sum payable shall be computed on that portion of the gross premiums allocated to this state pursuant to Subsec-

tion D of this section less the amount of gross premiums allocated to this state and returned to the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of such tax.

B. At the time of filing the [insert monthly, quarterly, annual] report as set forth in Section 18, each surplus lines licensee shall pay the premium receipts tax due for the period covered by the report.

C. If a surplus lines policy procured through a surplus lines licensee covers risks only partially resident, located or to be performed in this state, the tax payable shall be computed on the portions of the premium which are attributable to the risks located or to be performed in this state. In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state shall be considered written on property or risks located or resident in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this state be less than the tax due pursuant to Subsection D of this section; provided, however, in the event that the amount of tax due under this provision is less than $50 in any jurisdiction, it shall be payable in the jurisdiction in which the affidavit required in Section 9 is filed.

The Commissioner shall, at least annually furnish to the Commissioner, Director or Superintendent of a reciprocal state, as defined herein, a copy of all filings reporting an allocation of taxes as required by this section.

D. In determining the amount of gross premiums taxable in this state for a placement of surplus lines insurance covering risks resident, located or to be performed both within and without this state, the tax due shall be computed on that portion of the policy premium that is attributable to risks resident, located or to be performed in this state and which relates to the kinds of insurance being placed as determined by reference to an allocation schedule duly promulgated in a regulation by the Commissioner.

(1) If a policy covers more than one classification:

(a) For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed by using the Allocation Schedule for the corresponding portion of the premium;

(b) For any portion of the coverage not identified by a classification on the Allocation Schedule, the tax shall be computed by using an alternative equitable method of allocation for the property or risk;

(c) For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation which pertains to the classification describing the predominant coverage.

(2) If the information provided by the surplus lines licensee is insufficient to substantiate the method of allocation used by the surplus lines licensee, or if the Commissioner determines that the licensee's method is incorrect, the Commissioner shall determine the equitable and appropriate amount of tax due to this state as follows:

(a) By use of the Allocation Schedule where the risk is appropriately identified in the schedule;

(b) Where the Allocation Schedule does not identify a classification appropriate to the coverage, the Commissioner may give significant weight to documented evidence of the underwriting bases and other criteria used by the insurer. The Commissioner may also consider

other available information to the extent sufficient and relevant, including the percentage of the insured's physical assets in this state, the percentage of the insured's sales in this state, the percentage of income or resources derived from this state, and the amount of premium tax paid to another jurisdiction for the policy.

Drafting Note: Paragraph (2) above may be included in the Act or in a separate regulation at the option of the department.

It is highly recommended that the attached sample Allocation Schedule and reporting form be adopted by regulation in conjunction with the adoption of the above changes to the Model Surplus Lines Law. In order for the model law to work effectively, the allocation schedules used by the states should be as uniform as possible.

Editor's Note: The sample Allocation Schedule does not yet exist, but is in the process of development.

E. This section shall not apply to insurance of risks of the state government, its political subdivisions or of any agency thereof.

Section 20. Collection of Tax

If the tax collectible by a surplus lines licensee under this Act has been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the Commissioner against the surplus lines licensee and the surety on the bond filed under Section 15.

Section 21. Suspension, Revocation or Nonrenewal of Surplus Lines Licensee's License

The Commissioner may suspend, revoke, or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under the applicable provision of this state's laws upon any one or more of the following grounds:

A. Removal of the resident surplus lines licensee's office from this state;

B. Removal of the resident surplus lines licensee's office accounts and records from this state during the period during which such accounts and records are required to be maintained under Section 17 of this Act;

C. Closing of the surplus lines licensee's office for a period of more than thirty (30) business days, unless permission is granted by the Commissioner;

D. Failure to make and file required reports;

E. Failure to transmit required tax on surplus lines premiums to this state or any reciprocal state to which a tax is owing;

F. Failure to maintain required bond;

G. Violation of any provision of this Act; or

H. For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Sections [insert applicable citation].

Section 22. Actions Against Surplus Lines Insurer—Service of Process

A. A surplus lines insurer may be sued upon any cause of action arising in this state under any surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee pursuant to the procedure provided in Section [insert applicable section containing Unauthorized Insurers Process Act]. Any such policy issued by the surplus lines licensee shall contain a provision stating the substance of this section and designating the person to whom the Commissioner shall mail process.

B. Each surplus lines insurer assuming a surplus lines insurance shall be deemed thereby to have subjected itself to this Act.

C. The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

Section 23. Penalties

A. Any surplus lines licensee who in this state represents or aids a nonadmitted insurer in violation of this Act may be found guilty of a misdemeanor and subject to a fine not in excess of $1,000.

B. In addition to any other penalty provided for herein or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision of this Act shall be liable to a penalty not exceeding $1,000 for the first offense, and not exceeding $2,000 for each succeeding offense.

C. The above penalties are not exclusive remedies. Penalties may also be assessed under the [trade practices and fraud] statute of the insurance code of this state.

Section 24. Separability of Provisions

If any provisions of this Act, or the application of such provision to any person or circumstance, shall be held invalid, the remainder of the Act and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Section 25. Effective Date

This Act shall take effect [insert appropriate date].

Legislative History (all references are to the Proceedings of the NAIC*)*
1983 Proc. I 6, 36, 834, 900, 913-922 (adopted)
1985 Proc. II 11, 24, 702, 722, 723-724 (amended)
1986 Proc. I 9-10, 24, 799, 813, 814-821 (amended)
1990 Proc. I 6, 30, 840-841, 897-898, 900-901 (amended)
1991 Proc. I 9, 18, 908, 949, 950, 952-961 (amended and reprinted)

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The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama		ALA. CODE §§ 27-10-20 to 27-10-38 (1963/1980).
Alaska	ALASKA STAT. §§ 21.34.010 to 21.34.900 (1984/1987).	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-407 to 20-420 (1954/1981).
Arkansas		ARK. STAT. ANN. §§ 23-65-301 to 23-65-319 (1959/1985).
California		CAL. INS. CODE §§ 1760 to 1780 (1935/1985).
Colorado		COLO. REV. STAT. § 10-5-101 to 10-5-117 (1963/1982).
Connecticut		CONN. ADMIN. CODE tit. 38 §§ 78-1 to 78-18 (1985/1990).
Delaware		DEL. CODE ANN. tit. 18 §§ 1901 to 1919 (1953).
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 626.913 to 626.937 (1959/1990).
Georgia		GA. CODE ANN. §§ 33-5-20 to 33-5-35 (1960/1985).
Guam		GUAM GOV'T. CODE §§ 43260 to 43266 (1966) ("Surplus Line Broker or Agents").
Hawaii	HAWAII REV. STAT. §§ 431:8-300 to 431:8-320 (1988/1989).	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Idaho		IDAHO CODE §§ 41-1211 to 41-1232 (1961/1976).
Illinois		ILL. REV. STAT. ch. I.C. §§ 445 to 445.1 (1980/1987).
Indiana	NO ACTION TO DATE	
Iowa	NO ACTION TO DATE	
Kansas		KAN. STAT. ANN. §§ 40-246 to 40-246e (1982/1984).
Kentucky		KY. REV. STAT. §§ 304.10-010 to 304.10-210 (1970/1984).
Louisiana		LA. REV. STAT. ANN. §§ 22:1257 to 22:1270 (1958/1985).
Maine		ME. REV. STAT. ANN. tit. 24-A §§ 2001 to 2019 (1970/1978).
Maryland		MD. ANN. CODE art. 48A §§ 183 to 199 (1963/1984).
Massachusetts	NO ACTION TO DATE	
Michigan		MICH. COMP. LAWS §§ 500.1901 to 500.1955 (1981).
Minnesota		MINN. STAT. §§ 60A.195 to 60A.209 (1981/1987).
Mississippi	NO ACTION TO DATE	
Missouri	MO. REV. STAT. §§ 384.011 to 384.071 (1987/1989).	
Montana	MONT. CODE ANN. §§ 33-2-301 to 33-2-708 (1959/1989).	
Nebraska	NO ACTION TO DATE	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Nevada		NEV. REV. STAT. §§ 685A.010 to 685A.220 (1971/1985).
New Hampshire	NO ACTION TO DATE	
New Jersey		N.J. REV. STAT. §§ 17:22-6.40 to 17:226.69 (1960/1988).
New Mexico		N.M. STAT. ANN. §§ 59A-14-1 to 59A-14-18 (1985).
New York		N.Y. ADMIN. CODE tit. 11 §§ 27.0 to 27.14 (1962/1990) (Regulation 41) (Requires allocation of premium tax).
North Carolina	N.C. GEN. STAT. §§ 58-21-1 to 58-21-105 (1985/1986).	
North Dakota		N.D. CENT. CODE §§ 26.1-44-01 to 26.1-44-09 (1985).
Ohio	NO ACTION TO DATE	
Oklahoma		OKLA. STAT. tit. 36 §§ 1101 to 1120 (1957/1959).
Oregon	OR. REV. STAT. §§ 735.400 to 735.495 (1987/1989).	
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 15-101 to 15-116 (1966/1981).
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 1007 to 1018 (1961/1980).
Rhode Island		R.I. GEN. LAWS §§ 27-3-38 to 27-3-42 (1959/1982).
South Carolina	NO ACTION TO DATE	
South Dakota		S.D. CODIFIED LAWS ANN. §§ 58-32-1 to 58-32-58 (1966/1990).
Tennessee		TENN. CODE ANN. §§ 56-14-101 to 56-14-117 (1969/1985).

MODEL SURPLUS LINES LAW

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Texas		TEX. INS. CODE ANN. art. 1.14-2 (1967/1987).
Utah		UTAH CODE ANN. §§ 31A-15-103 to 31A-15-110 (1986/1987).
Vermont		VT. STAT. ANN. tit. 8 §§ 5021 to 5040 (1979/1990).
Virgin Islands		V.I. CODE ANN. tit. 22 §§ 653 to 667 (1968).
Virginia	VA. CODE §§ 38.2-4800 to 38.2-4815 (1986/1988).	
Washington		WASH. REV. CODE ANN. §§ 48.15.040 to 48.15.170 (1947/1985).
West Virginia		W. VA. CODE §§ 33-12-10 to 33-12-25 (1957/1981).
Wisconsin		WIS. STAT. § 618.41 (1971/1981).
Wyoming		WYO. STAT. §§ 26-11-101 to 26-11-122 (1983).

EXHIBIT F

UNAUTHORIZED INSURERS MODEL ACT

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Introduction

An Act relating to the regulation and control of the conduct of persons not authorized to conduct the business of insurance within this State.

Be it enacted by the Legislature of the State of [insert state]:

Section 1. Purpose

The purpose of this Act is to subject certain persons to the jurisdiction of the insurance commissioner and the courts of this state in suits by or on behalf of the state. The legislature declares that it is concerned with the protection of residents of this state against acts by persons not authorized to do an insurance business in this state, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized persons, and by protecting against the evasion of the insurance regulatory laws of this state. In furtherance of such state interest, the legislature herein provides methods for substituted service of process upon such persons in any proceeding, suit or action in any court and substituted service of any notice, order, pleading or process upon such persons in any proceeding by the commissioner of insurance to enforce or effect full compliance with the insurance laws of this state. In so doing, the state exercises its powers to protect residents of this state and to define what constitutes transacting an insurance business in this state, and also exercises powers and privileges available to this state by virtue of Public Law 79-15, 79th Congress of the United States, Chapter 20, 1st Sess., S.340. 59 Stat. 33; 15 U.S.C. §§ 1011 to 1015 inclusive, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

Section 2. Definitions

A. "Person" shall mean any natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

B. "Insurer" shall mean any person, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third party administrators. Insurer shall also mean medical service plans and hospital service plans as defined in Section [insert applicable section] health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

C. ["Commissioner"] shall mean the [Commissioner] of Insurance of this state.

D. "Policy" or "contract" shall mean any contract of insurance, indemnity, medical or hospital service, workers' compensation, fidelity, suretyship, or annuity.

Section 3. Certificate of Authority

A. It shall be unlawful for any person to transact insurance business in this state, as set forth in Subsection B of this section, without a certificate of authority from the insurance commissioner; provided, however, that this section shall not apply to:

(1) The lawful transaction of surplus lines insurance;

(2) The lawful transaction of reinsurance by insurers;

(3) Transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy;

(4) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(5) Transactions in this state involving group life and group sickness and accident or blanket sickness and accident insurance or group annuities where: (i) the master policy of such groups was lawfully issued and delivered in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and where the policyholder is domiciled or otherwise has a bona fide situs, and (ii) except for group annuities, the insurer complies with [insert appropriate statutory reference to Sections 1 and 2 of the NAIC Mass Marketed Life or Health Insurance Model Act]. The commissioner may require the insurer which has issued such master policy to submit such information as the commissioner reasonably requires in order to determine if probable cause exists to convene a hearing to determine whether the total charges for the insurance to the persons insured are reasonable in relation to the benefits provided under such policy;

(6) Transactions in this state involving any policy of insurance or annuity contract issued prior to the effective date of this act;

(7) Transactions in this state relative to a policy issued or to be issued outside this state involving insurance on vessels, craft or hulls, cargos, marine builder's risk, marine protection and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy.

B. Any of the following acts in this state effected by mail or otherwise by or on behalf of an unauthorized insurer is deemed to constitute the transaction of an insurance business in this state. The venue of an act committed by mail is at the point where the matter transmitted by mail is delivered and takes effect. Unless otherwise indicated, the term "insurer" as used in this section includes all corporations, associations, partnerships and individuals engaged as principals in the business of insurance and also includes inter-insurance exchanges and mutual benefit societies.

(1) The making of or proposing to make, as an insurer, an insurance contract;

(2) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(3) The taking or receiving of any application for insurance;

(4) The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof;

(5) The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

(6) Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another, any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state. The provisions of this subsection shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of such employer;

(7) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;

(8) The transacting or proposing to transact any insurance business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of the statutes.

(9) Offering any agreement or contract which purports to alter, amend or void coverage of an insurance contract shall itself be deemed to be a contract of insurance.

C. (1) The failure of an insurer transacting insurance business in this state to obtain a certificate of authority shall not impair the validity of any act or contract of such insurer and shall not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer transacting insurance business in this state without a certificate of authority shall be permitted to maintain an action in any court of this state to enforce any right, claim or demand arising out of the transaction of such business until such insurer shall have obtained a certificate of authority.

(2) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract.

Section 4. Violations

Whenever the commissioner believes, from evidence satisfactory to him, that any person is violating or about to violate the provisions of Section 3 of this Act, the commissioner may, through the attorney general of this state, cause a complaint to be filed in the [insert appropriate court] Court to enjoin and restrain such person from continuing such violation or engaging therein or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall

have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief as in its judgment is proper.

Section 5. Binding Transaction

A. Any act of transacting an insurance business as set forth in Section 3 of this Act by any unauthorized insurer is equivalent to and shall constitute an irrevocable appointment by such insurer, binding upon him, his executor or administrator, or successor in interest if a corporation, of the secretary of state or his successor in office, to be the true and lawful attorney of such insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the commissioner of insurance or by the state and upon whom may be served any notice, order, pleading or process in any proceeding before the commissioner of insurance and which arises out of transacting an insurance business in this state by such insurer. Any act of transacting an insurance business in this state by any unauthorized insurer shall be signification of its agreement that any such lawful process in such court action, suit or proceeding and any such notice, order, pleading or process in such administrative proceeding before the commissioner of insurance so served shall be of the same legal force and validity as personal service of process in this state upon such insurer.

B. Service of process in such action shall be made by delivering to and leaving with the secretary of state, or some person in apparent charge of his office, two copies thereof and by payment to the secretary of state of the fee prescribed by law. Service upon the secretary of state as such attorney shall be service upon the principal.

C. The secretary of state shall forthwith forward by certified mail one of the copies of such process or such notice, order, pleading or process in proceedings before the commissioner to the defendant in such court proceeding or to whom the notice, order, pleading or process in such administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on him which shall show the day and hour of service. Such service is sufficient, provided:

(1) Notice of such service and a copy of the court process or the notice, order, pleading or process in such administrative proceeding are sent within ten (10) days thereafter by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the commissioner of insurance in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in such administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding;

(2) The defendant's receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in court proceeding or of the commissioner of insurance in administrative proceeding, showing compliance therewith are filed with the clerk of the court in which such action, suit or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond thereto, or within such further time as the court or commissioner of insurance may allow.

D. No plaintiff shall be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the commissioner of insurance is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.

E. Nothing in this section shall limit or affect the right to serve any process, notice, order or demand upon any person or insurer in any other manner now or hereafter permitted by law.

Section 6. Legal or Administrative Procedures

A. Before any unauthorized insurer files or causes to be filed in any pleading in any court action, suit or proceeding or in any notice, order, pleading or process in such administrative proceeding before the commissioner instituted against such person or insurer, by services made as provided in Section 5 of this Act, such insurer shall either:

(1) Deposit with the clerk of the court in which such action, suit or proceeding is pending, or with the commissioner of insurance in administrative proceedings before the commissioner, cash or securities, or file with such clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in such action or administrative proceeding.

(2) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the commissioner need not assert the provisions of [insert sections of insurance laws relating to retaliation] against such insurer with respect to its application if he determines that such company would otherwise comply with the requirements for such certificate of authority.

B. The commissioner of insurance, in any administrative proceeding in which service is made as provided in this Act, may in his discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend such action.

C. Nothing in Subsection A of this section shall be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this Act, on the ground that such unauthorized insurer has not done any of the acts enumerated in Section 3 of this Act.

Section 7. Enforcement and Definitions

The attorney general, upon request of the commissioner, may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of insurance.

A. Definition - In this section:

(1) "Reciprocal state" means any state or territory of the United States the laws of which contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders in equity issued by courts located in other states or territories of the United States, against any insurer incorporated or authorized to do business in said state or territory.

(2) "Foreign decree" means any decree or order in equity of a court located in a "reciprocal state," including a court of the United States located therein, against any insurer incorporated or authorized to do business in this state.

(3) "Qualified party" means a state regulatory agency acting in its capacity to enforce the insurance laws of its state.

B. List of Reciprocal States: The insurance commissioner of this state shall determine which states and territories qualify as reciprocal states and shall maintain at all times an up-to-date list of such states.

C. Filing and Status of Foreign Decrees: A copy of any foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any [insert proper court] Court of this state. The clerk, upon verifying with the insurance commissioner that the decree or order qualifies as a "foreign decree" shall treat the foreign decree in the same manner as a decree of a [insert proper court] Court of this state. A foreign decree so filed has the same effect and shall be deemed as a decree of a [insert proper court] Court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a decree of a [insert proper court] Court of this state and may be enforced or satisfied in like manner.

D. Notice of Filing:

(1) At the time of the filing of the foreign decree, the attorney general shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant.

(2) Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the insurance commissioner of this state and shall make a note of the mailing in the docket. In addition, the attorney general may mail a notice of the filing of the foreign decree to the defendant and to the insurance commissioner of this state and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the attorney general has been filed.

(3) No execution or other process for enforcement of a foreign decree filed hereunder shall issue until thirty (30) days after the date the decree is filed.

E. Stay:

(1) If the defendant shows the [insert proper court] Court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(2) If the defendant shows the [insert proper court] Court any ground upon which enforcement of a decree of any [insert proper court] Court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.

F. Fees: Any person filing a foreign decree shall pay to the clerk of court [enter appropriate amount] dollars. Fees for docketing, transcription or other enforcement proceedings shall be as provided for decrees of the [insert proper court] Court.

Section 8. Penalty

Any unauthorized insurer who transacts any unauthorized act of an insurance business as set forth in this Act may be fined not more than ten thousand dollars ($10,000).

Section 9. Title

This Act may be cited as the "Uniform Unauthorized Insurers Act."

Section 10. Severability

If any provision of this Act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision and to this end the provisions of this Act are declared to be severable.

Legislative History (all references are to the Proceedings of the NAIC).

1969 Proc. I 168, 218, 222-227, 271 (adopted).
1978 Proc. I 13, 15, 348, 350 (amended).
1990 Proc. II 7, 13-14, 159-160, 187-191 (amended and reprinted).

UNAUTHORIZED INSURER MODEL ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama		ALA. CODE §§ 27-10-1 to 27-10-3 (1963/1971).
Alaska		ALASKA STAT. §§ 21.33.037 to 21.33.075 (1968/1984).
Arizona		ARIZ. REV. STAT. ANN. §§ 20-401 to 20-401.07 (1972).
Arkansas	NO ACTION TO DATE	
California	NO ACTION TO DATE	
Colorado	COLO. REV. STAT. §§ 10-3-901 to 10-3-910 (1963).	
Connecticut	CONN. GEN. STAT. §§ 38a-271 to 38a-278 (1970/1979).	
Delaware	NO ACTION TO DATE	
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 626.901 to 626.903 (1982).
Georgia	NO ACTION TO DATE	
Guam		GUAM GOV'T. CODE §§ 43125 to 43134.
Hawaii	HAWAII REV. STAT. §§ 431:8-201 to 431:8-211 (1988).	
Idaho	NO ACTION TO DATE	
Illinois	ILL. REV. STAT. ch. I.C. §§ 121 to 121-19 (1977/1981).	
Indiana	IND. CODE §§ 27-4-5-1 to 27-4-5-8 (1969/1985).	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Iowa	IOWA CODE §§ 507A.1 to 507A.11 (1967/1981).	
Kansas	KAN. STAT. ANN. §§ 40-2701 to 40-2709 (1969).	
Kentucky	KY. REV. STAT. §§ 304.11-010 to 304.11-050 (1970/1982).	
Louisiana	LA. REV. STAT. ANN. §§ 22:1249 to 22:1256 (1958/1972).	
Maine	NO ACTION TO DATE	
Maryland	MD. ANN. CODE art. 48A §§ 202 to 211A (1968/1989).	
Massachusetts	NO ACTION TO DATE	
Michigan	NO ACTION TO DATE	
Minnesota	MINN. STAT. §§ 72A.40 to 72A.45 (1967/1985).	
Mississippi	NO ACTION TO DATE	
Missouri	MO. REV. STAT. §§ 375.786 to 375.790 (1972).	
Montana	NO ACTION TO DATE	
Nebraska	NEB. REV. STAT. §§ 44-2001 to 44-2008 (1969/1983).	
Nevada	NEV. REV. STAT. §§ 685B.020 to 685B.080 (1971).	
New Hampshire	N.H. REV. STAT. ANN. §§ 406B:1 to 406B:15 (1967/1971).	
New Jersey	NO ACTION TO DATE	
New Mexico	N.M. STAT. ANN. §§ 59A-15-1 to 59A-15-10 (1985).	

UNAUTHORIZED INSURER MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
New York	NO ACTION TO DATE	
North Carolina	N.C. GEN. STAT. §§ 58-28-1 to 58-28-40 (1967/1985).	
North Dakota	N.D. CENT. CODE §§ 26.1-02-05 to 26.1-02-19 (1983/1985).	
Ohio	OHIO REV. CODE ANN. §§ 3901.17 to 3901.18 (1955-1956/1985).	
Oklahoma		OKLA. STAT. tit. 36 §§ 1101 to 1105 (1957).
Oregon	OR. REV. STAT. §§ 746.310 to 746.370 (1967/1981).	
Pennsylvania	NO ACTION TO DATE	
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 1001 to 1006 (1977).
Rhode Island	R.I. GEN. LAWS §§ 27-16-1 to 27-16-2.4 (1973).	
South Carolina	S.C. CODE ANN. §§ 38-25-10 to 38-25-570 (1988).	
South Dakota	S.D. CODIFIED LAWS ANN. §§ 58-8-1 to 58-8-5 (1966/1978).	
Tennessee	TENN. CODE ANN. §§ 56-2-601 to 56-2-704 (1955/1969).	
Texas	TEX. INS. CODE ANN. art. 1.14-1 (1967/1987).	
Utah	UTAH CODE ANN. §§ 31A-15-101 31A-15-102; 31A-2-309 to 31A-2-311 (1985).	
Vermont		VT. STAT. ANN. tit. 8 §§ 3368 to 3370 (1968).

UNAUTHORIZED INSURER MODEL ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Virgin Islands		V.I. CODE ANN. tit. 22 § 651 to 652 (1968).
Virginia	NO ACTION TO DATE	
Washington		WASH. REV. CODE ANN. §§ 48.15.020 to 48.15.030 (1947).
West Virginia	NO ACTION TO DATE	
Wisconsin		WIS. STAT. §§ 618.39, 618.47 to 618.61 (1971/1983).
Wyoming		WYO. STAT. §§ 26-12-102 to 26-12-103 (1967/1983).

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EXHIBIT G

MODEL TITLE INSURANCE ACT

Table of Contents.

Section 1. Title and Purpose.

(A) This act shall be known and may be cited as the ——— Title Insurance Act.

(B) The purpose of this act is to provide the state of ——— with a comprehensive body of law for the effective regulation and supervision of title insurance business transacted within this state in response to the McCarran-Ferguson Act (P.L. 79-15, 15 U.S.C. Section 1011-1015.)

Section 2. Application of Act and Construction with Other Laws.

(A) This act shall apply to all title insurers, title insurance rating organizations, title agents, applicants for title insurance, title insurance policyholders, and all persons engaged in title insurance transation in this state.

(B) Except as otherwise expressly provided in this act, and except where the context otherwise requires, all provisions of this insurance code applying to insurance and insurance companies generally shall apply to title insurance and title insurance companies.

(C) Nothing in this act shall be construed to authorize the practice of law by any person who is not duly admitted to practice law in this state nor shall it be construed to authorize the commissioner to regulate the practice of law.

Section 3. Definitions.

As used in this act, unless the context otherwise requires:

(A) "Alien title insurer" means any title insurer incorporated or organized under the laws of any foreign nation or any province or territory thereof.

(B) "Applicant" means a person, whether or not a prospective insured, who applies to a title insurer or title agent for a title insurance policy and who, at the time of the application, is not a title agent.

(C) "Approved attorney" means an attorney at law who is not an agent or employee of a title insurer, and whose certification as to status of title a title insurer is willing to accept as the basis for issuance of its title insurance policy.

(D) "Associate" means any:

(1) Business organized for profit in which a producer of title business is a director, officer, partner, employee or owner of 1% or more of the equity capital thereof.

(2) Employee of a producer of title business.

(3) Franchisor or franchisee of a producer of title business.

(4) Spouse, parent, or child of a producer of title business who is a natural person.

(5) Person, other than a natural person, that controls, is controlled by, or is under common control with, a producer of title business.

(6) Person with whom a producer of title business or any associate of such producer has any agreement, arrangement, or understanding, or pursues any course of conduct, the purpose or substantial effect of which is to evade the provisions of this act.

(E) "Charge" means any fee billed by a title agent or title insurer or both for the performance of services other than fees that fall within the definition of premium in subsection N of this section. Charge includes but is not limited to fees for document preparation; fees for the handling of escrows, settlements, or closings, and fees for services commenced but not completed.

"Charge" does not include fees collected by a title insurer or title agent in an escrow, settlement or closing when the fees are limited to the amount billed for services rendered by an entity independent of the title insurer or title agent.

(F) "Controlled business" means any portion of a title insurer's or title agent's business of title insurance in this state, referred to it by any producer of title business or by any associate of such producer, where the producer of title business, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred.

(G) "Domestic title insurer" means a title insurer organized under the laws of this state.

(H) "Escrow, settlement or closing fee" means the consideration for supervising the actual execution, delivery or recording of transfer and lien documents and for disbursing funds.

(I) "Financial interest" means any interest, legal or beneficial, that entitles the holder directly or indirectly to one percent (1%) or more of the net profits or net worth of the entity in which the interest is held.

(J) "Foreign title insurer" means any title insurer organized under the laws of any other state of the United States, the District of Columbia, or any other jurisdiction of the United States.

(K) "Gross operating revenue" means all premiums received by a title insurer or title agent.

(L) "Net retained liability" means the total liability retained by a title insurer for a single risk, after taking into account the deduction for ceded liability, if any.

(M) "Person" means any natural person, partnership, association, cooperative, corporation, trust, or other legal entity.

(N) "Premium" means fees for:

(1) Issuing a title insurance policy, including any service charge administration fee for the issuance of a title insurance policy;

(2) Abstracting, searching and examining title when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy.

(3) Preparing or issuing preliminary reports, property profiles, commitments, binders, or like products;

(4) Assuming liability under a contract of reinsurance.

(O) "Producer of title business" or "producer" means any person, including any officer, director, or owner of five percent (5%) or more of the equity or capital of any person, engaged in this state in the trade, business, occupation, or profession of:

(1) Buying or selling interests in real property;

(2) Making loans secured by interests in real property;

(3) Acting as broker, agent, representative or attorney of a person who buys or sells any interest in real property or who lends or borrows money with such interest as security.

(P) "Refer" means to direct or cause to be directed or to exercise any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.

(Q) "Single risk" means the insured amount of any title insurance policy, except that where two or more title insurance policies are issued simultaneously covering different estates in the same real property, "single risk" means the sum of the insured amounts of all such title insurance policies. Any title insurance policy insuring a mortgage interest a claim payment under which reduces the insured amount of a fee or leasehold title insurance policy shall be excluded in computing the amount of a single risk to the extent that the insured amount of the mortgage title insurance policy does not exceed the insured amount of the fee or leasehold title insurance policy.

(R) "Title agent" or "agent" means any person authorized in writing by a title insurer to:

(1) Solicit title insurance business;

(2) Collect premiums;

(3) Determine insurability in accordance with underwriting rules and standards prescribed by the title insurer; or

(4) Issue policies of the title insurer. "Title agent" does not include approved attorneys, officers, or employees of a title insurer.

(S) "Title insurance business" or "business of title insurance" means:

(1) Issuing as insurer or offering to issue as insurer a title insurance policy.

(2) Transacting or proposing to transact by a title insurer or title agent any of the following activities when conducted or performed in contemplation of the issuance of a title insurance policy:

(a) Soliciting or negotiating the issuance of a title insurance policy;

(b) Guaranteeing, warranting, or otherwise insuring the correctness of title searches;

(c) Handling of escrows, settlements, or closings;

(d) Execution of title insurance policies;

(e) Effecting contracts of reinsurance;

(f) Abstracting, searching, or examining titles; or

(g) Doing or proposing to do any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this act.

(T) "Title insurance policy" or "policy" means a contract issuing or indemnifying against loss or damage arising from any or all of the following existing on or before the policy date:

(1) Defects in or liens or encumbrances on the insured title;

(2) Unmarketability of the insured title; or

(3) Invalidity or unenforceability of liens or encumbrances on the stated property. "Title insurance policy" does not include a preliminary report, binder, commitment, or abstract.

(U) "Title insurer" or "insurer" means a company organized under laws of this state for the purpose of transacting as insurer the business of title insurance and any foreign or alien title insurer engaged in this state in the business of title insurance as insurer.

(V) "Title plant" means a set of records in which an entry has been made of documents or matters imparting constructive notice under the law of matters affecting title to real property or any interest therein or encumbrance thereon, which have been filed or recorded in the jurisdiction for which such title plant is maintained.

Section 4. **Corporate Form Required.**

No person other than a domestic, foreign, or alien title insurer organized on the stock plan and duly licensed under ——— of this Code shall transact title insurance business as an insurer in this state.

Section 5. **Title Insurers' Authorized Activities.**

Each title insurer may:

(A) Engage in the title insurance business in this state if licensed to do so by the (commissioner/director);

(B) Subject to the limitations of this act, provide any other service related or incidental to the sale and transfer of property if it has filed notice with the (commissioner/director) of its intention to provide the service, and if the (commissioner/director) has not disapproved the service within 30 days after his receipt of the notice;

(C) Conduct its operations on a direct basis through a branch office without using a title agent if it has filed notice in a form satisfactory to the (commissioner/director) describing the services to be rendered, the personnel to be employed and the location and facilities to be used, and if the (commissioner/director) has not disapproved such direct operations within 30 days after his receipt of the notice.

Section 6. Limitations on Powers.

(A) An insurer that transacts any class or kind of business other than title insurance is not eligible for the issuance of a license to transact the business of title insurance in this state, nor for the renewal thereof, nor shall title insurance be transacted, underwritten or issued by any insurer transacting or licensed to transact any other kind of insurance.

(B) An insurer shall not engage in the business of guaranteeing payment of the principal or the interest of bonds to mortgages.

(C) An insurer shall not engage in the business of guaranteeing the obligations of other persons other than issuing insured closing letters covering its agents in the normal course of business.

Section 7. Capital and Surplus Requirements.

A title insurer shall have a minimum capital, which shall be paid in and maintained, of not less than ——— and, in addition, paid-in initial surplus of at least ———.

Section 8. Deposits.

(A) A title insurer, before issuing any title insurance policy covering property located in this state, shall deposit with the (commissioner/director) or other designated official of this state a sum of ———, which deposit shall be known as a guarantee fund and shall be held for the security and protection of the holders or beneficiaries under its title insurance policies.

(B) The deposit required under this section may be made in lawful money of the United States or in the classes of investments authorized by the laws of the state in which such deposits are made or by (insert reference to applicable provisions of insurance code governing authorized investments).

(C) Assets deposited pursuant to this section may, with the approval of the (commissioner/director), be exchanged from time to time for other assets that qualify under subsection B of this section.

(D) The depositing title insurer shall receive the income, interests, and dividends on any assets deposited.

(E) A title insurer that has deposited assets pursuant to this section may, with the approval of the (commissioner/director), withdraw any part of the assets so deposited. If any such title insurer continues to engage in the business of title insurance, it shall not be permitted to withdraw assets that would reduce the amount of its deposits below the amount required by subsection A of this section.

(F) In the event of the insolvency or dissolution of a title insurer, the deposit made pursuant to this section shall be retained by the appropriate official of the state in which the deposit is made until such time as all outstanding liabilities created by the title insurance policies issued or reinsurance assumed by such title insurer have been discharged by reinsurance or otherwise. Such deposit, or so much thereof as shall be necessary, may be used by or with the written approval of the (commissioner/director) in the payment of claims arising under such title insurance policies or reinsurance assumed or to purchase reinsurance thereon. Any amounts then remaining shall be applied first to the payment of other obligations of such title insurer and second shall be distributed to the stockholders of such title insurer.

(G) In lieu of such a deposit maintained in this state, the (commissioner/director) shall accept the certificate in proper form of the public officer having general supervision of insurers in any other state to the effect that a deposit, in a like amount, by such insurer is being maintained for like purposes in public custody or control pursuant to the laws of such state.

Section 9. Limitation on Compliance with Sections 7 and 8.

If Section 7 or 8 of this act requires a greater amount of capital and surplus or deposits than that required ot a title insurer prior to the effective date of this act, such title insurer shall have three years after the effective date of this act to comply with any such increased requirement.

Section 10. Procedure when Capital Impaired.

The provisions of (insert reference to applicable provision of the insurance code) shall be followed with respect to impairment of capital, liquidation, and rehabilitation of title insurers.

Section 11. Single Risk Limitation.

(A) The net retained liability of a title insurer for a single risk on property located in this state, whether assumed directly or as reinsurance, may not exceed fifty percent (50%) of the sum of its total surplus to policyholders and reinsurance reserve, less the value assigned to title plants, as shown in the most recent annual statement of the insurer on file in the office of the commissioner.

(B) The (commissioner/director) may waive the limitation of this section for a particular risk upon application of the insurer and for good cause shown.

Section 12. Underwriting Standards and Record Retention.

(A) No title insurance policy may be written unless and until the title insurer or its title agent has caused to be conducted a reasonable search and examination of the title and has caused to be made a determination of insurability of title in accordance with sound underwriting practices. Evidence of the examination of title and determination of insurability shall be preserved and retained in the files of the title insurer or its title agent for a period of not less than fifteen years after the title insurance policy has been issued. Instead of retaining the original evidence, the title insurer or title agent may in the regular course of business establish a system whereby all or part of the evidence is recorded, copied, or reproduced by any process that accurately and legibly reproduces or forms a durable medium for reproducing the contents of the original. This subsection shall not apply to:

(1) A title insurer assuming liability through a contract of reinsurance; or

(2) A title insurer acting as coinsurer if one of the other coinsuring title insurers has complied with this section.

(B) Except as allowed by regulations promulgated by the (commissioner/director), no title insurer or title agent shall knowingly issue any title insurance policy or commitment to insure without showing all outstanding, enforceable recorded liens or other interests against the property title to which is to be insured.

Section 13. Reinsurance Reserve.

(A) A domestic title insurer shall establish and maintain a reinsurance reserve computed in accordance with this section, and all sums attributed to such reserve shall at all times and for all purposes be considered and constitute unearned portions of the original premiums. This reserve shall be reported as a liability of the title insurer in its financial statements.

(B) The reinsurance reserve shall be maintained by the title insurer for the protection of holders of title insurance policies. Except as provided in this section, assets equal in value to the reinsurance reserve are not subject to distribution among creditors or stockholders of the title insurer until all claims of policyholders or claims under reinsurance contracts have been paid in full, and all liability on the policies or reinsurance contracts has been paid in full and discharged or lawfully reinsured.

(C) A foreign or alien title insurance company licensed to transact title insurance business in this state shall maintain at least the same reserves on title insurance policies issued on properties located in this state as are required of domestic title insurance companies, unless the laws of jurisdiction of domicile of the foreign or alien title insurance company require a higher amount.

(D) The reinsurance reserve shall consist of:

(1) The amount of the reinsurance reserve on the effective date of this act; and

(2) A sum equal to $.20 for each $1,000 of net retained liability under each title insurance policy on a single risk written on properties located in this state written after the effective date of this act.

(E) Amounts placed in the reinsurance reserve in any year in accordance with subsection D.2 of this section shall be deducted in determining the net profit of the title insurer for that year.

(F) A title insurer shall release from the reinsurance reserve a sum equal to ten percent (10%) of the amount added to the reserve during a calendar year on July 1 of each of the five years following the year in which the sum was added, and shall release from the reinsurance reserve a sum equal to three and one-third percent (3-⅓%) of the amount added to the reserve during that year on each succeeding July 1 until the entire amount for that year has been released. The amount of the reinsurance reserve or similar unearned premium reserve maintained before the effective date of their act shall be released in accordance with the law in effect before the effective date of their act.

Section 14. Use of Reinsurance Reserve on Liquidation, Dissolution or Insolvency.

(A) If a domestic title insurer becomes insolvent, is in the process of liquidation or dissolution, or is in the possession of the (commissioner/director):

(1) Such amount of the assets of such title insurance company equal to the reinsurance reserve then remaining may be used by or with the written approval of the (commissioner/director) to pay for reinsurance of the liability of each title insurer upon all outstanding title insurance policies or reinsurance agreements to the extent for which claims for losses by the holders thereof are not then pending. The balance of such assets, if any, equal to the reinsurance reserve may then be transferred to the general assets of the title insurer.

(2) The assets net of the reinsurance reserve shall be available to pay claims for losses sustained by holders of title insurance policies then pending or arising up to the time reinsurance is effected. If claims for losses exceed such other assets of the title insurer such claims, when established, shall be paid pro rata out of the surplus assets attributable to the reinsurance reserve, to the extent of such surplus, if any.

(B) If reinsurance is not obtained, assets equal to the reinsurance reserve and assets constituting minimum capital, or so much as remains thereof after outstanding claims have been paid, shall constitute a trust fund to be held and invested by the (commissioner/director) for 20 years, out of which claims of policyholders shall be paid as they arise. The balance, if any, of the trust fund shall, at the expiration of 20 years, revert to the general assets of the title insurer.

Section 15. Loss and Loss Expense Reserve.

(A) All title insurers licensed in this state shall establish and maintain reserves against unpaid losses and loss expenses.

(B) Upon receiving notice from or on behalf of the insured of a title defect in or lien or adverse claim against the title of the insured that may result in a loss or cause expense to be incurred in the proper disposition of the claim, the title insurer shall determine the amount to be added to the reserve, which amount shall reflect a careful estimate of the loss or loss expense likely to result by reason of the claim.

(C) Reserves required under this section may be revised from time to time and shall be redetermined at least once each year.

Section 16. Reinsurance.

(A) A title insurer may obtain reinsurance for all or any part of its liability under one or more of its title insurance policies or reinsurance agreements and may also reinsure title insurance policies issued by other title insurers on risks located in this state or elsewhere. Reinsurance on policies issued on properties located in this state must be obtained from title insurers licensed to transact title insurance business in this state.

(B) Upon application by a title insurer, the commissioner may permit the insurer to obtain reinsurance from a title insurer not licensed in this state upon the following conditions:

(1) The title insurer is unable to obtain reinsurance from a title insurer licensed in this state; and

(2) The capital and surplus of the unlicensed title insurer meets the requirements for licensed companies under Section 7 of this act.

Section 17. Investments.

(A) Except as otherwise expressly provided in this section, the general investment provisions of (insert reference to applicable provisions of insurance code governing authorized investments) shall apply to all domestic title insurers.

(B) A domestic title insurer may invest in title plants. For determination of the financial condition of such title insurer, title plants will be treated as an asset valued at actual cost to the title insurer, not to exceed fifty percent (50%) of the surplus as regards policyholders as shown on the most recent annual statement of the title insurer.

(C) Any investment of a domestic title insurer acquired before the effective date of this act and which, under this section, would be considered ineligible as an investment on that date shall be disposed of within two years of the effective date of this act. The (commissioner/director), upon application and proof that forced sale of any such investment would be contrary to the best interests of the title insurer or its policyholders, may extend the period for disposal of the investment for a reasonable time.

Section 18. Conditions for Providing Escrow, Closing, or Settlement Services, or Maintaining Title Indemnification Accounts.

A title insurer or title agent may engage in the escrow, settlement, or closing business, or any combination of such businesses, and operate as an escrow, settlement, or closing agent, provided that:

(A) Funds deposited in connection with any escrow, settlement, closing, or title indemnification shall be deposited in a separate fiduciary trust account or accounts in a bank or other financial institution insured by an agency of the federal government. Such funds shall be the property of the person or persons entitled thereto under the provisions of the escrow, settlement, closing, or title indemnification and shall be segregated by escrow, settlement, closing or title indemnification in the records of the title insurer or title agent. Such funds shall not be subject to any debts of the title insurer or title agent and shall be used only in accordance with the terms of the individual escrow, settlement, closing or title indemnification under which the funds were accepted.

(B) Interest received on funds deposited with the title insurer or title agent in connection with any escrow, settlement, closing, or title indemnification shall be paid to the depositing party unless the instructions provide otherwise.

(C) The title insurer or title agent shall maintain separate records of all receipts and disbursements of escrow, settlement, closing, or title indemnification funds.

(D) The title insurer or title agent shall comply with any rules or regulations promulgated by the (commissioner/director) pertaining to escrow, settlement, closing or title indemnification transactions.

Section 19. Identification of Title Agents.

A title insurer shall provide to the (commissioner/director) on an annual basis a list of all of its title agents within this state.

Section 20. Title Agent License Requirement.

No person shall act as a title agent unless licensed in accordance with the provisions of this act.

Section 21. General Qualifications for Title Agent License.

(A) No license shall be issued to, continued, or permitted to exist for any person to act as a title agent unless the person:

(1) Is at least 18 years of age;

(2) Is a bona fide resident of, and resides within, this state; or any other state which has entered into a reciprocal title agent licensing agreement with the (commissioner/director);

(3) Is appointed as a title agent by a title insurer, subject to the issuance of a title agent's license.

(4) Passes an examination given by the commissioner or any testing service selected by the commissioner/director covering the search and examination of title to real property; insurance principles relating to title insurance; and the fiduciary duties and procedures of escrows, closings, and settlements of real estate transactions.

(B) Any person, other than a natural person, to whom a title insurance agent's license is issued shall designate to the (commissioner/director) those natural persons who are or will be exercising the powers and performing the duties of the title insurance agent. The designated individuals shall be subject to the provision of paragraphs 1 and 3 of subsection A of this section. Persons performing only clerical functions shall not be subject to the requirements of subsection A of this section.

(C) Any person, other than a natural person, to whom a title insurance agent's license is issued must demonstrate that each natural person designated to exercise the powers and perform the duties of the title insurance agent meets the requirements of subsection A of this section.

Section 22. Application for Title Agent License.

(A) Application for a license to act as a title agent shall be made in writing in the form and manner prescribed by the (commissioner/director). A nonrefundable application fee of ——— shall be paid at the time of application.

(B) The application shall be deemed to be a continuing one, and any prospective licensee or licensee shall inform the (commissioner/director) promptly if any information set forth in the application changes or is no longer accurate, or if any other relevant information regarding the application arises after the original application.

Section 23. Issuance, Expiration, and Renewal of Title Agent License.

(A) The (commissioner/director) shall issue a license to act as a title agent to any person if:

(1) The prospective licensee files an application pursuant to Section 22 of this act:

(2) The prospective licensee meets the requirements of Section 21 of this act:

(3) The prospective licensee has provided the (commissioner/director) with evidence of financial responsibility in the form and in a minimum amount required by regulations of the (commissioner/director).

(B) Each title agent's license shall expire on April 30 of each year, and may be renewed by the (commissioner/director) upon filing by the licensee, prior to the expiration of his license, of a properly completed renewal application in the form prescribed by the (commissioner/director), and upon payment of a renewal fee of ———.

Section 24. Title Agent Records and Reports.

(A) A title agent shall keep books of account and records and vouchers pertaining to the business of title insurance and to any escrow, closing, settlement, or title indemnification business transacted under Section 18 of this act. All such records shall be maintained in such a manner that the (commissioner/director) or his authorized representative, may readily ascertain from time to time whether the title agent has complied with all applicable provisions of this act.

(B) The (commissioner/director) or his representative may, at any time during normal business hours, examine, audit, and inspect books and records maintained by title agents under the provisions of this act. The title agent so examined shall be liable for the cost of such examination and shall pay the same to the (commissioner/director) upon presentation of written statement of charges.

(C) A title agent shall file with the (commissioner/director) a copy of every agency contract, and all amendments or related documents, 10 days prior to the effective date thereof. Any such contract, amendments, and related documents shall accurately reflect the complete business and financial relationship between the title insurer and title agent.

(D) The (commissioner/director) may disapprove any title agency contract, upon appropriate notice to the parties to the contract, if he finds that the contract; together with all amendments and related documents:

(1) Does not provide for adequate monitoring and reporting of the agent's financial transactions; or

(2) Provides for inadequate, unreasonable, or excessive amounts to be paid or retained by the title agent. Factors the (commissioner/director) may consider in this determination include but are not limited to the agent's duties and responsibilities under the contract and the general level of amounts paid to or retained by other title agents in the state performing comparable duties or assuming comparable responsibilities.

(E) No person shall act as a title agent under an agency contract that has been disapproved by the (commissioner/director).

Section 25. Title Agent Claims Reports.

(A) A title agent shall immediately report every loss claim to the title insurer that issued the policy against which the claim is presented.

(B) No title agent shall indemnify or pay the claim of any insured.

Section 26. Refusal, Suspension, or Revocation of Title Agent License; Fine in Lieu of Suspension.

(A) In addition to any other grounds stated in this act, the (commissioner/director) may refuse to license any person as a title agent, or may suspend a title agent's license, after providing due notice and an opportunity to be heard, upon a finding that the person:

(1) Fails to meet or fails to continue to meet the qualifications for licensure under this act;

(2) Has violated any provision of this act or any rule or regulation of the (commissioner/director);

(3) Has made a material misstatement in an application for a title insurance agent's license or has obtained a title insurance agent's license by fraud or willful misrepresentation.

(4) Has misappropriated or converted to his own use funds belonging to applicants, insureds, title insurers, escrow participants, or others;

(5) Has intentionally misrepresented the terms of a title insurance policy to any applicant or policyholder or has misrepresented material facts to, concealed material facts from, or made false statements to, any party to an escrow, settlement or closing transaction;

(6) Has, in the conduct of his affairs under his title insurance agent's license, used fraudulent, coercive, or dishonest practices, or has shown himself to be incompetent, untrustworthy, financially irresponsible, or a source of injury and loss to the public; or

(7) Has aided, abetted, or assisted another person in violating the provisions of this act, or any rule or regulation promulgated under this act.

(B) The (commissioner/director) may revoke the title agent's license of any person convicted by final judgment of a felony.

(C) In addition to or without imposing the foregoing penalties, the (commissioner/director) may in his discretion, impose a fine in an amount not to exceed $2,500 for each violation of this section or of any rule or regulation promulgated under this section.

(D) Any of the penalties provided under this section may be imposed on a title agent other than a natural person for action of individuals designated by that insurance agent under Section 21B.

Section 27. Prohibition on Rebates and Inducements.

(A) No title insurer or title agent shall:

(1) Pay, directly or indirectly, to the insured, to any producer of title business, to any associate of a producer, or to any other person any commission, any part of its premiums, fees, or other charges; or any other consideration as inducement or compensation for the referral of title business or for performance of any escrow or other service by the title insurer or title agent.

(2) Issue any title insurance policy or perform any service in connection with any transaction in which it has paid or intends to pay any commission, rebate, or inducement which it knows to be in violation of this section.

(B) No insured named in a title insurance policy, no producer of title business, no associate of a producer, nor any other person may knowingly receive or accept, directly or indirectly, any commission, rebate, or inducement referred to in subsection A.

(C) Nothing in this section shall be construed as prohibiting reasonable payments, other than for the referral of title insurance business, for services actually rendered to either a title insurer or a title agent in connection with title insurance business.

Section 28. Division of Premiums and Charges.

Nothing in this act shall be construed as prohibiting the division of premiums and charges between or among a title insurer and its title agent, two or more title insurers, one or more title insurers and one or more title agents, or two or more title agents, provided such division of premiums and charges does not constitute:

(A) An unlawful rebate or inducement under the provisions of this act: or

(B) Payment of a forwarding fee or finder's fee.

Section 29. Disclosure of Financial Interest.

(A) No title insurer or title insurance agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller, lender the financial interest of the producer of title business or associate referring the title business. The disclosure must be made in writing on forms prescribed by the (commissioner/director). The title insurer or agent shall maintain the disclosure forms for a period of 3 years.

(B) Each title insurer and title agent shall file with the (commissioner/director), on forms prescribed by the (commissioner/director), reports setting forth the names and addresses of those persons, if any, who have had a financial interest in the title insurer or title agent during the calendar year, who are known or reasonably believed by the title insurer or title agent to be producers of title business or associates of producers.

(1) Each title insurer shall file the report required under this subsection with its application for a license and at any time there is a change in the information provided in the last report.

(2) Each title agent shall file the report required under this subsection with its application for license and at any time there is a change in the information provided in its last report.

(3) Each title insurer or title agent licensed on the effective date of this act shall file the report required under this subsection within 90 days after the effective date.

(C) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if (i) the title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent and (ii) twenty percent (20%) or more of the gross operating revenue of that title insurer or title agent in the calendar year in which the transaction takes place is derived from controlled business.

(D) For purposes of subsection C of this section, the percentage limitation set forth in paragraph (ii) of subsection C shall be eighty percent (80%) in the first calendar year after the effective date of this act; sixty percent (60%) in the second calendar year after the effective date of this act; forty percent (40%) in the third calendar year after the effective date of this act; and twenty percent (20%) in any later calendar year.

(E) No license may be issued, renewed, or continued for a title insurer or title agent who fails to comply with this section.

Section 30. Favored Title Agent or Insurer.

(1) No producer or other person shall require, directly or indirectly, or through any trustee, director, officer, agent, employee, or affiliate, as a condition, agreement, or understanding to selling or furnishing any other person any loan, or extension thereof, credit, sale, property, contract, lease or service, that such other person shall place any contract of title insurance of any kind through any particular title agent or title insurer. No title agent or title insurer shall knowingly participate in any such prohibited plan or transaction. No person shall fix a price charged for such thing or service, or discount from or rebate upon price, on the condition, agreement or understanding that any title insurance is to be obtained through a particular title agent or title insurer.

(2) Any producer or other person who violates the provisions of this section, or any title insurer or title agent who accepts an order for title insurance knowing that it is in violation of the provision of this section shall, in addition to any other action which may be taken by the regulatory authority having jurisdiction, be subject to a fine by the (commissioner/director) in an amount equal to 5 times the premium for the title insurance.

(3) The (commissioner/director) may invoke the aid of the courts in enforcing any fines imposed under this section.

Section 31. Premium Rate Standards.

(A) Premium rates shall not be inadequate, excessive, or unfairly discriminatory.

(B) Rates are excessive if in the aggregate they are likely to produce a long run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

(C) Rates are inadequate if they are clearly insufficient, together with investment income attributable to them, to sustain projected losses and expenses, or if the continued use of such fees will have the effect of substantially lessening competition or the effect of tending to create a monopoly.

(D) Premium rates are unfairly discriminatory if the premium charged for any classification is not reasonably related to the services performed or the risks assumed by the insurer. Provided, however, within rate classifications premiums may, to a reasonable degree, be less in the case of smaller insurances and the excess may be charged against larger insurances, without rendering the rate unfairly discriminatory.

(E) In making or reviewing rates, due consideration shall be given to past and prospective loss experience, to exposure to loss, to underwriting practice and judgment, to past and prospective expenses including amounts paid to or retained by title agents, to investment income, to a reasonable margin for profit and contingencies, and to all other relevant factors both within and outside of this state. A five year experience period is required for all filings of rates, provided that the filing of any insurer in existence less than five years shall be supported by experience consistent with the period of its existence.

(F) The (commissioner/director) may promulgate rules or regulations setting forth guidelines for evaluation of rates. Such regulations may include consideration of:

(1) Costs of underwriting risks assumed by the insurer;

(2) Amounts paid to or retained by title agents;

(3) Operating expenses of the insurer other than underwriting and claims expenses;

(4) Payment of claims and claim related expenses;

(5) Investment income;

(6) Reasonable profit;

(7) Premium taxes; and

(8) Any other factors the (commissioner/director) deems relevant.

Section 32. Premium Rate Schedules.

(A) A title insurer shall file with the (commissioner/director) the premium rate schedules it proposes to use in this state. If the (commissioner/director) finds in his review of a filing that it does not violate Section 31 of this act, he shall approve the schedule within 30 days of filing. Prior to such approval, the (commissioner/director) may conduct public hearings with respect to the filing. Filings that the (commissioner/director) has failed to approve or disapprove within 30 days of filing shall be deemed approved. Upon notice to the title insurer, the period for review of rate filing may be extended for an additional 30 days.

(B) If at any time after the approval of filing, the (commissioner/director) has reason to believe that the filing does not meet the requirements of this section or is otherwise contrary to law, or if any party having an interest in the filing makes a written complaint to the (commissioner/director) setting forth specific and reasonable grounds for the complaint, or if any insurer, upon notice of disapproval by the (commissioner/director) of a filing pursuant to this section, should so request, the (commissioner/director) shall hold a hearing within 30 days and shall give written notice of the hearing to all parties in interest. The (commissioner/director) may confirm, modify, change, or rescind any previous action, if warranted by the facts shown at the hearing.

(C) No title insurer or title agent may use or collect any premium after the effective date of this act, except in accordance with the premium rate schedule filed with and approved by the (commissioner/director) as required by this section. The (commissioner/director) may provide by regulation for interim use of premium rate schedules in effect prior to the effective date of this act.

Section 33. Publication of Schedules of Premiums and Charges.

(A) Each title insurer and title agent shall print and make available to the public schedules of its currently effective premiums and charges.

(B) The schedules shall:

(1) Be dated to show the date the premiums and charges became effective;

(2) Be kept available to the public during normal business hours in each office of the title insurer or title agent in this state; and

(3) Set forth the total premium and charge for each type of title insurance policy or service issued or provided by the title insurer or title agent either by stating the premium or charge for each type of title insurance policy in given amounts of coverage or for each service, or by stating the premium or charge rate per unit amount of coverage, or by a combination of the two.

(C) Each title insurer and title agent shall keep a complete file of its schedules of premiums and charges and of all changes and amendments to those schedules until at least 5 years after they have ceased to be in effect.

Section 34. Form Filing.

(A) A title insurer shall file with the (commissioner/director) all forms it proposes to use in this state, including:

(1) Title insurance policies, including standard form endorsements.

(2) "Preliminary reports," "commitments," "binders," or any other reports issued prior to the issuance of a title insurance policy.

If the (commissioner/director) finds in his review of a filing that it does not violate Section 35 of this act, he shall approve the form within 30 days of filing. Prior to such approval, the (commissioner/director) may conduct public hearings with respect to the filing. Filings that the (commissioner/director) has failed to approve or disapprove within 30 days of filing shall be deemed approved. Upon notice to the insurer, the period for review of a form filing may be extended for an additional 30 days.

(B) A title insurer need not file reinsurance contracts and agreements.

(C) No title insurer may issue, directly or through a title agent, any policy after the effective date of this act, unless the policy form has been approved pursuant to this section. The (commissioner/director) may provide by regulation for interim use of forms in effect prior to the effective date of this act.

Section 35. Form Standards.

The (commissioner/director) shall approve any form filed under Section 34 of this act only if the form:

(1) Is written in simple language logically and clearly arranged and is understandable to a person of normal intelligence without special insurance or legal knowledge or training;

(2) Does not contain or incorporate by reference any inconsistent, ambiguous, or misleading clauses, exceptions, or conditions deceptively affecting the risk purported to be assumed in the affirmative coverage of the contract;

(3) Does not contain any misleading title, heading, or other indication of its coverage;

(4) Is not printed or otherwise reproduced in such a manner as to render any provision of the form substantially illegible; and

(5) Is otherwise in compliance with this code.

Section 36. Endorsements.

Any approved policy form or endorsement providing any coverage for which no identifiable premium is assessed shall be incorporated in every policy of title insurance of the type to which the form or endorsement pertains issued by the insurer offering the approved form or endorsements. The insurer shall disclose any such additional coverage to the insured. The provisions of this section shall not operate to eliminate any underwriting standard or conditions relating to such approved policy forms or endorsements.

Section 37. Notice of Issuance of Mortgage Policy.

(A) A title insurer or title agent that issues a mortgagee's policy of title insurance on a loan made simultaneous to the purchase of all or part of the residential property securing the loan, where no owner's policy has been ordered, shall inform the borrower in writing that the mortgagee's policy does not protect the borrower, and that the borrower may obtain an owner's title insurance policy for his protection. This notice must be provided before disbursement of the loan proceeds and before issuance of a mortgagee's policy. The notice must be on a form prescribed by the (commissioner/director).

(B) If the borrower elects not to purchase an owner's title insurance policy, the title insurer or title agent shall obtain from him a statement in writing that the notice has been received and that the borrower waives the right to purchase an owner's title insurance policy. If the buyer refuses to provide the statement and waiver, the title insurer or title agent shall so note in the file. The statement and waiver must be on a form prescribed by the (commissioner/director), and must be retained by the title insurer or title agent for at least five years after receipt.

Section 38. Filing by Rating Bureaus.

(A) A title insurer may satisfy its obligation to make premium rate and form filings as required by this act by becoming a member of, or a subscriber to, a rating organization organized and licensed under the provisions of this code, which organization makes such filings, and by authorizing the (commissioner/director) in writing to accept such filings on its behalf.

(B) Nothing in this act shall be construed as requiring any title insurer to become a member of, or a subscriber to, any rating organization. Nothing in this act shall be construed as prohibiting the filing of deviations from rating organization filings by any member or subscriber.

Section 39. Title Plant Standards.

The (commissioner/director) may promulgate rules or regulations setting forth standards for operation of title plants in this state. Such standards may include standards for tract indices, general name indices, maps, plats and other organizing devices.

Section 40. Regulations.

In addition to any other powers granted under this act, the (commissioner/director) may adopt rules or regulations to protect the interests of the public including but not limited to regulations governing sales practices; escrow, collection, settlement, or closing procedures; policy coverage standards; rebates and inducements; controlled business; the approval of agency contracts; unfair trade practices and fraud; statistical plans for data collection; consumer education; any other consumer matters; the business of title insurance; or any regulations otherwise implementing or interpreting the provisions of this act.

Section 41. Enforcement.

(A) Except as provided in Section 30 any violation of this chapter shall carry with it, in addition to or in lieu of suspension or revocation of the violator's license a civil penalty of $500 per violation. For purposes of this chapter each individual transaction which is not in conformance with the provisions of this chapter shall be considered a violation.

(B) This act shall be enforceable only by the (commissioner/director) and shall not create any private cause of action or other private legal recourse.

(C) The (commissioner/director) may invoke the aid of the courts in enforcing the provisions of this act.

Section 42. Severability.

The provisions of this act shall be severable, and, if any of its provisions are held to be unconstitutional or invalid, the validity of the remaining provisions of this act will not be affected. It is hereby declared as legislative intent that this act would have been adopted by the legislature of this state had such unconstitutional or invalid provisions not been included.

Legislative History (all references are to the Proceedings of the NAIC).

1983 Proc. I 6, 36, 835, 928, 929-943 (adopted).

MODEL TITLE INSURANCE ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	NO ACTION TO DATE	
Alaska		ALASKA STAT. §§ 21.66.010 to 21.66.480 (1966/1985).
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1561 to 20-1592 (1967).
Arkansas	NO ACTION TO DATE	
California		CAL. INS. CODE §§ 12340 to 12417 (1935/1991).
Colorado		COLO. REV. STAT. §§ 10-11-101 to 10-11-121 (1963/1987).
Connecticut	CONN. GEN. STAT. §§ 38a-400 to 38a-425 (1990).	
Delaware	NO ACTION TO DATE	
D.C.		D.C. CODE ANN. §§ 26-401 to 26-436 (1901/1980).
Florida		FLA. STAT. §§ 627.7711 to 627.7892 (1982/1986).
Georgia	NO ACTION TO DATE	
Guam	NO ACTION TO DATE	
Hawaii	HAWAII REV. STAT. §§ 431:20-101 to 431:20-125 (1988).	
Idaho		IDAHO CODE §§ 41-2701 to 41-2713 (1961/1977).
Illinois		ILL. REV. STAT. ch. 73 §§ 478 to 487 (1901/1981).
Indiana		IND. CODE §§ 27-7-3-1 to 27-7-3-20 (1937/1985).
Iowa	NO ACTION TO DATE	

MODEL TITLE INSURANCE ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Kansas	NO ACTION TO DATE	
Kentucky		KY. REV. STAT. §§ 304.22-010 to 304.22-040 (1972).
Louisiana	NO ACTION TO DATE	
Maine	NO ACTION TO DATE	
Maryland		MD. ANN. CODE art. 48A §§ 486 to 486-1 (1967/1971).
Massachusetts		MASS. GEN. LAWS ch. 175 §§ 114 to 116A (1884/1939).
Michigan		MICH. COMP. LAWS §§ 500.7300 to 500.7318 (1966).
Minnesota		MINN. STAT. §§ 68A.01 to 68A.02 (1967/1974).
Mississippi		MISS CODE ANN. §§ 83-15-1 to 83-15-11 (1958/1977).
Missouri	MO. REV. STAT. §§ 381.010 to 381.200 (1987/1988).	
Montana	MONT. CODE ANN. §§ 33-25-104 to 33-25-403 (1985) (Parts of Model).	
Nebraska		NEB. REV. STAT. §§ 44-1901 to 44-1920 (1967).
Nevada		NEV. REV. STAT. §§ 692A.011 to 692A.230 (1977).
New Hampshire		N.H. REV. STAT. ANN. §§ 416-A:1 to 416-A:22 (1971).
New Jersey		N.J. REV. STAT. §§ 17:46B-1 to 17:46B-62 (1975/1990).
New Mexico		N.M. STAT. ANN. §§ 59A-30-1 to 59A-30-15 (1985/1989).
New York		N.Y. INS. LAW §§ 6401 to 6411 (1984).

MODEL TITLE INSURANCE ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
North Carolina		N.C. GEN. STAT. §§ 58-26-1 to 58-26-40 (1899/1974).
North Dakota		N.D. CENT. CODE §§ 26.1-20-01 to 26.1-20-06 (1984).
Ohio		OHIO REV. CODE ANN. §§ 3953.01 to 3953.28 (1967).
Oklahoma		OKLA. STAT. tit. 36 §§ 5001 to 5005 (1957).
Oregon		See OR. ADMIN. R. 836-80-305 to 836-80-345 (1980/1988).
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 61-101 to 61-154 (1963).
Puerto Rico		P.R. LAWS ANN. tit.26 §§ 2401 to 2404 (1976).
Rhode Island	NO ACTION TO DATE	
South Carolina	S.C. CODE ANN. §§ 38-75-905 TO 38-75-1000 (1988)(Parts of model).	
South Dakota		S.D. CODIFIED LAWS ANN. §§ 58-25-1 to 58-25-21 (1966/1979).
Tennessee		TENN. CODE ANN. §§ 56-35-101 to 56-35-205 (1955/1985).
Texas		TEX. INS. CODE ANN. art. 9.01 to 9.57 (1967/1983).
Utah	NO ACTION TO DATE	
Vermont	NO ACTION TO DATE	
Virgin Islands		V.I. CODE ANN. tit. 22§§ 1151 to 1161 (1968).
Virginia		VA. CODE §§ 38.2-4600 to 38.2-4615 (1986/1987).
Washington		WASH. REV. CODE ANN. §§ 48.29.010 to 48.29.170 (1947/1981).

MODEL TITLE INSURANCE ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
West Virginia	NO ACTION TO DATE	
Wisconsin	NO ACTION TO DATE	
Wyoming	WYO. STAT. §§ 26-23-301 to 26-23-326 (1983).	

EXHIBIT H

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

Table of Contents

Section 1. Short Title

This Act may be cited as the Health Maintenance Organization Act of [insert year].

Introductory Comment:

Nature of the Health Maintenance Organization

A health maintenance organization may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by or on behalf of the enrollees. An HMO can be organized, operated and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, insurance companies, etc. Generally speaking, an HMO delivery system is predicated on three principles: (1) It is an organized system for the delivery of health care which brings together health care providers; (2) Such an arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability; (3) The payments will be made on a prepayment basis, whether by the individual enrollees, Medicare, Medicaid or through employer-employee arrangements.

How might the HMO concept contribute to alleviating the difficulties posed by the current health care delivery system?

An HMO can directly address itself to the problems of availability, accessibility and continuity, since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentives toward lessening costs in delivering health care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment and, in general, provide a monitoring mechanism.

The Need for State Authorizing and Regulatory Legislation

From 1970 to 1973, the administration and committees in both houses of Congress spent much time analyzing the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMOs. This analysis resulted in the enactment of the federal HMO Act in 1973. Since then, the number of health maintenance organizations and the number of HMO enrollees has grown rapidly. Prior to 1972, however, few states had a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation, and other supervision was being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. Because the HMO is a unique type of organization, many provisions of such state laws were inapplicable, highly restrictive or prohibitive to the formation and operation of an HMO. Therefore, in 1972 the NAIC adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMOs.

Purpose of a State Model Bill

The model bill clearly authorizes the establishment and operation of HMOs. Restrictive provisions in other laws which are inappropriate to HMOs are rendered inapplicable. Appropriate grants of authority are established to enable the HMOs to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient and ethical operation of HMOs. As is the case with insurance and hospital and medical service corporations, HMOs are "affected with the public interest." Regulatory safeguards dovetailed to the unique nature of HMOs are essential. Thus, the purpose of this model bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMOs of a wide variety including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the model bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system..

Of course, it is also possible that the statutes of a given state are presently broad enough to allow operation of at least certain types of HMOs and provide the commissioner with appropriate authority to regulate them. In those states, a bill such as this may be desirable in order to consolidate and define more clearly the authority for and manner of regulation of an HMO. However, it may be possible to form HMOs under existing laws in some states before passage of this model legislation and it is anticipated that such programs can develop concurrently with any legislative activity.

The model, or substantial portions of it, has been enacted in 27 states and substantial experience has been gained in implementing and regulating HMOs under its terms. In addition, as HMOs have become insolvent and commissioners have had to deal with the results of those insolvencies, the model act has been revised to reflect changes which have occurred in the federal law, to reflect experience gained in administering the law, and to clarify and strengthen the provisions relating to HMO solvency.

It may be necessary to modify or replace certain language in the model bill prior to legislative consideration to make terminology consistent with existing law in a particular state. To simplify this adjustment, three frequently used terms known to be subject to variation from state to state are enclosed in brackets wherever used in order to facilitate necessary modification. These terms are: (1) commissioner, whose counterparts in some states are known as director or superintendent; (2) commissioner of public health, whose counterparts in other states are known as director of public health or by some other title; and (3) hospital or medical service corporations, whose counterparts in other states may be known as health service corporations, hospital indemnity corporations, etc. Where specific reference to existing state laws is required, the nature of the citation is indicated in brackets.

The model bill provides that the principal regulator is the commissioner of insurance. It may be desirable for the commissioner to have an advisory council to advise him in carrying out his duties under the Act. Such an advisory council could be established through the promulgation of a regulation pursuant to Section 23 of the model bill or by adding a new section to the model bill.

Section 2. Definitions

A. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

B. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

C. "Carrier" shall mean a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

D. "Commissioner" [director, superintendent] means the commissioner [director, superintendent] of insurance.

E. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

F. "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

G. "Enrollee" means an individual who is covered by a health maintenance organization.

H. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder.

I. "Extension of benefits" shall mean the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

J. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

K. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

L. "Group contract holder" means the person to which a group contract has been issued.

M. "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and/or deductibles.

N. "Health maintenance organization producer" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for HMO membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such.

O. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

P. "Insolvent" or "Insolvency" shall mean that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

Q. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

Comment: Examples of Subsection Q agreements include but are not limited to payments on a DRG or per diem basis or where there is an agreement between a hospital and health maintenance organization and which are under common ownership or control.

R. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

S. "Participating provider" means a provider as defined in U below who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

T. "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts or corporations.

U. "Provider" means any physician, hospital or other person licensed or otherwise authorized to furnish health care services.

V. "Replacement coverage" shall mean the benefits provided by a succeeding carrier.

W. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

X. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner [director, superintendent].

Comment: Subsection X defines uncovered expenditures for use in Section 13. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

Section 3. Establishment of Health Maintenance Organizations

A. Notwithstanding any law of this state to the contrary, any person may apply to the commissioner [director, superintendent] for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under [insert citation] and compliance with all provisions of this Act and other applicable state laws.

B. Any health maintenance organization which has not previously received a certificate of authority to operate as a health maintenance organization as of the effective date of this Act shall submit an application for a certificate of authority under Subsection C within [insert number] days of the effective date of this Act. Each such applicant may continue to operate until the commissioner [director, superintendent] acts upon the application. In the event that an application is denied under Section 4, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

C. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner [director, superintendent], and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses and official positions and biographical information on forms acceptable to the commissioner [director, superintendent] of the persons who are to be responsible for the conduct of the affairs and day to day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

Comment: NAIC biographical forms are recommended.

(4) A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third party administrators, marketing consultants or persons listed in Paragraph (3) and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

(7) Financial statements showing the applicant's assets, liabilities and sources of financial support. Include both a copy of the applicant's most recent (regular) certified financial statement and an unaudited current financial statement;

(8) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by such applicant, if not domiciled in this state,

appointing the commissioner [director, superintendent] and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement or map reasonably describing the geographic area or areas to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in Section 13;

(14) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

(15) Such other information as the commissioner [director, superintendent] may require to make the determinations required in Section 4.

D. (1) The commissioner [director, superintendent] may promulgate such rules and regulations as he deems necessary to the proper administration of this Act to require a health maintenance organization, subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in Subsection C of this section to the commissioner [director, superintendent], either for his approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to both [the commissioner of public health] and the commissioner [director, superintendent] at the time of the next succeeding site visit or examination.

(2) Any modification or amendment for which the commissioner's [director's, superintendent's] approval is required shall be deemed approved unless disapproved within thirty (30) days, provided that the commissioner [director, superintendent] may postpone the action for such further time, not exceeding an additional thirty (30) days, as necessary for proper consideration.

Comment: Section 3 requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity in which the responsibilities imposed by this Act are vested, serves as the focus of regulatory attention to assure that the consuming public is well served.

Subsection A is intended to provide a general override to existing state laws which restrict or prevent the formation or operation of health maintenance organizations. Among other restrictions, existing state laws may:

(1) Require approval of a health maintenance organization by a medical society;

(2) Require that physicians constitute all or a majority of the governing body of a health maintenance organization;

(3) Require that all physicians or a percentage of physicians in the local medical society be permitted to participate in rendering the services of the organization;

(4) Require that such organization submit to regulation as an insurer of health care services;

(5) Require that only unincorporated individuals or associations or partnerships may provide health care services;

(6) Prohibit advertising by a professional group for recruitment of enrollees.

In addition to the general override provided in Subsection A, Section 26 specifically provides that the insurance law, the hospital and medical service corporation law and certain other provisions do not apply to HMOs.

It is assumed that, restrictive provisions of state law having been overcome, the "person" making application for a certificate of authority, if not an individual, will be created through existing state mechanisms such as the applicable nonprofit corporation act, business corporation act, etc. as appropriate. Since state laws generally establish detailed procedures related to business organizations, inclusion of organizational procedures in a model act of this nature would appear unnecessary. A business having incorporated under the law of a foreign state could qualify under this act after following appropriate state procedures required of foreign corporation seeking to do business in the state.

Section 4. Issuance of Certificate of Authority

A. (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner [director, superintendent] shall forthwith transmit copies of such application and accompanying documents to the [commissioner of public health].

(2) The [commissioner of public health] shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished has complied with Section 7 of this Act.

(3) Within forty-five (45) days of receipt of the application for issuance of a certificate of authority, the [commissioner of public health] shall certify to the commissioner [director, superintendent] that the proposed health maintenance organization meets the requirements of Section 7 or notify the commissioner [director, superintendent] that the health maintenance organization does not meet such requirements and specify in what respects it is deficient.

B. The commissioner [director, superintendent] shall within forty-five (45) days of receipt of certification or notice of deficiencies from the [commissioner of public health] issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the commissioner [director, superintendent] being satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) Any deficiencies identified by the [commissioner of public health] have been corrected and the [commissioner of public health] has certified to the commissioner [director, superintendent] that the health maintenance organization's proposed plan of operation meets the requirements of Section 7;

(3) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments and/or deductibles; and

(4) The health maintenance organization is in compliance with Sections 13 and 15 of this Act.

C. A certificate of authority shall be denied only after the commissioner [director, superintendent] complies with the requirements of Section 20.

Comment: A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. Section 4 provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the state insurance and health departments. It is felt that the expertise of the state insurance department on fiscal and other regulatory matters and the familiarity of the state health department with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency — the insurance department. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the insurance commissioner obligated to rely on the health department with respect to the latter's sphere of expertise.

Comment: Subsection B(3) makes explicit the requirement that an health maintenance organization must provide a minimum package of services on a prepaid basis. Reasonable copayments, however, are permitted and do not violate the requirement for prepayment. Such copayments may be used to (1) reduce the amount of prepayments and (2) minimize frivolous utilization of services. In addition, an health maintenance organization may have more than one benefit package involving different levels of copayments.

Section 5. Powers of Health Maintenance Organizations

A. The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc,) between affiliates or between the health maintenance organization and its parent;

(3) The furnishing of health care services through providers, provider associations or agents for providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(7) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

B. (1) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner [director, superintendent] prior to the exercise of any power granted in Subsections A(1), (2) or (4) which may affect the financial soundness of the health maintenance organization. The commissioner [director, superintendent] shall disapprove such exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization

and endanger its ability to meet its obligations. If the commissioner [director, superintendent] does not disapprove within thirty (30) days of the filing, it shall be deemed approved.

(2) The commissioner [director, superintendent] may promulgate rules and regulations exempting from the filing requirement of Paragraph (1) those activities having a de minimis effect.

Section 6. Fiduciary Responsibilities

A. Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors and partners in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner [director, superintendent].

Comment: As an optional additional subsection, language may be included that would make the appropriate provisions of the state's insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section 7. Quality Assurance Program

A. The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

(a) The health maintenance organization's scope and purpose in quality assurance;

(b) The organizational structure responsible for quality assurance activities;

(c) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(d) Confidentiality policies and procedures;

(e) A system of ongoing evaluation activities;

(f) A system of focused evaluation activities;

(g) A system for credentialing providers and performing peer review activities; and

(h) Duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) A written statement describing the system of ongoing quality assurance activities including:

(a) Problem assessment, identification, selection and study;

(b) Corrective action, monitoring, evaluation and reassessment; and

(c) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

C. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the [commissioner of public health].

D. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Enrollee clinical records shall be available to the [commissioner of public health] or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the [commissioner of public health].

F. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organizations.

Section 8. **Requirements for Group Contract, Individual Contract and Evidence of Coverage**

A. (1) Every group and individual contract holder is entitled to a group or individual contract.

(2) The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by [cite section of state law which implements the NAIC Unfair Trade Practices Act];

(3) The contract shall contain a clear statement of the following:

(a) Name and address of the health maintenance organization;

(b) Eligibility requirements;

(c) Benefits and services within the service area;

(d) Emergency care benefits and services;

(e) Out of area benefits and services (if any);

(f) Copayments, deductibles or other out-of-pocket expenses;

(g) Limitations and exclusions;

(h) Enrollee termination;

(i) Enrollee reinstatement (if any);

(j) Claims procedures;

(k) Enrollee grievance procedures;

(l) Continuation of coverage;

(m) Conversion;

(n) Extension of benefits (if any);

(o) Coordination of benefits (if applicable);

(p) Subrogation (if any);

(q) Description of the service area;

(r) Entire contract provision;

(s) Term of coverage;

(t) Cancellation of group or individual contract holder;

(u) Renewal;

(v) Reinstatement of group or individual contract holder (if any);

(w) Grace period; and

(x) Conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraphs (3)(a) to (q) of this subsection.

B. In addition to those provisions required in Subsection A(3)(a) to (x), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, he or she must pay for such services.

C. (1) Every subscriber shall receive an evidence of coverage from the group contractholder or the health maintenance organization.

(2) The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by [cite section of state law which implements the NAIC Unfair Trade Practices Act];

(3) The evidence of coverage shall contain a clear statement of the provisions required in Subsection A(3)(a) to (q).

D. The commissioner [director, superintendent] may adopt regulations establishing readability standards for individual contract, group contract, and evidence of coverage forms.

Comment: The commissioner [director, superintendent] may adopt standards provided for in the NAIC "Life and Health Insurance Policy Language Simplification Act."

E. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner [director, superintendent], subject to Subsection F and G of this section.

F. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner [director, superintendent] of this state for approval.

G. Every form required by Section 8 shall be filed with the commissioner [director, superintendent] not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty (30) day period, the commissioner [director, superintendent] may extend the period for review for an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner [director, superintendent] has taken no action. The filer must notify the commissioner [director, superintendent] in writing prior to using a form that is deemed approved.

At any time, after thirty (30) days notice and for cause shown, the commissioner [director, superintendent] may withdraw approval of any form, effective at the end of the thirty (30) days.

When a filing is disapproved or approval of a form is withdrawn, the commissioner [director, superintendent] shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing will be conducted within thirty (30) days after the commissioner [director, superintendent] has received the request for hearing.

H. The commissioner [director, superintendent] may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

Section 9. Annual Report

A. Every health maintenance organization shall annually, on or before the first day of Ma... file a report verified by at least two principal officers with the commissioner [direct...

superintendent], with a copy to the [commissioner of public health] covering the preceding calendar year. Such report shall be on forms prescribed by the commissioner [director, superintendent]. In addition, the health maintenance organization shall file by the first day of March, unless otherwise stated:

(1) Audited financial statements on or before June 1;

(2) A list of the providers who have executed a contract that complies with Section 13(D)(1) of this Act; and

(3) (a) A description of the grievance procedures, and

(b) The total number of grievances handled through such procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

B. The commissioner [director, superintendent] may require such additional reports as are deemed necessary and appropriate to enable the commissioner [director, superintendent] to carry out his duties under this Act.

Section 10. Information to Enrollees or Subscribers

A. The health maintenance organization shall provide to its subscribers a list of providers, upon enrollment and re-enrollment.

B. Every health maintenance organization shall provide within thirty (30) days to its subscribers notice of any material change in the operation of the organization that will affect them directly.

C. An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

D. The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained and a number where the enrollee can contact the HMO, at no cost to the enrollee.

Comment: For the purpose of this section any major change in the provider network is considered a material change.

Section 11. Grievance Procedures

A. Every health maintenance organization shall establish and maintain a grievance procedure which has been approved by the commissioner [director, superintendent], after consultation with the [commissioner of public health], to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of such grievances.

B. The commissioner [director, superintendent] or the [commissioner of public health] may examine such grievance procedures.

Section 12. Investments

With the exception of investments made in accordance with Section 5A(1), the funds of a health maintenance organization shall be invested only in accordance with [cite section of law or regulation implementing the NAIC "Health Maintenance Organization Investment Guidelines."]

Section 13. Protection Against Insolvency

A. Net Worth Requirements

(1) Before issuing any certificate of authority, the commissioner, [director, superintendent] shall require that the health maintenance organization have an initial net worth of one million five hundred thousand dollars ($1,500,000) and shall thereafter maintain the minimum net worth required under Paragraph (2).

(2) Except as provided in Paragraphs (3) and (4) of this subsection, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(a) One million dollars ($1,000,000); or

(b) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner [director, superintendent] on the first $150,000,000 of premium and one percent of annual premium on the premium in excess of $150,000,000; or

(c) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner [director, superintendent]; or

(d) An amount equal to the sum of:

(i) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner [director, superintendent]; and

(ii) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner [director, superintendent].

(3) A health maintenance organization licensed before the effective date of this Act must maintain a minimum net worth of:

(a) Twenty-five percent (25%) of the amount required by Section 13(A)(2) by December 31, 19__;

(b) Fifty percent (50%) of the amount required by Section 13(A)(2) by December 19__;

(c) Seventy-five percent (75%) of the amount required by Section 13(A)(2) by December 31, 19__;

(d) One hundred percent (100%) of the amount required by Section 13(A)(2) by December 31, 19__.

(4) (a) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner [director, superintendent]. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(c) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner [director, superintendent], shall not be considered a liability and shall be recorded as equity.

B. Deposit Requirements

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner [director, superintendent] or, at the discretion of the commissioner [director, superintendent], with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to him which at all times shall have a value of not less than three hundred thousand dollars ($300,000).

(2) A health maintenance organization that is in operation on the effective date of this section shall make a deposit equal to one hundred fifty thousand dollars ($150,000).

In the second year, the amount of the additional deposit for a health maintenance organization that is in operation on the effective date of the section shall be equal to one hundred fifty thousand dollars ($150,000), for a total of three hundred thousand dollars ($300,000).

(3) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(4) All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner [director, superintendent] before being deposited or substituted.

(5) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The commissioner [director, superintendent] may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

(6) The commissioner [director, superintendent] may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner [director, superintendent], or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of such health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner [director, superintendent] a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

C. Liabilities

Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

Such liabilities shall be computed in accordance with regulations promulgated by the commissioner [director, superintendent] upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

D. Hold Harmless

(1) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

(3) No participating provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

E. Continuation of Benefits

The commissioner [director, superintendent] shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner [director, superintendent] may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit;

(5) Any other arrangements to assure that benefits are continued as specified above.

F. Notice of Termination

An agreement to provide health care services between a provider and a health maintenance

organization must require that if the provider terminates the agreement, the provider shall give the organization at least sixty (60) days' advance notice of termination.

Section 14. Uncovered Expenditures Insolvency Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner [director, superintendent], with any organization or trustee acceptable to the commissioner [director, superintendent] through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. Such deposit shall at all times have a fair market value in an amount of 120% of the HMO's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 13 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from such deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from such deposit or account quarterly with the approval of the commissioner [director, superintendent].

C. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if (1) a substitute deposit of cash or securities of equal amount and value is made, (2) the fair market value exceeds the amount of the required deposit, or (3) the required deposit under Subsection A is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner [director, superintendent].

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner [director, superintendent] may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner [director. superintendent] may by regulation prescribe the time. manner and form for filing claims under Subsection D.

F. The commissioner [director. superintendent] may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports as he deems necessary to demonstrate compliance with this section. The commissioner [director. superintendent] may require that the reports include liability for uncovered expenditures as well as an audit opinion.

Section 15. Enrollment Period, Replacement Coverage in the Event of Insolvency

A. Enrollment Period

(1) In the event of an insolvency of a health maintenance organization. upon order of the

commissioner [director, superintendent] all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner [director, superintendent] determines that the other health benefit plan(s) lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner [director, superintendent] shall allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The commissioner [director, superintendent] shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

Comment: Amendments to the insurance code regulating indemnity carriers may be necessary to bring the insurance carriers into the jurisdiction of this provision.

B. Replacement Coverage

(1) "Discontinuance" shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

Section 16. Filing Requirements for Rating Information

A. No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner [director, superintendent].

B. Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee shall not be individually determined based on the status of his/her health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner [director, superintendent] as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

C. The commissioner [director, superintendent] shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of Subsection B are met. If the commissioner [director, superintendent] disapproves such filing, he shall notify the health maintenance organization. In the notice, the commissioner [director, superintendent] shall specify the reasons for his disapproval. A hearing will be conducted within thirty (30) days after a request in writing by the person filing. If the commissioner [director, superintendent] does not take action on such schedule or methodology within thirty (30) days of the filing of such schedule or methodology, it shall be deemed approved.

Section 17. Regulation of Health Maintenance Organization Producers

A. The commissioner [director, superintendent] may, after notice and hearing, promulgate such rules and regulations as are necessary to provide for the licensing of health maintenance organization producers. Such rules shall establish:

(1) The requirements for licensure of resident health maintenance organization producers;

(2) The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

(3) Any examination, prelicensing or continuing education requirements;

(4) The requirements for registering and terminating the appointment of health maintenance organization producers;

(5) Any requirements for registering any assumed names or office locations in which an health maintenance organization producer does business;

(6) The conditions for health maintenance organization producer license renewal;

(7) The grounds for denial, refusal, suspension or revocation of an health maintenance organization producer's license;

(8) Any required fees for the licensing activities of health maintenance organization producers; and

(9) Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

B. None of the following shall be required to hold a health maintenance organization producer license:

(1) Any regular salaried officer or employee of a health maintenance organization who devotes substantially all of his time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

(2) Employers or their officers or employees or the trustees of any employee benefit plan to the extent that such employers, officers, employees or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships; provided that such employers, officers, employees or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing such health maintenance organization memberships;

(3) Banks or their officers and employees to the extent that such banks, officers and employees collect and remit charges by charging same against accounts of depositors on the orders of such depositors; or

(4) Any person or the employee of any person who has contracted to provide administrative, management or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this Act.

C. The commissioner [director, superintendent] may by rule exempt certain classes of persons from the requirement of obtaining a license:

(1) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(2) If other existing safeguards make regulation unnecessary.

Section 18. Powers of Insurers and [Hospital and Medical Service Corporations]

A. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

B. Notwithstanding any provision of insurance and hospital or medical service corporation laws [citations], an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Section 19. Examinations

A. The commissioner [director, superintendent] may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.

B. The [commissioner of public health] may make an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.

C. Every health maintenance organization and provider shall submit its books and records for such examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner [director, superintendent] and the [commissioner of public health] may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of such providers concerning their business.

D. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner [director, superintendent] or the [commissioner of public health] for whom the examination is being conducted.

E. In lieu of such examination, the commissioner [director, superintendent] or [commissioner of public health] may accept the report of an examination made by the commissioner [director, superintendent] or [commissioner of public health] of another state.

Section 20. Suspension or Revocation of Certificate of Authority

A. Any certificate of authority issued under this Act may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner [director, superintendent] finds that any of the conditions listed below exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 3, unless amendments to such submissions have been filed with and approved by the commissioner [director, superintendent];

(2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Section 8 and 16;

(3) The health maintenance organization does not provide or arrange for basic health care services;

(4) The [commissioner of public health] certifies to the commissioner [director, superintendent] that:

(a) The health maintenance organization does not meet the requirements of Section 4A(2); or

(b) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to correct, within the time prescribed by Subsection C, any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired;

(7) The health maintenance organization has failed to implement the grievance procedures required by Section 11 in a reasonable manner to resolve valid complaints;

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has otherwise failed substantially to comply with this Act.

B. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to [insert amount] dollars for each cause for suspension or revocation.

C. The following shall pertain when insufficient net worth is maintained:

(1) Whenever the commissioner [director, superintendent] finds that the net worth maintained by any health maintenance organization subject to the provisions of this Act is less than the minimum net worth required to be maintained by Section 13 of this Act, he shall give written notice to the health maintenance organization of the amount of the deficiency and require: (a) filing with the commissioner [director, superintendent] a plan for correction of the deficiency acceptable to the commissioner [director, superintendent] and (b) correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the commissioner [director, superintendent]. Such a deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation or liquidation.

(2) Unless allowed by the commissioner [director, superintendent] no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing such coverage is impaired, and the fact of such impairment is known to the health maintenance organization or to such person.

However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

D. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

(1) Suspension or revocation of a certificate of authority or the denial of an application or the imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail and to the [commissioner of public health]. The written order shall state the grounds, charges or conduct on which suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, such order shall be final upon the expiration of said thirty (30) days.

(2) If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner [director, superintendent] shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the [commissioner of public health] stating:

(a) A specific time for the hearing, which may not be less than twenty nor more than thirty (30) days after mailing of the notice of hearing; and

(b) A specific place for the hearing, which may be either in [location of regulatory body] or in the county where the health maintenance organization's or applicant's principal place of business is located.

(c) If a hearing is requested, the [commissioner of public health] or his designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the [commissioner of public health] with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner [director, superintendent].

After such hearing, or upon failure of the health maintenance organization to appear at such hearing, the commissioner [director, superintendent] shall take whatever action he deems necessary based on written findings and shall mail his decision to the health maintenance organization or applicant with a copy to the [commissioner of public health]. The action of the commissioner [director, superintendent] and the recommendation and findings of the [commissioner of public health] shall be subject to review under the State Administrative Review Act (or other applicable statutory review process).

E. The provisions of the [Administrative Procedure Act] of this state shall apply to proceedings under this section to the extent they are not in conflict with Subsection D(2).

F. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

G. When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner [director, superintendent] may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section 21. Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

A. Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner [director, superintendent] pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner [director, superintendent] may apply for an order directing him to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in [cite sections of state rehabilitation law], or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

B. For purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by [insert state statute for liquidation of insurers] for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in [insert citation to insurance code].

Section 22. Summary Orders and Supervision

A. Whenever the commissioner [director, superintendent] determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this Act, he may, after notice and hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner [director, superintendent];

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take such other steps as the commissioner [director, superintendent] may deem appropriate under the circumstances.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which such health maintenance organization is subject shall be deemed a violation of this Act.

C. The commissioner [director, superintendent] is authorized, by rules and regulations, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in Subsection A of this section.

D. The remedies and measures available to the commissioner [director, superintendent] under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner [director, superintendent] under the provisions of [cite law which implements Sections 9 and 10 of the NAIC Rehabilitation and Liquidation Model Act].

Section 23. Regulations

The commissioner [director, superintendent] may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this Act. Such rules and regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of such rules].

Section 24. Fees

A. Every health maintenance organization subject to this Act shall pay to the commissioner [director, superintendent] the following fees:

(1) For filing an application for a certificate of authority or amendment thereto [insert amount] dollars;

(2) For filing an amendment to the organization documents that requires approval, [insert amount] dollars;

(3) For filing an amendment "for information only," [insert amount] dollars; and

(4) For filing each annual report, [insert amount] dollars.

B. Fees charged under this section shall be distributed as follows: [insert dollar amount] to the commissioner [director, superintendent] and [insert dollar amount] to the [commissioner of public health].

[Alternative language to Subsections A and B above:

The commissioner [director, superintendent] shall promulgate rules for collecting fees from health maintenance organizations.]

Comment: Each state should examine its statutory authority to collect fees and select the appropriate language suggested above.

Section 25. Penalties and Enforcement

A. The commissioner [director, superintendent] may, in lieu of suspension or revocation of a certificate of authority under Section 20, levy an administrative penalty in an amount not less than [insert amount] dollars nor more than [insert amount] dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner [director, superintendent] may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

B. (1) If the commissioner [director, superintendent] or the [commissioner of public health] shall for any reason have cause to believe that any violation of this Act has occurred or is threatened, the commissioner [director, superintendent] or [commissioner of public health] may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation; and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner [director, superintendent] or the [commissioner of public health] may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this Act are satisfied.

C. (1) The commissioner [director, superintendent] may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this Act.

(2) Within [insert number] days after service of the cease and desist order, the [illegible] may request a hearing on the question of whether acts or practices in viola[illegible] this Act have occurred. Such hearings shall be conducted pursuant to [cite sections of state administrative procedure act], and judicial review shall be available as provided by [cite sections of state administrative procedure act].

D. In the case of any violation of the provisions of this Act, if the commissioner [director, superintendent] elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to Subsection C, the commissioner [director, superintendent] may institute a proceeding to obtain injunctive or other appropriate relief in the [name of court of primary jurisdiction for actions of this nature].

Comment: Sections 25C and 25D authorize the commissioner to issue a cease and desist order and to apply for injunctive relief. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

E. Notwithstanding any other provisions of this Act, if a health maintenance organization fails to comply with the net worth requirement of this Act, the commissioner [director, superintendent] is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

Section 26. Statutory Construction and Relationship to Other Laws

A. Except as otherwise provided in this Act, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

C. Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [citation] relating to the practice of medicine.

Section 27. Filings and Reports as Public Documents

All applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 9 of this Act.

Section 28. Confidentiality of Medical Information and Limitation of Liability

A. Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

B. A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any records, information or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the health maintenance organization which established such committee or the officers, directors, employees or agents of such health maintenance organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

C. (1) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to

produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting such committee, or any person assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(2) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to Subsection C(1) by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

D. To fulfill its obligations under Section 7, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

Section 29. [Commissioner of Public Health's] Authority to Contract

The [commissioner of public health], in carrying out his obligations under this Act, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the [commissioner of public health].

Section 30. Acquisition of Control of or Merger of a Health Maintenance Organization

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner [director, superintendent] and has sent to the health maintenance organization, information required by Section [cite Sections 2(b)(1), (2), (3), (4), (5), and (12) of the NAIC Model Insurance Holding Company System Regulatory Act] and the offer, request, invitation, agreement or acquisition has been approved by the commissioner [director, superintendent]. Approval by the commissioner [director, superintendent] shall be governed by Section [cite law which implements Section 3(d)(1) and (2) of the NAIC Model Insurance Holding Company System Regulatory Act].

Section 31. Dual Choice [optional]

Each employer, public or private, in this state which offers its employees a health benefit plan and employs not less than twenty-five (25) employees, and each employee benefit fund in this state which offers its members any form of basic health benefit, shall make available to and inform its employees or members of the option to enroll in at least one group practice health maintenance organization and one other health maintenance organization holding a valid certificate of authority which provides basic health care services in the geographic areas in which a substantial number of such employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organization(s) to be made available to the employees shall

be made under the agreement. No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of basic health benefits to its employees. The employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount which does not financially discriminate against an employee who enrolls in such health maintenance organization. For purposes of the preceding sentence, an employer's contribution does not financially discriminate if the employer's method of determining the contributions on behalf of all employees is reasonable and is designed to assure employees a fair choice among health benefits plans.

Comment: This section, which is optional, is similar to Section 1310 of the federal Health Maintenance Organization Act, but extends the dual choice requirement to state licensed health maintenance organizations.

The purpose for this provision is to assist in the growth and development of state licensed health maintenance organizations. A state that wants to continue to promote the development of health maintenance organizations or to establish a standard on which employer contributions are made may want to enact this section.

Section 32. Coordination of Benefits

A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

B. If health maintenance organizations adopt coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans.

C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are: received from non-participating providers; provided outside their service areas; or not covered under the terms of their group contracts or evidence of coverage.

Section 33. Insolvency Protection; Assessment

A. When a health maintenance organization in this state is declared insolvent by a court of competent jurisdiction, the commissioner [director, superintendent] may levy an assessment on health maintenance organizations doing business in this state to pay claims for uncovered expenditures for enrollees who are residents of this state and to provide continuation of coverage for subscribers or enrollees not covered under Section 15. The commissioner [director, superintendent] may not assess in any one calendar year more than two percent (2%) of the aggregate premium written by each health maintenance organization in this state the prior calendar year.

B. The commissioner [director, superintendent] may use funds obtained under Subsection A to pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under Section 15, and administrative costs. The commissioner [director, superintendent] may by regulation prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

C. (1) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(2) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the commissioner [director, superintendent] to the extent of the benefits received. The commissioner [director, superintendent] may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon such person. The commissioner [director, superintendent] is subrogated to these rights against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(3) The assignment or subrogation rights of the commissioner [director, superintendent] and allowed claim under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

D. When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the commissioner [director, superintendent] will distribute on a pro rata basis any amounts received under Subsection A which are not de minimis to the health maintenance organizations which have been assessed under this section.

E. The aggregate coverage of uncovered expenditures under this section shall not exceed $300,000 with respect to any one individual. Continuation of coverage shall not continue for more than the lesser of one year after the health maintenance organization coverage is terminated by insolvency or the remaining term of the contract. The commissioner [director, superintendent] may provide continuation of coverage on any reasonable basis; including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the commissioner [director, superintendent].

F. The commissioner [director, superintendent] may waive an assessment of any health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within thirty (30) days after notice is subject to a civil forfeiture of not more than $1,000 per day and/or suspension or revocation of its certificate of authority. Any action taken by the commissioner [director, superintendent] in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with [the administrative procedures act].

Drafting Comment: Section 33 is not recommended for all states. A state should carefully review its health maintenance organization market to determine whether the assessment procedure under this section is feasible. If health maintenance organization premium volume is small or dominated by a few organizations, a state may wish to rely solely on the protections provided under Section 14 and 15.

For those states where an assessment is feasible, this section provides assurance that funds will be available to pay uncovered expenditures even if those liabilities have been underestimated by the organization or have significantly escalated as the financial condition of the organization deteriorated. In addition, an assessment provides a means for continued coverage for those subscribers or enrollees who are not protected under Section 15.

Section 34. Severability

If any section, term, or provision of this Act shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term or provision of this Act; but the remaining sections, terms and provisions shall be and remain in full force and effect.

Legislative History (all references are to the Proceedings of the NAIC).

1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).
1973 Proc. II 139 (synopsis of model).
1974 Proc. I 12, 14, 405, 413 (amended).
1982 Proc. I 19, 28, 431, 498-499, 530-554 (revised and reprinted).
1989 Proc. I 9, 22, 180-181, 327, 331-335 (amended).
1989 Proc. II 13, 25-26, 40, 51-79 (amended and reprinted).
1990 Proc. I 6, 26, 171, 374-376, 377-379 (amended).
1991 Proc. I 9, 19-20, 86, 108 (technical amendment).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA. CODE §§ 27-21A-1 to 27-21A-32 (1986).	
Alaska	ALASKA STAT. §§ 21-86.010 to 21.86.900 (1990).	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1069 (1973/1990) ("Health Care Service Organizations").
Arkansas	ARK. STAT. ANN. §§ 23-76-101 to 23-76-130 (1975/1987).	
California		CAL. HEALTH & SAFETY CODE §§ 1340 to 1399.64 (1979/1992) ("Knox-Keene Health Care Services Plan").
Colorado	COLO. REV. STAT. §§ 10-16-401 to 10-16-428 (1992).	
Connecticut		CONN. GEN. STAT. §§ 33-179a to 33-179t (1971/1990) "Health Care Centers".
Delaware		DEL. CODE ANN. tit. 16 §§ 9101 to 9115 (1982); See also: tit. 18 §§ 6401 to 6406 (1987) (Dept. of Public Health).
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 641.17 to 641.3921 (1985/1991).
Georgia	GA. CODE ANN. §§ 33-21-1 to 33-21-28 (1979/1986).	
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Idaho		IDAHO CODE §§ 41-3901 to 41-3934 (1974/1985).
Illinois	ILL. REV. STAT. ch. 111 1/2 §§ 1401 to 1417 (1974/1992) (Public Health and Safety Code).	
Indiana		IND. CODE §§ 27-8-7-1 to 27-8-7-18 (1979/1987) ("Proposed Health Care Delivery Plans").
Iowa	IOWA CODE §§ 514B.1 to 514B.32 (1973).	
Kansas	KAN. STAT. ANN. §§ 40-3201 to 40-3227 (1974/1991).	
Kentucky		KY. REV. STAT. §§ 304.38-010 to 304.38-210 (1982/1990).
Louisiana	LA. REV. STAT. ANN §§ 22:2001 to 22:2026 (1986/1989).	
Maine	ME. REV. STAT. ANN. tit. 24-A §§ 4201 to 4226 (1975/1990).	ME. REV. STAT. ANN. tit. 24-A §§ 4202-A, 4204-A, 4207-A (1992) (Point of service provisions).
Maryland		MD. ANN. CODE art. 19 §§ 701 to 734 (1982/1991) (Health Code).
Massachusetts		MASS. GEN LAWS ch. 176G §§ 1 to 17 (1976/1986).
Michigan		MICH. COMP. LAWS. §§ 333.21001 to 333.21098 (1982/1990) (Public Health Code).
Minnesota	MINN. STAT. §§ 62D.01 to 62D.30 (1973/1988) (Dept. of Health).	
Mississippi	MISS. CODE ANN. § 41-7-401 et seq. (1986)(Dept. of Health).	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Missouri	MO. REV. STAT. §§ 354.400 to 354.550 (1983).	
Montana	MONT. CODE ANN. §§ 33-31-101 to 33-31-405 (1987/1991).	
Nebraska	NEB. REV. STAT §§ 44-3292 to 44-32,180 (1990).	
Nevada		NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973/1991).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:22 (1977/1990).
New Jersey	N.J. REV. STAT. §§ 26:2J-1 to 26:2J-30 (1973) (Dept. of Health).	
New Mexico	N.M. STAT. ANN. §§ 59A-46-1 to 59A-46-32 (1985/1989).	
New York		N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976/1987).
North Carolina	N.C. GEN. STAT. §§ 58-67-1 to 58-67-185 (1979/1992).	Dir. 92-D-5 (1992) (Point of service products).
North Dakota	N.D. CENT. CODE §§ 26.1-18-01 to 26.1-18-35 (1983/1989).	
Ohio	OHIO REV. CODE ANN. §§ 1742.01 to 1742.39 (1976/1991).	
Oklahoma		OKLA. STAT. tit. 63 §§ 2501 to 2510 (1975/1988)(Dept. of Public Health)
Oregon		OR. REV. STAT. §§ 750.003 to 750.075 (1985).
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 83-101 to 83-119 (1981); See also: PA. ADMIN. CODE tit. 31 §§ 301.201 to 301.204 (Statement of policy on point of service).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 1901 to 1927.
Rhode Island	R.I. GEN. LAWS §§ 27-41-1 to 27-41-34 (1983/1991).	
South Carolina	S.C. CODE ANN. §§ 38-33-10 to 38-33-300 (1988/1991).	
South Dakota		S.D CODIFIED LAWS ANN. §§ 58-41-1 to 58-41-97 (1974).
Tennessee	TENN. CODE ANN. §§ 56-32-201 to 56-32-225 (1986/1987).	
Texas	TEX. INS. CODE ANN. art. 20A.01 to 20A.35 (1975/1989).	
Utah		UTAH CODE ANN. §§ 31A-8-101 to 31A-8-408 (1986/1991) (Includes point-of-service provision).
Vermont	VT. STAT. ANN. tit. 8 §§ 5101 to 5113 (1979) (Most of model.)	
Virgin Islands	NO ACTION TO DATE	
Virginia	VA. CODE §§ 38.2-4300 to 38.2-4321 (1986/1990).	
Washington		WASH. REV. CODE ANN. §§ 48.46.010 to 48.46.920 (1975/1990) (Parts of model).
West Virginia	W.VA. CODE §§ 33-25A-1 to 33-25A-29 (1977/1991).	
Wisconsin		WIS. STAT. §§ 609.91 to 609.98 (1985/1989); See also: § 628-36 (2m) providing that Commissioner may make rules for HMOs.
Wyoming	WYO. STAT. §§ 26-34-101 to 26-34-128 (1986).	

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ALIEN INSURERS

1) American International Assurance Company (Bermuda), Ltd.
American International Bldg., Richmond Road
Pembroke, Bermuda

Date Admitted : March 26, 1992
Classes of Insurance: Disability & Life
General Agent : Calvo-UMDA Insurance Co., Ltd.

2) Korea Automobile Fire & Marine Insurance Co., Ltd.
21-9, Chodong, Chung-gu
C.P.O. Box 658
Seoul Korea

Date Admitted : January 01, 1985
Classes of Insurance: All Lines Except Life
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

3) Mitsui Marine & Fire Insurance Co.,Ltd.
9, Kanda Surugadai 3-Chome
Chiyoda-ku, Tokyo
Japan 101-11

Date Admitted : July 01, 1982
Classes of Insurance: All Lines Except Disability & Life
General Agent : Microl Corporation
dba Microl Insurance

4) New Zealand Insurance Company, Ltd.
35/F-37/F, World Trade Centre
Causeway Bay, GPO Box 783
Hong Kong

Admitted : June 06, 1975
Classes of Insurance: All Lines Except Life
General Agent : Microl Corporation
dba Microl Insurance

5) Sumitomo Marine & Fire Insurance Co., Ltd.
27-2 Shinkawa 2-chome
Chuo-ku, Tokyo 104
Japan

Date Admitted : January 30, 1991
Classes of Insurance: All Lines Except Life
General Agent : Associated Insurance Underwriters of the Pacific, Inc.

6) Tokio Marine and Fire Insurance Co., Ltd.
2-1, Marunouchi 1-Chome
Chiyoda-ku, Tokyo 100, Japan

Date Admitted : June 12, 1972
Classes of Insurance: All Lines Except Life
General Agent : Pacifica Insurance Underwriters, Inc.

7) Yasuda Fire and Marine Insurance Co., Ltd.
26-1 Nishi-Shinjuku, Itochome
Shinju-ku, Tokyo, Japan

Date Admitted : November 29, 1984
Classes of Insurance: All Lines Except Disability & Life
General Agent : Universe Insurance Underwriters (Micronesia), Inc,

DOMESTIC INSURERS

1) Century Insurance Company, Ltd.
Caller Box PPP 193
Saipan, MP 96950

Date Admitted : June 21, 1988
Classes of Insurance : All Lines Except Life
General Manager/Agent: Benigno R. Fitial

2) Davilyn Insurance Underwriters, Inc.
Caller Box AAA-1001
Saipan, MP 96950

Date Admitted : February 15, 1990
Classes of Insurance : Surety
General Manager/Agent: David C. Sablan

3) Equitable Insurance Company, Inc.
P. O. Box 686
Saipan, MP 96950

Date Admitted : November 06, 1990
Classes of Insurance : Surety
General Manager/Agent: Alex C. Tudela

4) First Home Insurance Company, Inc.
P. O. Box 658
Saipan, MP 96950

Date Admitted : March 15, 1990
Classes of Insurance : Surety
General Manager/Agent: Moylan's Insurance Underwriters (Int'l), Inc.

5) Global Insurance, Inc.
P. O. Box 1638
Saipan, MP 96950

Date Admitted : January 01, 1989
Classes of Insurance : Surety
General Manager/Agent: Norman T. Tenorio

6) J.T.S. Insurance Company, Inc.
P. O. Box 2119
Saipan, MP 96950

Date Admitted : July 23, 1987
Classes of Insurance : All Lines Except Life
General Manager/Agent: John T. Sablan

7) Marianas Insurance Company, Ltd.
P. O. Box 2505
Saipan, MP 96950

Date Admitted : May 19, 1989
Classes of Insurance : All Lines Except Life
General Manager/Agent: Rosalia S. Cabrera

8) National Pacific Insurance, Inc.
P. O. Box 2892
Saipan, MP 96950

Date Admitted : January 04, 1990
Classes of Insurance : All Lines Except Life
General Manager/Agent: Thomas Lee Ngiratereged

9) Royal Crown Insurance Corporation
Caller Box AAA 295
Saipan, MP 96950

Date Admitted : September 24, 1992
Classes of Insurance : All Lines Except Life
General Manager/Agent: Gregorio De Torre

10) Surety & Guaranty Insurance Corporation
P. O. Box 1126
Saipan, MP 96950

Date Admitted : December 06, 1989
Classes of Insurance : Offshore Surety
General Manager/Agent: Bruce MacMillan

11) World Surety and Insurance Underwriters, Inc.
P. O. Box 2183
Saipan, MP 96950

Date Admitted : June 22, 1988
Classes of Insurance : Surety
General Manager/Agent: Young J. Oh

FOREIGN INSURERS

1) Aetna Life Insurance Co.
151 Farmington Avenue
Hartford, CT. 06156

Date Admitted : November 08, 1990
Classes of Insurance: Disability & Life
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

2) American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999

Date Admitted : May 18, 1988
Classes of Insurance: Disability & Life
General Agent : Pacific Basin Insurance, Inc.

3) American Home Assurance Company
70 Pine Street
New York, NY 10270

Date Admitted : June 29, 1976
Classes of Insurance: All Lines Except Life
General Agents : - Calvo's Insurance Underwriters, Inc.
- Moylan's Insurance Underwriters (Int'l), Inc.

4) Commercial Bankers Life Insurance Company
790 The City Drive South, Suite 210
P. O. Box 14172
Orange, CA 92613-1572

Date Admitted : September 23, 1983
Classes of Insurance: Disability & Life
General Agents : - Bank of Saipan
- Carl Peterson

5) The Continental Insurance Company
One Continental Drive
Cranbury, NJ 08570-0001

Date Admitted : July 01, 1980
Classes of Insurance: All Lines Except Life
General Agent : Associated Insurance Underwriters of the Pacific, Inc.

6) Delaware American Life Insurance Company
P. O. Box 667
Wilmington, Delaware 19899

Date Admitted : January 01, 1988
Classes of Insurance: Disability & Life
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

7) Grand Pacific Life Insurance Company
925 Bethel Street
Honolulu, HI 96813

Date Admitted : 1984
Classes of Insurance: Disability & life
General Agents : - Pacifica Insurance Underwriters, Inc.
- Pacific Basin Insurance, Inc.

8) Individual Assurance Company, Life, Health & Accident
1600 Oak Street
Kansas City, MO 64108-1406

Date Admitted : October 24, 1985
Classes of Insurance: Disability & Life
General Agents : - Moylan's Insurance Underwriters (Int'l), Inc.
- Donald C. Barcinas

9) Insurance Company of North America
1601 Chestnut Street
P. O. Box 7716
Philadelphia, PA 19192

Date Admitted : June 10, 1986
Classes of Insurance: All Lines Except Life
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

10) John Hancock Mutual Life Insurance Company
John Hancock Place, P.O. Box 111
Boston, Massachusetts 02117

Date Admitted : April 01, 1983
Classes of Insurance: Disability & Life
General Agent : Universe Insurance Underwriters (Micronesia), Inc.

11) John Hancock Variable Life Insurance Company
John Hancock Place, P. O. Box 717
Boston, Massachusetts 02117

Date Admitted : July 01, 1988
Classes of Insurance: Life
General Agent : Universe Insurance Underwriters (Micronesia), Inc.

12) Lincoln National Life Insurance Company
1300 South Clinton Street
Fort Wayne, Indiana 46801

Date Admitted : July 01, 1982
Classes of Insurance: Disability & Life
General Agent : Associated Insurance Underwriters of the Pacific, Inc.

13) Lucky Insurance Company, Ltd.
c/o Wm. H. McGee & Co., Inc.
4 World Trade Center
New York, NY 10048

Date Admitted : May 14, 1991
Classes of Insurance: Marine, Property & Vehicle
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

14) Lumbermens Mutual Casualty Co.
Route 22
Long Grove, Illinois 60049

Date Admitted : January 01, 1988
Classes of Insurance: All Lines Except Disability & Life
General Agent : Associated Insurance Underwriters of the Pacific, Inc.

15) Midland National Life Insurance Company
One Midland Plaza
Siox Falls, SD 57193

Date Admitted : July 20, 1992
Classes of Insurance: Disability & Life
General Agent : Midland Insurance Underwriters, Inc.

16) Municipal Bond Investors Assurance Corporation
113 King Street
Armonk, NY 10504

Date Admitted : July 01, 1988
Classes of Insurance: Surety
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

17) National Union Fire Insurance Company of Pittsburgh, PA
70 Pine Street
New York, NY 10270

Date Admitted : January 01, 1988
Classes of Insurance: All Lines Except Life
General Agent : Calvo's Insurance Underwriters, Inc.

18) National Western Life Insurance Co.
850 East Anderson Lane
Austin, TX 78752-1602

Date Admitted : October 01, 1984
Classes of Insurance: Life
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

19) Occidental Life Insurance Company of North Carolina
1001 Wade Avenue, P.O.Box 10234
Raleigh, North Carolina 27605

Date Admitted : June 30, 1987
Classes of Insurance: Disability & Life
General Agent : Moylan's Insurance Underwriters (Int'l), Inc.

20) Pacific Guardian Life Insurance Company, Ltd.
1440 Kapiolani Blvd., Suite 1700
Honolulu, HI 96814

Date Admitted : August 09, 1973
Classes of Insurance: Disability & Life
General Agents : Pacifica Insurance Underwriters, Inc.

21) Primerica Life Insurance Company*
3120 Breckinridge Boulevard
Duluth, Georgia 30199-0001

Date Admitted : June 10, 1986
Classes of Insurance: Disability & Life
General Agent : Juan R. Sablan

*NOTE: Amended to be effective July 01, 1992 (formerly MILICO)

22) The Prudential Insurance Company Life of America
751 Broad Street
Newark, NJ 07102-3777

Date Admitted : October 19, 1990
Classes of Insurance: Life
General Agent : Harry Mathewson

23) Sunset Life Insurance Company of America
3200 Capitol Boulevard South
Olympia, WA 98501-3396

Date Admitted : June 13, 1991
Classes of Insurance: Disability & Life
General Agent : Pacific Basin Insurance, Inc.

24) Zurich Insurance (Guam), Inc.
P. O. Box 677
Agana, Guam 96910

Date Admitted : April 05, 1990
Classes of Insurance: All Lines Except Life
General Agent : - D.B.Davis & Associates (SPN), Inc.
- Davis Insurance Services, Inc. dba Staywell Health Plan

GENERAL AGENTS

1) Associated Insurance Underwriters of the Pacific, Inc.
P. P. Box 1369
Saipan, MP 96950

Location : Garapan
Telephone: 234-3152/6865/7222
Manager : Magdalena S. George

Companies Represented:
1. Continental Insurance Company
2. Lincoln National Life Insurance Co.
3. Lumbermens Mutual Casualty Co.
4. Sumitomo Marine & Fire Insurance Company, Ltd.

2) Bank of Saipan
P. O. Box 690
Saipan, MP 96950

Location : Sablan Building, Chalan Kanoa, District #2
Telephone: 235-6260
Manager : Ronald C. Guerrero

Company Represented: Commercial Bankers Life Insurance Company

3) Donald C. Barcinas
dba American Pacific Insurance Agency
P. O. Box 73 CHRB
Saipan, MP 96950

Location : Capitol Hill
Telephone: 322-9870/0870/0960

Company Represented: Individual Assurance Company, Life, Health & Accident

4) Rosalia S. Cabrera
P. O. Box 2505
Saipan, MP 96950

Location : Sablan Building, Chalan Kanoa, District #2
Telephone: 234-5091/5092

Company Represented: Marianas Insurance Company, Ltd.

5) Calvo's Insurance Underwriters, Inc.
P. O. Box 235 CHRB
Saipan, MP 96950

Location : Oleai Center, Chalan Laulau
Telephone: 234-5696/5699
Manager : Eli Buenaventura

Companies Represented: 1. American Home Assurance Company
2. National Union Fire Insurance Co.

6) Calvo-UMDA Insurance Co., Ltd.
P. O. Box 235 CHRB
Saipan, MP 96950

Location : Oleai Center, Chalan Laulau
Telephone: 234-5696/5699
Manager : Eli Buenaventura

Company Represented: American International Assurance Co. (Bermuda), Ltd.

7) Davis Insurance Services, Inc.
dba Staywell Health Plan
Caller Box AAA A-19
Saipan, MP 96950

Location : ACE Building, Chalan Piao
Telephone: 235-4260
Marketing Representative: Frances T. Robertson

Company Represented: Zurich Insurance (Guam), Inc.

8) D.B. Davis & Associates (SPN), Inc.
dba Staywell Health Plan
c/o P. O. Box 241 CHRB
Saipan, MP 96950

Location : ACE Building, Chalan Piao
Telephone: 235-4260
Marketing Representative: Frances T. Robertson

Company Represented: Zurich Insurance (Guam), Inc.

9) Harry Mathewson
P. O. Box 908
Saipan, MP 96950

Location : Summer Holiday Inn, Garapan
Telephone: 233-6081

Company Represented: The Prudential Insurance Company of America

10) Microl Corporation
dba Microl Insurance
P. O. Box 267
Saipan, MP 96950

Location : Lim's Building, San Jose
Telephone: 234-2811
Manager : Peter D. Sibly

Companies Represented:
1. New Zealand Insurance Co., Ltd.
2. Mitsui Marine & Fire Insurance Co., Ltd.

11) Midland Insurance Underwriters, Inc.
Caller Box AAA 295
Saipan, MP 96950

Location : Horiguchi Building, Suite 5C, Garapan
Telephone: 234-2256/2257
President: Gregorio De Torres

Company Represented: Midland National Life Insurance Co.

12) Carl Peterson
414 W. Soledad #704
Agana, Guam 96910

Company Represented: Commercial Bankers Life Insurance Co.

13) Moylan's Insurance Underwriters (Int'l), Inc.
P. O. Box 658
Saipan, MP 96950

Location : Sablan Building, San Jose
Telephone: 234-6442/6571/7185
Manager : Vivian Guerrero

Companies Represented:
1. Aetna Life Insurance Company
2. American Home Assurance Company
3. Delaware American Life Insurance Company
4. Individual Assurance Company, Life, Health & Accident
5. Insurance Company of North America
6. Korea Automobile, Fire & Marine Insurance Company
7. Lucky Insurance Company, Ltd.
8. Municipal Bond Investors Assurance Corporation
9. National Western Life Insurance Co.
10. Occidental Life Insurance Co.
11. First Home Insurance Co., Inc.

14) Pacifica Insurance Underwriters, Inc.
P. O. Box 168
Saipan, MP 96950

Location : Joeten Center, Susupe
Telephone: 234-6267/7310/7722
President: Norman T. Tenorio

Companies Represented:
1. Tokio Marine & Fire Insurance Company, Ltd.
2. Global Insurance, Inc.
3. National Pacific Insurance, Inc.
4. Grand Pacific Life Insurance Company, Ltd.
5. Pacific Guardian Life Insurance Company, Ltd.

15) Pacific Financial Corporation
P. O. Box 1657
Saipan, MP 96950

Location : Professional Building, San Jose
Telephone: 234-9711/9712
Manager : Sherly Sizemore-Camacho

Company Represented: National Pacific Insurance, Inc.

16) Pacific Basin Insurance, Inc.
P. O. Box 710
Saipan, MP 96950

Location : Garapan
Telephone: 234-5860/7861
President: Joseph C. Reyes

Companies Represented:
1. National Pacific Insurance, Inc.
2. World Surety & Insurance Underwriters, Inc.
3. American Family Life Assurance Co.
4. Grand Pacific Life Insurance Co.
5. Sunset Life Insurance Company of America

17) Juan R. Sablan
P. O. Box 964
Saipan, MP 96950

Location : J.E.Tenorio Building, Gualo Rai
Telephone: 234-1209

Company Represented: Primerica Life Insurance Company (formerly Massachusetts Indemnity Life Insurance Company - MILICO)

18) Universe Insurance Underwriters (Micronesia), Inc.
P. O. Box 512
Saipan, MP 96950

Location : UIU Building, San Jose
Telephone : 234-6982/7557
Vice President: Lorenzo LG. Cabrera

Companies Represented:
1. Yasuda Fire & Marine Insurance Company, Ltd.
2. John Hancock Mutual Life Insurance Company
3. John Hancock Variable Life Insurance Company

SURPLUS LINE BROKERS/AGENTS

1) Microl Corporation
dba Microl Insurance
P. O. Box 267
Saipan, MP 96950

Location : Lim's Building, San Jose
Telephone: 234-2811
Manager : Peter D. Sibly

2) Pacifica Insurance Underwriters, Inc.
P. O. Box 168
Saipan, MP 96950

Location : Joeten Center, Susupe
Telephone: 234-6267/7310/7722
President: Norman T. Tenorio

3) Pacific Basin Insurance, Inc.
P. O. Box 710
Saipan, MP 96950

Location : Garapan
Telephone: 234-5860/7861
President: Joseph C. Reyes

BROKERS

1) Bangayan, Generoso M.
P. O. Box 800
Saipan, MP 96950

Location : Gualo Rai
Telephone: 235-2161/4387/4388

2) Barcinas, Donald C.
dba American Pacific Insurance Agency
P. O. Box 5073 CHRB
Saipan, MP 96950

Location : Capitol Hill
Telephone: 322-0870

3) Davilyn Insurance Underwriters, Inc.
Caller Box AAA-1001
Saipan, MP 96950

Location : Gualo Rai
Telephone: 234-3488
Manager : David C. Sablan

4) Friendly Finance Company, Inc.
P. O. Box 486
Saipan, MP 96950

Location : Sablan Building, San Jose
Telephone: 234-3318/6676
Manager : Peter Michael P. Tenorio

5) George, Magdalena S.
P. O. Box 1369
Saipan, MP 96950

Location : Garapan
Telephone: 234-7222/6865/3152

6). Hyea Sung Corporation
dba Young's Insurance Agency
Caller Box PPP 390
Saipan, MP 96950

Location : Chong's Building, Gualo Rai
Telephone: 234-0849/3777
President: Tae song Yang

7) Isla Financial Services, Inc.
P. O. Box 3219
Saipan, MP 96950

Location : Joeten Center
Telephone: 235-5278/5279
Manager : Anne D. Nabong

8) Jones, Jose M.
P. O. Box 1369
Saipan, MP 96950

Location : Garapan
Telephone: 234-6865/7222

9) J.T.S.Insurance Co., Inc.
P. O. Box 2119
Saipan, MP 96950

Location : Garapan
Telephone: 234-8808/8809
President: John T. Sablan

10) Lee & Associates, Inc.
dba Leeland Insurance Underwriter
Caller Box PPP 378
Saipan, MP 96950

Location : Gualo Rai
Telephone: 234-7739
President: Godofredo G. Lee

11) Manglona, Vicente M.
P. O. Box 50
San Jose, Tinian 96952

Location : San Jose, Tinian
Telephone: 433-3037

12) Marianas Insurance Co., Ltd.
P. O. Box 2505
Saipan, MP 96950

Location : Sablan Building, Chalan Kanoa, Dist.#2
Telephone: 234-5091/5092
Manager : Rosalia S. Cabrera

13) Microl Corporation
dba Microl Insurance
P. O. Box 267
Saipan, MP 96950

Location : Lim's Building, San Jose
Telephone: 234-2811
Manager : Peter Sibly

14) Myung Sung Corporation
dba International Insurance Agency
Caller Box PPP 528
Saipan, MP 96950

Location : Chalan Piao
Telephone: 234-1941/1942
President: Ok-Rye Yi Khang

15) Reyes, Antonio A.
dba Aloha Insurance Services
Caller Box PPP 598
Saipan, MP 96950

Location : San Vicente
Telephone: 234-3350

16) Pacific Basin Insurance, Inc.
P. O. Box 710
Saipan, MP 96950

Location : Garapan
Telephone: 234-5860/7861
President: Joseph C. Reyes

17) Universe Insurance Underwriters (Micronesia), Inc.
P. O. Box 512
Saipan, MP 96950

Location : UIU Building, San Jose
Telephone : 234-6982/7557/7445
Vice President: Lorenzo LG. Cabrera

SUB-AGENTS

1) Calvo-UMDA Insurance Co., Ltd.
P. O. Box 235 CHRB
Saipan, MP 96950

Location : Oleai Center, Chalan Laulau
Telephone: 2340-5690/5699
Manager : Eli Buenaventura

Calvo's Insurance Underwriters, Inc.
(National Union Fire Insurance Company of Pittsburgh, PA)

2) Junko Atalig
P. O. Box AU
Agana, Guam 96910

Harry Mathewson - The Prudential Insurance Co. of America

3) Dante R. Flojo
P. O. Box 1989
Saipan, MP 96950

Harry Mathewson - The Prudential Insurance Co. of America

4) Alice W. Mathewson
P. O. Box 908
Saipan, MP 96950

Harry Mathewson - The Prudential Insurance Co. of America

5) Juanita M. Mendiola
P. O. Box 174
San Jose, Tinian, MP 96952

Harry Mathewson - The Prudential Insurance Co. of America

6) John S. Pillsbury
130 E. Marine Dr.
Bldg. C, Room 102
Agana, Guam 96910

Harry Mathewson - The Prudential Insurance Co. of America

7) Francisco B. Salas
P. O. Box AU
Agana, Guam 96910

Harry Mathewson - The Prudential Insurance Co. of America

8) Peter D. Sibly
P. O. Box 267
Saipan, MP 96950

Harry Mathewson - The Prudential Insurance Co. of America

9) Larry K. Henry
P. O. Box AU
Agana, Guam 96910

Harry Mathewson - The Prudential Insurance Co. of America

10) United Enterprises, Inc.
dba United Insurance Underwriters
P. O. Box 2183
Saipan, MP 96950

Microl Corporation dba Microl Insurance

11) Imants E. Klingberg
P. O. Box 405
Saipan, MP 96950

Moylan's Insurance Underwriters (Int'l), Inc.

12) Marlyn U. Igitol
P. O. Box 658
Saipan, MP 96950

Moylan's Insurance Underwriters (Int'l), Inc.

13) Carmen DLG. Borja
P. O. Box 922
Saipan, MP 96950

Moylan's Insurance Underwriters (Int'l), Inc.

14) Vicent M. Calvo
dba Luta Insurance Underwriters
P. O. Box 584
Rota, MP 96951

Moylan's Insurance Underwriters (Int'l), Inc.

15) Ann A. Krusee
P. O. Box 10463
Tamuning, Guam 96911

Pacific Basin Insurance, Inc. - AFLAC

16) Jesus M. Dela Cruz
P. O. Box 710
Saipan, MP 96950

Pacific Basin Insurance, Inc. - AFLAC

17) Joseph B. Quintanilla
P. O. Box 893
Agana, Guam 96910

Pacific Basin Insurance, Inc. - AFLAC

18) Tennyson K.W. Lum, CLU, ChFC
641 Keeaumoku St.
Honolulu, HI 96914

Pacific Basin Insurance, Inc. - AFLAC

19) Romidez s. Plaza
P. O. Box 710
Saipan, MP 96950

Pacific Basin Insurance, Inc. - AFLAC

20) Julie B. Roberto
P. O. Box 710
Saipan, MP 96950

Pacific Basin Insurance, Inc. - AFLAC

21) Sheryl Sizemore-Camacho
P. O. Box 2152
Saipan, MP 96950

Pacific Basin Insurance, Inc. - AFLAC

22) Pilar RC Santos
P. O. Box BS
Agana, Guam 96910

Pacific Basin Insurance, Inc. - AFLAC

23) Roger N. Ludwick
P. O. Box 710
Saipan, MP 96950

Pacific Basin Insurance, Inc. - AFLAC

24) Tinian Center, Inc.
P. O. Box 103
San Jose, Tinian MP 96952

Pacific Basin Insurance, Inc. - AFLAC

25) Friendly Finance Company, Inc.
P. O. Box 486
Saipan, MP 96950

Pacific Basin Insurance, Inc. - Grand Pacific Life Insurance Company

26) Donald C. Barcinas
P. O. Box 5073 CHRB
Saipan, MP 96950

Universe Insurance Underwriters (Micronesia), Inc.

27) Maria M. Farnsworth
P. O. Box 1713
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

28) Augustin K. Castro, Jr.
Gualo Rai
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

29) Conrado C. Castro
Fina Sisu
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

30) Daria M. Kintol
c/o P. O. Box 964
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

31) Alicia G. Taman
c/o P. O. Box 964
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

32) Geraldine S. Teregeyo
Dan
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

33) Emilia E. Maratita
P. O. Box 545
Rota, MP 96951

Juan R. Sablan - Primerica Life Insurance Company

34) Janice A. Tenorio
c/o P. O. Box 964
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

35) Freddie D. Guajardo
P. O. Box 205
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

36) Plasido M. Tagabuel
P. O. Box 5768 CHRB
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

37) Martina O. Barcinas
P. O. Box 73 CHRB
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

38) Guadalupe P. Manglona
P. O. Box 1368
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

39) Jesus C. Bermudes
P. O. Box 2972
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

40) Lucia T. Mundo
P. O. Box 576
Rota, MP 96951

Juan R. Sablan - Primerica Life Insurance Company

41) Angeline F. Sablan
P. O. Box 964
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

42) Antonio R. Cabrera
P. O. Box 1658
Saipan, MP 96950

Juan R. Sablan - Primerica Life Insurance Company

43) Pacific International Marianas, Inc.
dba Midway Motors
P. O. 887
Saipan, MP 96950

L. Carl Peterson - Commercial Bankers Life Insurance Co.

44) Celeste S. Mendiola
dba Mendiola Enterprises: Basic Business Services
P. O. Box 579
Rota, MP 96951

Associated Insurance Underwriters of the Pacific, Inc.
(Continental Insurance Company)

45) Antonio C. Chong
P. O. Box 579
Rota, MP 96951

Associated Insurance Underwriters of the Pacific, Inc.
(Continental Insurance Company)

46) Celeste S. Mendiola
dba Mendiola Enterprises: Basic Business Services
P. O. Box 579
Rota, MP 96951

Pacific Financial Corporation
(National Pacific Insurance, Inc.)

ADJUSTERS

1) Generoso M. Bangayan
P. O. Box 800
Saipan, MP 96950

2) Joanne T. Deleon Guerrero
P. O. Box 168
Saipan, MP 96950

3) Guam Insurance Adjusters, Inc.
P. O. Box 615
Saipan, MP 96950

4) Independent Adjustment Co., Inc.
P. O. Box 1369
Saipan, MP 96950

5) Martin Moore J. II
P. O. Box 1369
Saipan, MP 96950

6) Tadashi Nakanishi
P. O. Box 168
Saipan, MP 96950

7) Thomas L. Ngiratereged
P. O. Box 2892
Saipan, MP 96950

8) Pacific Basin Insurance,Inc.
P. O. Box 710
Saipan, MP 96950

9) Anthony C. Reyes
P. O. Box 710
Saipan, MP 96950

10) Norman T. Tenorio
P. O. Box 168
Saipan, MP 96950

SOLICITORS

1) Marina A. Cuyugan
P. O. Box 658
Saipan, MP 96950

Moylan's - Disability & Life

2) Aaron S. Feinstein
P. O. 487
Saipan, MP 96950

Calvo-UMDA - General Casualty, Property & Vehicle

3) Filipinas R. Indefenzo
P. O. Box 658
Saipan, MP 96950

Moylan's - Disability & Life

4) Roland G. Jastillana
P. O. Box 331
Saipan, MP 96950

Calvo-UMDA - General Casualty, Marine, Property, Surety & Vehicle

5) Vicente C. Lizama
P. O. Box 1593
Saipan, MP 96950

Calvo-UMDA - Disability, General Casualty, Marine, Surety & Vehicle

6) Bermanis A. Terry
P. O. Box 2572
Saipan, MP 96950

Pacific Financial Corporation - General Casualty and Vehicle

SOLICITORS

1) Marina A. Cuyugan
P. O. Box 658
Saipan, MP 96950

Moylan's - Disability & Life

2) Aaron S. Feinstein
P. O. 487
Saipan, MP 96950

Calvo-UMDA - General Casualty, Property & Vehicle

3) Filipinas R. Indefenzo
P. O. Box 658
Saipan, MP 96950

Moylan's - Disability & Life

4) Roland G. Jastillana
P. O. Box 331
Saipan, MP 96950

Calvo-UMDA - General Casualty, Marine, Property, Surety & Vehicle

5) Vicente C. Lizama
P. O. Box 1593
Saipan, MP 96950

Calvo-UMDA - Disability, General Casualty, Marine, Surety & Vehicle

6) Bermanis A. Terry
P. O. Box 2572
Saipan, MP 96950

Pacific Financial Corporation - General Casualty and Vehicle

ALIEN INSURANCE COMPANIES SECURITIES DEPOSITS/BOND

NAME OF COMPANY	TYPE OF SECURITY	AMOUNT	MATURITY DATE	ISSUER
1) American International Assurance Company (Bermuda), Ltd.	TCD	$105,013.70	01/18/94	Union Bank, Saipan
2) Korea Automobile, Fire & Marine Insurance Company, Ltd.	Bond	$100,000.00	06/30/94	Insurance Company of North America
3) Mitsui Marine and Fire Insurance Company, Ltd.	Bond	$100,000.00	12/31/93	New Zealand Insurance Company, Ltd.
4) New Zealand Insurance Company, Ltd.	TCD	$100,000.00	09/22/94	Bank of Hawaii,Saipan
5) Sumitomo Marine and Fire Insurance Company, Ltd.	Bond	$100,000.00	Continuous	Continental Insurance Company
6) Tokio Marine and Fire Insurance Company, Ltd.	TCD	$100,000.00	02/16/94	Union Bank, Saipan
7) Yasuda Fire and Marine Insurance Company, Ltd.	Bond	$100,000.00	04/01/94	Insurance Company of North America

FINANCIAL STATEMENT OF LICENSED ALIEN INSURANCE COMPANIES
As of December 31, 1992

IN THOUSANDS (OMIT 000)

NAME OF COMPANY	ASSETS	LIABILITIES	CAPITAL	SURPLUS
1) American International Assurance Company (Bermuda), Ltd.	$ 584,891	$ 485,474	$ 3,600	$ 95,817
2) Korea Automobile, Fire & Marine Insurance Company, Ltd.	739,515	697,828	25,268	16,419
3) Mitsui Marine & Fire Insurance Company, Ltd.	NO REPORT -			
4) New Zealand Insurance Company, Ltd.	607,314	428,295	100,000	79,019
5) Sumitomo Marine & Fire Insurance Co., Ltd. (U.S. Branch)	152,501	83,455	-0-	69,046
6) Tokio Marine & Fire Insurance Co. ,Ltd. (U.S. Branch)	648,554	513,604	-0-	134,950
(FOR FINANCIAL YEAR ENDED MARCH 31, 1992) 7) Yasuda Fire & Marine Insurance Company, Ltd.	26,155,499	24,461,159	438,675	1,255,665
1992 TOTAL	28,888,274	26,669,815	567,543	1,650,916
1991 TOTAL	1,770,518	1,391,081	90,255	289,182
% CHANGE	1532	1817	529	471

FINANCIAL STATEMENT OF LICENSED FOREIGN INSURANCE COMPANIES
As of December 31, 1992

IN THOUSANDS (OMIT 000)

NAME OF COMPANY	ASSETS	LIABILITIES	CAPITAL	SURPLUS
1) Aetna Life Insurance Company	$ 50,896,523	$ 48,682,756	$ 62,765	$ 2,151,002
2) American Family Life Assurance Company of Columbus	10,014,004	9,149,489	3,879	860,636
3) American Home Assurance Company	7,363,397	5,637,574	4,238	1,721,585
4) Commercial Bankers Life Insurnace Company	104,510	95,020	1,100	8,390
5) Continental Insurance Company	NO REPORT- - - - - - - - - - - - - - - - - - - -			
6) Delaware American Life Insurance Company	320,724	300,051	2,500	18,173
7) Grand Pacific Life Insurance Company	NO REPORT- - - - - - - - - - - - - - - - - - - -			
8) Individual Assurance Company, Life,Health & Accident	23,045	16,160	1,500	5,385
9) Insurance Company of North America	NO REPORT- - - - - - - - - - - - - - - - - - - -			
10) John Hancock Mutual Life Insurance Company	39,146,116	37,418,372	-0-	1,727,744
11) John Hancock Variable Life Insurance Company	2,347,675	2,108,185	25,000	214,490
12) Lincoln National Life Insurance Company	28,796,297	27,589,919	25,000	1,181,378
13) Lucky Insurance Company, Ltd.	8,912	3,402	-0-	5,510

(continuation)

FINANCIAL STATEMENT OF LICENSED FOREIGN INSURANCE COMPANIES

IN THOUSANDS (OMIT 000)

NAME OF COMPANY	ASSETS	LIABILITIES	CAPITAL	SURPLUS
14) Lumbermens Mutual Casualty Company	6,812,134	5,110,410	-0-	1,701,724
15) Midland National Life Insurance Company	NO REPORT- - - - - - - - - - - - - - - - - - - -			
16) Municipal Bond Investors Assurance Corporation	2,572,541	1,676,548	15,000	880,993
17) National Union Fire Insurance Co. of Pittsburgh, PA	7,593,076	6,191,813	4,479	1,396,784
18) National Western Life Insurance Company	2,294,665	2,165,274	3,478	125,913
19) Occidental Life Insurance Company of North Carolina	210,964	199,697	2,500	8,767
20) Pacific Guardian Life Insurance Company, Ltd.	198,449	167,131	6,350	24,968
21) Primerica Life Insurance Company	1,628,753	1,141,871	2,500	484,382
22) The Prudential Insurance Company of America	154,779,418	147,414,742	-0-	7,364,676
23) Sunset Life Insurance Company of America	NO REPORT- - - - - - - - - - - - - - - - - - - -			
24) Zurich Insurance (Guam), Inc.	6,673	5,007	1,000	666
1992 TOTAL	315,117,876	295,073,421	161,289	19,875,615
1991 TOTAL	310,245,113	289,798,147	266,486	20,180,480
% CHANGE	2	2	(39)	(2)

FINANCIAL STATEMENT OF LICENSED DOMESTIC INSURANCE COMPANIES
As of December 31, 1992

ACTUAL FIGURES

NAME OF COMPANY	ASSETS	LIABILITIES	CAPITAL	SURPLUS
1) Century Insurance Company, Ltd.	$ 2,707,873	$ 1,198,019	$ 1,000,000	$ 509,854
2) Davilyn Insurance Underwriters, Inc.	118,761	674	25,000	93,087
3) Equitable Insurance Company, Inc.	NO REPORT- - - - - - - - - - - - - - - - - - - -			
4) First Home Insurance Company, Inc.	27,256	1,979	25,000	277
5) Global Insurance, Inc.	84,006	6,330	30,000	47,676
6) J.T.S. Insurance Company, Inc.	1,079,229	373,789	100,000	605,440
7) Marianas Insurance Company, Ltd.	1,193,903	645,292	150,000	398,611
8) National Pacific Insurance, Inc.	1,287,339	986,240	100,000	201,099
9) Royal Crown Insurance Corporation	100,748	770	100,000	(22)
10) Surety & Guaranty Insurance Corporation	4,194,782	3,207,864	25,000	961,918
11) World Surety & Insurance Underwriters, Inc.	491,034	159,198	50,000	281,836
1992 TOTAL	11,284,931	6,580,155	1,605,000	3,099,776
1991 TOTAL	10,306,772	6,349,755	1,480,000	2,477,017
% CHANGE	9	4	8	25

1992 ANNUAL REPORT
Summary of Total Lines of Business by Property and Casualty Companies
For Calendar Year Ending December 31, 1992

LINES OF BUSINESS	GROSS PREMIUMS, INCLUDING MEMBERSHIP FEES, LESS RETURN PREMIUMS ON POLICIES NOT TAKEN		DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID (DEDUCTIBLE) SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED				
1) Fire	2,083,073	1,269,711	672,127	2,023,192	468,771	236,386
2) Allied lines	494,519	101,363	38,016	4	4	
3) Homeowners multiple peril	117,536	96,046	43,067	14,528	6,014	2,586
4) Commercial multiple peril	1,154,403	888,833	521,181	67,515	98,062	1,025
5) Ocean marine	417,533	226,188	71,350	21,800	21,001	17,797
6) Inland marine	3,401	3,235				
7) Typhoon	94,242	118,497	30,627			
8) Earthquake	69,403	30,322	7,239			
9) All other A & H	1,109,697	901,425	512,849	981,339	514,571	132,489
10) Workers' compensation	1,638,474	1,225,014	823,762	305,847	418,392	177,826
11) Other liability	839,918	659,363	339,122	68,570	183,752	117,672
12) Other private passenger auto liability	390,341	327,912	118,698	132,069	129,838	38,550
13) Other commercial auto liability	439,489	411,531	60,515	645,111	302,599	226,081

(continuation)

Summary of Total Lines of Business by Property and Casualty Companies
For Calendar Year Ending December 31, 1992

LINES OF BUSINESS	GROSS PREMIUMS LESS RETURN PREMIUMS ON POLICIES NOT TAKEN		DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID DEDUCTIBLE SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED				
14) Private passenger auto physical damage	1,384,639	892,857	354,810	362,992	506,083	91,612
15) Commercial auto physical damage	1,103,271	983,564	433,711	463,438	432,164	102,417
16) Fidelity	6,356	4,122	2,463			
17) Surety	1,129,680	931,667	213,478	55,411	68,238	152,762
18) Glass	14,592	10,121	2,662	3,402	635	117
19) Burglary and theft	78,840	49,549	12,697	51,797	28,388	11,158
20) Boiler and machinery	150	62	(17)	22	16	17
21) Aggregate write-ins for other lines of business	106,845	268,547	20,894	171,671	291,150	121,617
1992 TOTAL	12,676,402	9,399,929	4,279,251	5,368,708	3,469,678	1,430,113
1991 TOTAL	13,073,513	11,325,361	4,787,112	4,546,565	4,151,032	1,687,249
% CHANGE	(3)	(17)	(13)	18	(16)	(15)

FIRE
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992
(PROPERTY & CASUALTY COMPANIES)

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Co.	223	279	112	25	40	25
2) Century Insurance Co.,Ltd.	336,509	26,927	13,680	37,699	16,492	10,000
3) Korea Automobile, Fire & Marine Insurance Co., Ltd.	6,217	17,498				
4) Marianas Insurance Co., Ltd.	85,381	28,718	56,663	6,239	6,239	
5) National Pacific Insurance, Inc.	482,985	269,903	141,701	76,650	52,122	55,715
6) National Union Fire Insurance Co.	86	44	43			
7) New Zealand Insurance Co., Ltd.	126,205	138,767	40,938			
8) The Tokio Marine & Fire Insurance Co., Ltd.	425,546	396,578	190,066	4,333	(5,692)	
9) Yasuda Fire & Marine Insurance Co., Ltd.	619,921	390,997	228,924	1,898,246	399,570	170,646
T O T A L	1,600,088	1,269,711	672,127	2,023,192	468,771	236,386

ALLIED LINES
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Co.				2	2	
2) Century Insurance Co.,Ltd.	438,428	34,431	19,742			
3) National Union Fire Insurance Company				2	2	
4) New Zealand Insurance Co., Ltd.	56,091	66,932	18,274			
T O T A L	494,519	101,363	38,016	4	4	

HOMEOWNERS MULTIPLE PERIL
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Co.	29	35	15	(1)		1
2) Korea Automobile, Fire & Marine Insurance Co., Ltd.		396				
3) Marianas Insurance Co., Ltd.	29,757	8,265	21,492			
4) National Pacific Insurance, Inc.	22,383	16,760	8,575	3,301	2,415	2,582
5) National Union Fire Insurance Co.	27	13	14		3	3
6) New Zealand Insurance Co., Ltd.	21,895	27,873	7,146	192	192	
7) Tokio Marine and Fire Insurance Co., Ltd.	10,227	12,890	2,421			
8) Yasuda Fire and Marine Insurance Co., Ltd.	33,218	29,814	3,404	11,036	3,404	
T O T A L	117,536	96,046	43,067	14,528	6,014	2,586

COMMERCIAL MULTIPLE PERIL
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	19	67	10	10	10	
2) Century Insurance Co., Ltd.	65,695	19,115	17,568			
3) Lucky Insurance Co.,Ltd. (U.S.Branch)	(28,077)	(10,782)				
4) National Union Fire Insurance Co.	1		1			
5) Tokio Marine and Fire Insurance Co., Ltd.	1,045,367	862,632	450,005	67,505	44,455	1,025
6) Yasuda Fire and Marine Insurance Co., Ltd.	71,398	17,801	53,597		53,597	
T O T A L	1,154,403	888,833	521,181	67,515	98,062	1,025

OCEAN MARINE

EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	6	5	2	6	7	4
2) Century Insurance Co., Ltd.	131,992	54,417		3,114	2,158	500
3) Korea Automobile, Fire and Marine Insurance Co., Ltd.	10,885	12,690		948	948	
4) National Pacific Insurance, Inc.	110,610	36,218	(12,927)	16,313	11,935	12,759
5) National Union Fire Insurance Co.	12	10	3			
6) New Zealand Insurance Co., Ltd.	46,257	61,326	23,327	748	748	
7) Tokio Marine and Fire Insurance Co., Ltd.	117,771	61,522	60,945	671	5,205	4,534
T O T A L	417,533	226,188	71,350	21,800	21,001	17,797

INLAND MARINE

EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) Korea Automobile, Fire and Marine Insurance Company Limited	416	250				
2) Yasuda Fire and Marine Insurance Company Limited	2,985	2,985				
T O T A L	3,401	3,235				

TYPHOON

EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) New Zealand Insurance Co., Ltd.	94,242	118,497	30,627			
T O T A L	94,242	118,497	30,627			

EARTHQUAKE

EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) Century Insurance Company Limited	51,625	4,304	2,133			
2) Korea Automobile, Fire and Marine Insurance Company Limited	2,071	5,085				
3) New Zealand Insurance Company Ltd.	15,707	20,933	5,106			
T O T A L	69,403	30,322	7,239			

ALL OTHER A & H
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	24	33	12	27	27	
2) Century Insurance Company Limited	9,908	5,527	2,665			
3) National Pacific Insurance, Inc.	32,555	8,045	(3,805)	4,802	3,513	3,755
4) Tokio Marine and Fire Insurance Company Limited	756,716	634,161	457,142	325,031	347,081	22,050
5) Yasuda Fire and Marine Insurance Company Limited	237,372	180,537	56,835	660,652	158,348	101,513
6) Zurich Insurance (Guam), Inc.	73,122	73,122		431	5,602	5,171
T O T A L	1,109,697	901,425	512,849	990,943	514,571	132,489

WORKERS' COMPENSATION
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	118	203	59	72	61	83
2) Century Insurance Company, Ltd.	183,753	196,262	106,616	26,752	10,518	29,384
3) J. T. S. Insurance, Inc.	28,186	28,186				
4) Korea Automobile, Fire and Marine Insurance Company Ltd.	483	4,270		802	802	9,800
5) Marianas Insurance Company, Ltd.	445,979	130,315	315,664	95,225	109,167	13,942
6) National Pacific Insurance, Inc.	338,248	304,167	65,420	75,351	147,115	61,315
7) National Union Fire Insurance Co.	146	77	73	9	13	4
8) New Zealand Insurance Company Ltd.	176,173	176,128	97,270	50,023	59,023	9,000
9) Tokio Marine and Fire Insurance Company Ltd.	360,129	319,212	199,595	6,306	46,605	48,275
10) Yasuda Fire and Marine Insurance Company, Ltd.	105,259	66,194	39,065	51,307	45,088	6,023
T O T A L	1,638,674	1,225,014	823,762	305,847	418,392	177,826

OTHER LIABILITY
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	61	71	31	324	64	23
2) Korea Automobile, Fire and Marine Insurance Company, Ltd.	3,301	3,379				
3) Marianas Insurance Company, Ltd.	41,703	20,306	21,397	120	120	
4) National Pacific Insurance, Inc.	123,391	50,059	44,454	18,199	13,315	34,902
5) National Union Fire Insurance Co.	62	39	31		50	50
6) New Zealand Insurance Company, Ltd.	50,305	41,924	14,454			
7) Tokio Marine and Fire Insurance Company, Ltd.	545,524	516,681	210,088	40,839	118,864	80,025
8) Yasuda Fire and Marine Insurance Company, Ltd.	75,571	26,904	48,667	9,088	51,339	2,672
T O T A L	839,918	659,363	339,122	68,570	183,752	117,672

OTHER PRIVATE PASSENGER AUTO LIABILITY
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	41	52	21	32	56	68
2) Korea Automobile, Fire and Marine Insurance Company, Ltd.	8,093	7,391		2,830	3,930	2,300
3) National Pacific Insurance, Inc.	188,191	99,614	55,496	5,197	6,[illegible]	21,709
4) National Union Fire Insurance Co.	51	28	26	1[illegible]	17	7
5) New Zealand Insurance Company, Ltd.	193,965	220,827	63,155	1[illegible],[illegible]0	118,993	14,466
T O T A L	390,341	327,912	118,698	1[illegible],069	129,838	38,550

OTHER COMMERCIAL AUTO LIABILITY

EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	1		1			
2) Korea Automobile, Fire and Marine Insurance Company, Ltd.	32,385	35,676		20,000	19,400	1,000
3) Lucky Insurance Co., Ltd.(U.S.Branch)	(51,576)	(25,788)				
4) New Zealand Insurance Co., Ltd.	7,296	8,378	2,396			
5) Yasuda Fire and Marine Insurance Co., Ltd.	451,383	393,265	58,118	625,111	283,199	225,081
T O T A L	439,489	411,531	60,515	645,111	302,599	226,081

PRIVATE PASSENGER AUTO PHYSIC[illegible]MAGE
EXHIBITS OF PREMIUMS AND L[illegible]
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIREC[illegible] LOS[illegible]	DIRECT LOSSES UNPAID
1) American Home Assurance Company	262	391	131	19	205	93
2) Korea Automobile, Fire and Marine Insurance Co., Ltd.	18,884	18,144		1[illegible]	12,848	3,600
3) National Pacific Insurance, Inc.	1,059,961	545,001	255,272		227,514	67,918
4) National Union Fire Insurance Co.	277	166	139	[illegible]8	139	31
5) New Zealand Insurance Co., Ltd.	305,255	329,155	99,268	2,992	265,377	19,970
T O T A L	1,384,639	892,857	354,810	302,992	506,083	91,612

COMMERCIAL AUTO PHYSICAL DAMAGE
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) Century Insurance Co., Ltd.	290,522	173,070	117,521	105,437	101,266	30,852
2) Korea Automobile, Fire and Marine Insurance Co., Ltd.	8,106	10,616		4,477	1,477	1,500
3) National Union Fire Insurance Co.	55	27	28			
4) New Zealand Insurance Co., Ltd.	19,418	22,143	6,333	8,046	8,115	69
5) Tokio Marine and Fire Insurance Co., Ltd.	785,170	777,708	309,829	345,478	321,306	69,996
T O T A L	1,103,271	983,564	433,711	463,438	432,164	102,417

FIDELITY & SURETY
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	5	2	3			
2) Century Insurance Company, Ltd.	198,740	183,168	86,542	560	36,560	134,999
3) Davilyn Insurance Underwriters, Inc.	41,941					
4) Global Insurance, Inc.	35,394	35,394				
5) J. T. S. Insurance Company, Inc.	297,922	297,922		11,653		
6) Korea Automobile, Fire and Marine Insurance Company, Ltd.	150	90				
7) Marianas Insurance Company, Ltd.	298,356	189,529	108,8	14,414	23,808	9,394
8) National Pacific Insurance, Inc.	72,553	40,984	18,	10,701	7,829	8,369
9) New Zealand Insurance Company, Ltd.	1,000	1,000				
10) Royal Crown Insurance Corporation	748	748				
11) Tokio Marine and Fire Insurance Company, Ltd.	6,356	4,122	2,463			
12) World Surety & Insurance Underwriters, Inc.	180,361	180,361		18,083		
13) Yasuda Fire and Marine Insurance Company, Ltd.	2,510	2,469	41		41	
T O T A L	1,136,036	935,789	215,941	55,411	68,238	152,762

NO ACTIVITY

OFFSHORE SURETY
EXHIBIT OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID

GLASS

EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) Century Insurance Company, Ltd.	4,127	1,469	1,373	526	526	
2) Korea Automobile, Fire and Marine Insurance Company, Ltd.	113	158				
3) Marianas Insurance Company, Ltd.	903	412	491			
4) National Pacific Insurance, Inc.	1,009	216	(118)	1	109	117
5) New Zealand Insurance Company, Ltd.	2,337	1,763	916			
6) Yasuda Fire and Marine Insurance Company, Ltd.	6,103	6,103		/27		
T O T A L	14,592	10,121	2,6	3,402	635	117

BURGLARY AND THEFT
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) American Home Assurance Company	3	4	2			
2) Century Insurance Company, Ltd.	12,637	7,824	2,932			
3) Korea Automobile, Fire and Marine Insurance Company, Ltd.		304				
4) Marianas Insurance Company, Ltd.	6,515	2,063	4,452	3,149	3,149	
5) National Pacific Insurance, Inc.	24,344	6,188	(2,845)	3,590	2,627	2,808
6) New Zealand Insurance Company, Ltd.	11,478	10,136	4,791	13,424	13,424	
7) Tokio Marine and Fire Insurance Company, Ltd.	7,587	7,588	2,525			
8) Yasuda Fire and Marine Insurance Company, Ltd.	16,273	15,435	838	31,634	9,188	8,350
T O T A L	78,837	49,542	12,691	51,797	28,388	11,158

BOILER AND MACHINERY
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) National Pacific Insurance, Inc.	150	62	(17)	22	16	17
T O T A L	150	62	(17)	22	16	17

AGGREGATE WRITE-INS FOR OTHER LINES OF BUSINESS
EXHIBITS OF PREMIUMS AND LOSSES
FOR THE YEAR ENDED DECEMBER 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT UNEARNED PREMIUMS RESERVED	DIRECT LOSSES PAID SALVAGE	DIRECT LOSSES INCURRED	DIRECT LOSSES UNPAID
1) Century Insurance Company, Ltd.	30,043	71,280	9,924			
2) Korea Automobile, Fire and Marine Insurance Company, Ltd.	4,661	7,144				
3) National Pacific Insurance, Inc.	13,800	3,403	(1,612)	2,035	1,489	1,592
4) New Zealand Insurance Company, Ltd.	16,527	12,465	6,389			
5) Tokio Marine and Fire Insurance Company, Ltd.	42,038	174,479	6,193	169,636	289,661	120,025
6) Yasuda Fire and Marine Insurance Company, Ltd.	(224)	(224)				
T O T A L	106,845	268,547	20,894	171,671	291,150	121,617

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<u>SURPLUS LINE INSURANCE</u>
SUMMARY OF PREMIUMS WRITTEN
FOR THE YEAR ENDED DECEMBER 31, 1992

COMPANY	Aviation	Hull & Machinery	Marine Hull	Passenger Liability
1) Pacifica Insurance Underwriters, Inc.		37,255		3,465
2) Microl Corporation dba Microl Insurance	NO REPORT -			
3) Pacific Basin Insurance, Inc.	NO REPORT -			
T O T A L		37,255		3,465

Summary of Life Insurance
Direct Premiums and Annuity Considerations
for Calendar Year Ending December 31, 1992

INSURERS	ORDINARY LIFE	CREDIT LIFE (GROUP and INDIVIDUALS)	GROUP	TOTAL
American Family Life Assurance Company of Columbus			2,883	2,883
Commercial Bankers Life Insurance Company	32,961			32,961
Individual Assurance Company Life, Health & Accident	19,954	394,891	3,173,816	3,588,661
Lincoln National Life Insurance Company	373,107			373,107
Midland National Life Insurance Company	3,180			3,180
Occidental Life Insurance Company of North Carolina	200,759			200,759
1992 TOTAL	629,961	394,891	3,176,699	4,201,551
1991 TOTAL	923,494	390,695	2,534,608	3,848,797
% CHANGE	(32)	1	25	9

Summary of Life Insurance Direct Claims and Benefits Paid
for Calendar Year Ending December 31, 1992

INSURERS	ORDINARY	CREDIT LIFE (GROUP and INDIVIDUALS)	GROUP	TOTAL
Commercial Bankers Life Insurance Company Individual Assurance Company, Life, Health & Accident Lincoln National Life Insurance Company				
1) Death Benefits		110,673	1,633,100	1,743,773
2) Matured Endowments				
3) Annuity Benefits				
4) Surrender Value	63,763			63,763
5) Aggregate Write-Ins for Miscellaneous Direct Claims and Benefits Paid				
6) All Other Benefits Except Accident and Health				
7) TOTALS	63,763	110,673	1,633,100	1,807,536

Exhibit of Life Insurance Direct Claims and Benefits Paid
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY	CREDIT LIFE (GROUP and INDIVIDUALS)	GROUP	TOTAL
Commercial Bankers Life Insurance Company				
1) Death Benefits				
2) Matured Endowments				
3) Annuity Benefits				
4) Surrender Value	7,434			7,434
5) Aggregate Write-Ins for Miscellaneous Direct Claims and Benefits Paid				
6) All Other Benefits Except Accident and Health				
7) TOTALS	7,434			7,434

Exhibit of Life Insurance Direct Claims and Benefits Paid
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY	CREDIT LIFE (GROUP and INDIVIDUALS)	GROUP	TOTAL
Individual Assurance Company, Life, Health & Accident				
1) Death Benefits		110,673	1,633,100	1,743,773
2) Matured Endowments				
3) Annuity Benefits				
4) Surrender Value				
5) Aggregate Write-Ins for Miscellaneous Direct Claims and Benefits Paid				
6) All Other Benefits Except Accident and Health				
7) TOTALS		110,673	1,633,100	1,743,773

Exhibit of Life Insurance Direct Claims and Benefits Paid
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY	CREDIT LIFE (GROUP and INDIVIDUALS)	GROUP	TOTAL
Lincoln National Life Insurance Company				
1) Death Benefits				
2) Matured Endowments				
3) Annuity Benefits				
4) Surrender Value	56,329			56,329
5) Aggregate Write-Ins for Miscellaneous Direct Claims and Benefits Paid				
6) All Other Benefits Except Accident and Health				
7) TOTALS	56,329			56,329

Summary of Life Insurance Policy
for Calendar Year Ending December 31, 1992

INSURERS	ORDINARY		CREDIT LIFE (Group/Individuals)		GROUP		TOTAL	
	No.	Amount	No of Ind policies& GrpCertif	Amount	No.	Amount	No.	Amount
Commercial Bankers Life Insurance Company Individual Assurance Co. Life, Health & Accident Occidental Life Insurance Company of North Carolina								
1) In force December 31, previous year	660	34,043,604			17	630 4	677	34,673,678
2) Issued during year	75	308,475	2,649	14,290	2	61,282	2,726	384,047
3) Ceased to be in force during year (net)	225	11,719,701	(2,827)	(4,615)			(2,602)	11,715,086
4) In force December 31 of current year	510	22,632,378	5,476	18,905	19	691,356	6,005	23,342,639

Exhibit of Life Insurance Policy
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY		CREDIT LIFE (GRP/INDS)		GROUP		TOTAL	
	No.	Amount	No. of Ind Policies & Grp. Cert.	Amount	No. of Pol.	Amount	No.	Amount
Commercial Bankers Life Insurance Company								
1) In force December 31, previous year	67	5,915,000					67	5,915,000
2) Issued during year								
3) Ceased to be in force during year (net)	3	520,000					3	520,000
4) In force December 31 of current year	64	5,395,000					64	5,395,000

Exhibit of Life Insurance Policy
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY		CREDIT LIFE (GRP/INDS)		GROUP		TOTAL	
	No.	Amount	No. of Ind Policies & Grp. Cert.	Amount	No. of Pol.	Amount	No.	Amount
Individual Assurance Co., Life, Health & Accident								
1) In force December 31, previous year	43	1,256			17	630,074	60	631,330
2) Issued during year	69	1,631	2,649	14,290	2	61,282	2,720	77,203
3) Ceased to be in force during year (net)	3	41	(2,827)	(4,615)			(2,824)	(4,574)
4) In force December 31 of current year	109	2,846	5,476	18,905	19	691,356	5,604	713,107

Exhibit of Life Insurance Policy
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY		CREDIT LIFE (GRP/INDS)		GROUP		TOTAL	
	No.	Amount	No. of Ind Policies & Grp. Cert.	Amount	No. of Pol.	Amount	No.	Amount
Occidental Life Insurance Company of North Carolina								
1) In force December 31, previous year	550	28,127,348					550	28,127,348
2) Issued during year	6	306,844					6	306,844
3) Ceased to be in force during year (net)	219	11,199,660					219	11,199,660
4) In force December 31 of current year	337	17,234,532					337	17,234,532

Summary of Life Insurance Direct Death Benefits Incurred
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY		CREDIT LIFE (Group/Individuals)		GROUP		TOTAL	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Individual Assurance Company, Life, Health & Accident								
1.0 Unpaid December 31, previous year			3	8,594	50	547,383	53	555,977
2.0 Incurred during current year			33	118,680	104	2,021,576	137	2,140,256
SETTLED DURING CURRENT YEAR:								
3.1 By payment in full			32	110,673	83	1,633,100	115	1,743,773
3.2 By payment on compromised claims								
3.3 Total Paid			32	110,673	83	1,633,100	115	1,743,773
3.4 Reduction by compromise								
3.5 Amount rejected								
3.6 Total settlements			32	110,673	83	1,633,100	115	1,743,773
4.0 Unpaid December 31, 1990 (1+2-3.6)			4	16,601	71	935,859	75	952,460

Exhibit of Life Insurance Direct Death Benefits Incurred
for Calendar Year Ending December 31, 1992

INSURER	ORDINARY		CREDIT LIFE (Group/Individuals)		GROUP		TOTAL	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Individual Assurance Co., Life, Health & Accident								
1.0 Unpaid December 31, previous year			3	8,594	50	547,383	53	555,977
2.0 Incurred during current year			33	118,680	104	2,021,576	137	2,140,256
SETTLED DURING CURRENT YEAR: 3.1 By payment in full			32	110,673	83	1,633,100	115	1,743,773
3.2 By payment on compromised claims								
3.3 Total Paid			32	110,673	83	1,633,100	115	1,743,773
3.4 Reduction by compromise								
3.5 Amount rejected								
3.6 Total settlements			32	110,673	83	1,633,100	115	1,743,773
4.0 Unpaid December 31, 1990 (1+2-3.6)			4	16,601	71	935,859	75	952,460

Summary of Accident and Health Insurance
for Calendar Year Ending December 31, 1992

INSURERS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
American Family Life Assurance Co. of Columbus Individual Assurance Co., Life, Health & Accident				
1.0) Group Policies	1,029	1,021		
1.1) Credit (Group and Individual)		62		
1.2) Collectively Renewal Policies				
OTHER INDIVIDUAL POLICIES: 2.1) Non-cancelable				
2.2) Guaranteed Renewal	19,884	20,045	2,917	2,941
2.3) Non-renewable for stated reasons only				
2.4) Other accident only				
2.5) All other				
2.6) Totals (sum of 2.1 to 2.5)	19,884	20,045	2,917	2,941
3.0) Totals (lines 1+1.1+1.2+2.6)	20,913	21,128	2,917	2,941

Exhibit of Accident and Health Insurance
for Calendar Year Ending December 31, 1992

INSURER	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
American Family Life Assurance Company of Columbus				
1.0) Group Policies	1,029	1,021		
1.1) Credit (Group and Individual)				
1.2) Collectively Renewal Policies				
OTHER INDIVIDUAL POLICIES: 2.1) Non-cancelable				
2.2) Guaranteed Renewal	19,726	19,892	2,800	2,793
2.3) Non-renewable for stated reasons only				
2.4) Other accident only				
2.5) All other				
2.6) Totals (sum of 2.1 to 2.5)	19,726	19,892	2,800	2,793
3.0) Totals (lines 1+1.1+1.2+2.6)	20,755	20,913	2,800	2,793

Exhibit of Accident and Health Insurance
for Calendar Year Ending December 31, 1992

INSURER	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
Individual Assurance Company, Life, Health and Accident				
1.0) Group Policies				
1.1) Credit (Group and Individual)		62		
1.2) Collectively Renewal Policies				
OTHER INDIVIDUAL POLICIES: 2.1) Non-cancelable				
2.2) Guaranteed Renewal	158	153	117	148
2.3) Non-renewable for stated reasons only				
2.4) Other accident only				
2.5) All other				
2.6) Totals (sum of 2.1 to 2.5)	158	153	117	148
3.0) Totals (lines 1+1.1+1.2+2.6)	158	215	117	148

PUBLIC NOTICE

Proposed Regulations Promulgated Pursuant to Article XXI of the Commonwealth Constitution and the Tinian Casino Gaming Control Act of 1989.

The Tinian Casino Gaming Control Commission (Commission) hereby gives public notice that pursuant to its duties and responsibilities under Article XXI of the Constitution, as amended, and the authority given the Commission by and through the Tinian Casino Gaming Control Act of 1989 promulgates these proposed amendments to TCGCC Regulations Chapter 1, Applications to be utilized by the Commission under the Tinian Casino Gaming Act of 1989.

The Commission hereby advises the general public that the Rules and Regulations are available at the Commission Office, P.O. Box 143, San Jose Village, Tinian, M.P. 96952.

These amendments to the rules and regulations shall be effective upon notice of their adoption as provided by the Commonwealth Administrative Procedure Act and supersedes prior publication dated May 26, 1992, and July 15, 1992.

Dated this 2nd day of Dec, 1993.

TINIAN CASINO GAMING CONTROL COMMISSION

BY: _____
Joseph M. Mendiola
Chairman

Filed by: SOLEDAD B. SASAMOTO
Registrar of Corporations

Date: 01/12/94

Received by: DONNA J. CRUZ
Governor's Office

Date: 01/12/94

NOTICIA PUBLICKO

Ma-propopone na Areglo yan Regulasion ni ma-establesi sigun i Attikulo XXI gi Commonwealth Constituion yan i Tinian Casino Gaming Control Act of 1989.

I Tinian Casino Gaming Control Commission (Commission) hana' guaha noticia publicko sigun gi responsablidad gi papa i attikulo XXI gi Constitution, ni ma-amenda, yan i autoridad ni nina'e i Commission gi papa i Tinian Casino Gaming Control Act of 1989, na ha-establesi este siha i ma-propopone na amendasion gi Chapter 1 pot Applikasion ni para hu ma usa gi papa i Tinian Casino Gaming Control Act of 1989.

I Commission ha-abibisa i publiku henerat na i areglu yan Regulasion gaige gi Offisinan i Commission, P.O. Box 143, San Jose Village, Tinian, M.P. 96952.

Este siha na amendasion gi areglu yan regulasion para u efektibo gi noticia na ma-adabta sigun ni maprobiniyi gi Commonwealth Administrative Procedures Act ya ayo na amendasion i monhayan ma publika gi Mayo 26, 1992 yan Julio 15, 1992, tinilaika nu este na amendasion.

Mafecha gi mina 2 na ha'ane gi Dec, 1993.

TINIAN CASINO GAMING CONTROL COMMISSION

BY: _____
Joseph M. Mendiola
Chairman

Filed by: SOLEDAD B. SASAMOTO
Registrar of Corporations
Date: 01/12/94

Received by: DONNA J. CURZ
Governor's Office
Date: 01/12/94

TINIAN CASINO GAMING CONTROL COMMISSION

CHAPTER 1

APPLICATIONS

Historical Notes

All provisions of this chapter were adopted pursuant to authority of the Tinian Casino Gaming Control Act of 1989.
Criteria Regulations became effective on July 25, 1991.
Application Regulations became effective on July 25, 1991, Resolution 91-13.
Fee Regulations became effective on September 12, 1991, Resolution 91-18.

These amendments to the rules and regulations shall be effective upon notice of their adoption as provided by the Commonwealth Administrative Procedure Act and supersedes prior publication dated May 26, 1992 and July 15, 1992.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. LICENSE AND REGISTRATION REQUIREMENTS

1:1.1 Casino Licenses

(a) No person shall own or operate a casino unless a casino license shall have first been issued to every person eligible to apply for a casino license concerning the said casino.

(b) Only the following persons shall be eligible to apply for a casino license:

1. Any person who either owns 100 percent of an approved hotel or owns or has a contract to purchase or construct a hotel which in the judgment of the Tinian Casino Gaming Control Commission (Commission) can become an approved hotel within 30 months;

2. Any person who in accordance with Section 21 of the Tinian Casino Gaming Control Act of 1989 (Act), whether under terms involving payments of a fixed sum or otherwise and whether as either a lessor or a lessee, either leases 100 percent of an approved hotel or leases or has an agreement to lease 100 percent of a hotel which in the judgment of the Commission can become an approved hotel with 30 months unless otherwise extended by the Commission;

3. Any person who both has an agreement for the complete management of a casino in accordance with Section 22 of the Act, whether under terms involving payments of a fixed sum or otherwise, and either owns 100 percent of or controls any approved hotel; and

4. Any other person who is eligible in accordance with Part III or any other provision of the Act.

(c) No corporation shall be eligible to apply for or hold a casino license unless it shall, in accordance with the provisions of the Act and the regulations of the Commission:

1. Have been incorporated in the Commonwealth of the Northern Mariana Islands (CNMI);

2. Maintain an office in the premises licensed or to be licensed;

3. Comply with all requirements of the laws of the CNMI pertaining to corporations;

4. Maintain a ledger in its principal office in the CNMI reflecting the current ownership of every class of security issued by the said corporation;

5. Maintain all operating accounts required by the Commission in a bank or banks in the CNMI.

6. Provide in its charter among the purposes stated the conduct of casino gaming;

7. If not a publicly traded corporation, establish by appropriate charter or bylaw provisions that, upon Commission disapproval of any future transfer of any corporate security of, share of or other interest in the applicant corporation or any holding company intermediary company or subsidiary thereof, such corporations and companies shall have the absolute right to repurchase same; and

8. If a publicly traded corporation, establish by appropriate charter or, bylaw provisions that, upon Commission disqualification of any holder of any security of the applicant corporation, such holder shall dispose of his security interest therein.

(d) No corporation shall be eligible to apply for or hold a casino license unless each corporate and noncorporate holding company and intermediary company with respect thereto shall first qualify to do business in the CNMI.

1:1.2 Casino service industry licenses

(a) No enterprise shall, on a regular or continuing basis, provide any goods or services to or conduct any business whatsoever with a casino, a casino licensee, its employees or agents, whether or not said goods, services or business directly relates to casino or gaming activity, unless a casino service industry license authorizing the particular casino service business shall have first been issued to the enterprise.

(b) No casino licensee shall conduct any school teaching gaming or playing or dealing techniques unless a separate casino service industry license authorizing the particular gaming school shall have first been issued to the casino licensee.

(c) The following casino service industry enterprises shall be required to be licensed as casino service industries in accordance with Section 47 of the Act:

1. All enterprises providing goods and services or doing any business whatsoever which directly relates to casino or gaming activity;
2. All schools teaching gaming, playing or dealing techniques;
3. All gaming equipment manufacturers, suppliers, distributors, servicers and repairers; and
4. All casino hotel security service enterprises.
5. All enterprises providing goods or services or doing any business whatsoever which does not directly relate to casino or gaming activity;
6. All suppliers of alcoholic beverages, food and nonalcoholic beverages;
7. All garbage handlers;
8. All vending machine providers;
9. All linen suppliers;
10. All maintenance companies;
11. All shopkeepers located within any approved hotel; and
12. All limousine service enterprises.

(f) The Commission may exempt any person or field of commerce from the casino service industry licensing requirements of Section 47 of the Act if it finds:

1. That such person or field of commerce is regulated by a public agency; and

2. That licensure is not necessary to protect the public interest; and

3. That licensure is not necessary to accomplish the policies established by the Act.

1:1.3 Employee licenses

(a) No natural person shall be employed in the operation of a licensed casino in a supervisory capacity or empowered to make discretionary decisions which regulate casino operation unless he shall be over 21 years of age and unless a casino key employee license authorizing the particular position of employment shall have first been issued to him in accordance with Section 31 of the Act. While excluding casino employees as defined in the Act, this category includes:

1. Pit bosses;
2. Shift bosses;
3. Supervisors;
4. Cashiers;
5. Casino managers;
6. Casino assistant managers;
7. Supervisors of casino security employees;
8. Any employee of a casino licensee empowered to procure or purchase or contract for any entertainment, food, beverages, supplies, equipment, furnishings or any other goods or services whatsoever involving an annual expenditure of $500.00 or greater;
9. Junket representatives; and
10. Any employee whatsoever of a casino licensee so designated by the Commission.

(b) No natural person shall be employed in the operation of a licensed casino whose employment duties require or authorize access to the casino unless he shall be over 21 years of age and unless a casino employee license authorizing the particular position of employment shall have first been issued to him in accordance with section 31 of the Act. This category includes:

1. Boxmen;
2. Dealers;
3. Croupiers;
4. Floormen;
5. Tellers
6. Countroom personnel
7. Any natural person employed by a casino or its agent to provide physical security in a casino hotel; and
8. Any employee whatsoever of a casino licensee so designated by the Commission.

(d) Every casino key employee and casino employee, except those approved by the Chairman, shall wear in a conspicuous manner their license credential issued by the Commission at all times while employed in the casino area which includes without limitation, the casino floor, cashier's cage, countrooms, eye-in-the-sky and closed circuit television monitoring.

(e) No casino licensee shall permit any casino key employee or casino employee, except those approved by the Chairman, to work in the casino area without the wearing of their license credential as required herein.

(f) Each casino licensee shall provide each such employee with a holder for the Commission license credential which shall contain the name of the casino/hotel complex, shall be numerically controlled and shall permit the prominent display of the information contained on the license credential. Thirty days prior to the use of any such holder, a casino licensee or permittee shall submit a prototype to the Commission along with a narrative description of the proposed manner in which employees will be required to wear such holder.

(g) In those situations where a license credential is lost or destroyed, a casino key or casino employee may be authorized to enter the casino area to perform employment duties so long as:

1. The loss or destruction of the license is promptly reported in writing to the Commission;

2. The employee applies for a new license credential; and

3. Permission is received from a duly authorized Commission representative to do so.

(h) For any violation of subsections (d) and (e) of this section, the Commission may impose the sanctions authorized by the Act.

1:1.4 (Reserved)

SUBCHAPTER 2. CASINO HOTEL FACILITIES

1:2.1 Impact of facilities

(a) The Commission can require as conditions in a license that the licensee guarantee and prove at specified times in the future that:

1. That the casino, its related facilities and its proposed location are suitable;

2. That the proposed casino hotel will not adversely affect other licensed casino operations or facilities;

3. That the proposed facilities comply in all respects with all requirements of the Act and the regulations of the Commission;

4. That the proposed facilities comply in all respects with all requirements of the master plan of the Municipality of Tinian and Aguiguan.

5. That the patron market is adequate; and

6. That the proposal will not adversely affect overall environmental, economic, social, demographic or competitive conditions or natural resources of either Tinian or the Commonwealth.

1:2.2 The hotel

(a) No plenary casino license shall be issued unless the casino shall be located within an approved hotel which conforms in all respects to all facilities requirements of the Act and the regulations of the Commission, unless such approved hotel:

1. Is under one ownership;

2. Is a single building located within Tinian with or without additional buildings or facilities annexed by means of physical connection;

3. Contains not fewer than 300 sleeping units of at least 325 square feet each held available and used regularly for the lodging of tourists and convention guests;

4. Contains the minimum amount of indoor dining; entertaining and sports facilities space;

5. Contains a casino room of a minimum of 10,000 square feet conforming in all respects to the entrance and visibility requirements set forth in the Act, and the facilities of which are arranged to promote maximum patron comfort and optimum casino operational security and an atmosphere of social graciousness;

6. Contains a closed circuit television system;

7. Contains specifically designated and secure areas for the inspection, repair and storage of gaming equipment;

8. Contains a count room and such other secure facilities for the inspection, counting and storage of cash, coins, tokens, checks, dice, cards, chips and other representatives of value; and

9. Contains such facilities in the ceiling of the casino room commonly referred to as an "eye-in-the-sky" appropriate to permit direct overhead visual surveillance of all gaming therein; provided, however, that the Commission may exempt from this requirement any casino room in any building if it is satisfied that same contains an acceptable approved alternative and that such an exemption would not be inimical to the policy of this Act and of the regulations of the Commission; and

10. Contains facilities suitable for all family, cabaret and pub entertainment requirements.

11. Comply with the Tinian Master Plan and all Commonwealth and Local laws and ordinances.

1:2.3 Declaratory rulings as to proposed casino hotel facilities

(a) Upon the petition of any person who owns, has a contract to purchase or construct, leases or has an agreement to lease any building or site located within the limits of Tinian and who intends to and is able to complete a proposed casino hotel facility therein or thereon, the Commission may in its discretion make a declaratory ruling as to whether or not the conformance of the proposed casino hotel facility to any of the facilities requirements of the Act and the regulations of the Commission has been established by clear and convincing evidence.

(b) It shall be the affirmative responsibility of each such petitioner to file all information, documentation and assurances material to the requested declaratory ruling in such form as is required of an applicant for a casino license, which may include the filing of a completed "casino hotel facility statement".

(c) The Commission shall afford the interested parties an opportunity for hearing upon any petition for a declaratory ruling as to a proposed casino hotel facility.

(d) A declaratory ruling as to a proposed casino hotel facility shall bind the Commission and the parties to the proceedings on the statement of facts set forth therein and shall be deemed a final action provided, however, that no casino license shall be issued unconditionally concerning any such casino hotel facility unless compliance with every requirement of the Act and regulations of the Commission as of the time of the issuance of such license shall have first been established.

(e) No petition for a declaratory ruling shall be accepted by the Commission unless the petitioner shall first have paid in full a fee of not less than $5,000 and in such further amount as the Commission may, in its discretion, deem reasonable, proper and appropriate in relation to the operating expenses of the Commission in considering the petition.

1:2.4 Duty to maintain and operate a superior quality facility

Every casino licensee shall have a continuing duty to maintain and operate its entire convention hotel complex as a facility of a superior, exceptional, first class, five star and deluxe quality, to submit the said complex to periodic inspections by the Commission and to promptly comply with all requirements and directives of the Commission relating to the maintenance and operation of the said complex as a facility of a superior and first class quality.

SUBCHAPTER 3. PERSONS REQUIRED TO BE QUALIFIED

1:3.1 Casino licenses

(a) No casino license shall be issued unless the individual qualifications of each of the following persons shall have first been established in accordance with all provisions, including those cited, of the Act and of the regulations of the Commission:

1. Each applicant for and person required to apply for a casino license in accordance with the casino license standards as set forth in section 17 of the Act;

2. Each of the following financial sources, either in effect or proposed, of, in or to the submitted casino proposal in accordance with the casino license standards as set forth in section 17(b) of the Act;

   i. Each financial backer;
   ii. Each investor;
   iii. Each mortgagee;
   iv. Each bond holder; and
   v. Each holder of debenture, notes or other evidence of indebtedness, either in effect or proposed;

3. Each of the following persons of every corporate applicant for a casino license and of every corporate holding company of and corporate intermediary company of every corporate applicant for a casino license in accordance with the casino key employee standards;

   i. Each officer;
   ii. Each director;
   iii. Each person who directly or indirectly holds any beneficial interest or ownership of the securities issued by the corporation;
   iv. Any person who in the opinion of the Commission has the ability to control the corporation or elect a majority of the board of directors of that corporation, other than a banking or other licensed lending institution which holds a mortgage or other lien acquired in the ordinary course of business;
   v. Each principal employee; and
   vi. Any lender, underwriter, agent or employee of the corporation whom the Commission may consider appropriate for approval or qualification;

4. In the case of a publicly-traded corporate holding company of a corporate applicant for a casino license, the individual qualifications may be waived as to:

   i. Any such person of the publicly-traded corporate holding company who is not significantly involved in the activities of the corporate applicant for the casino license; and

ii. Any such security holder of a publicly-traded corporate holding company who does not have the ability to elect a director of or to control the said holding company;

5. Each of the following persons of every noncorporate applicant for a casino license and of every noncorporate holding company of and noncorporate intermediary company of every corporate applicant for a casino license in accordance with the casino key employee standards:

i. Each person who directly or indirectly holds any beneficial interest or ownership in the applicant for the casino license;
ii. Each person who in the opinion of the Commission has the ability to control the applicant for the casino license; and
iii. Each person whom the Commission may consider appropriate for approval or qualification.

6. The Commission may, if its investigations reveal that an applicant has established his suitability for a license under Section 17 of the Initiative, issue a license to that applicant which has as a condition, with time deadlines which predate the opening of the casino, the satisfactory establishment of all other persons described in paragraphs 1:3.1 (a) 2 through 5 as persons suitable to hold a license in accordance with the criteria of Section 17 of the Initiative.

1:3.2 Casino service industry licenses

(a) No casino service industry license shall issue unless the individual qualifications of each of the following persons shall have first been established in accordance with all provisions, including those cited, of the the Act and of the regulations of the Commission:

1. In the case of casino service industry licenses issued in accordance with Section 47 of the Act;

i. Each such casino service industry enterprise, its owners, its management personnel, its supervisory personnel and its principal employees in accordance with the casino employee standards; and
ii. Each employee of such casino service industry school teaching gaming or playing or dealing techniques in accordance with the casino employee standard.

1:3.3 Employee licenses

No employee license shall issue unless the individual qualifications of the natural person applying therefor shall have first been established in accordance with the standards of the Act and of the regulations of the Commission.

1:3.4 (Reserved)

SUBCHAPTER 4. STANDARDS FOR QUALIFICATIONS

1:4.1 SCOPE

No plenary casino license shall be issued unless each person required to qualify shall have first qualified in accordance with the standards set forth in 1:4.2 applicable to the said person as set forth in the Act and the regulations of the Commission.

1:4.2 CASINO AND EMPLOYEE LICENSING STANDARDS

A) GENERAL AND AFFIRMATIVE CRITERIA:

1) It shall be the affirmative responsibility of each applicant and licensee to establish by clear and convincing evidence his individual qualifications, and for a casino licensee the qualifications of each person who is required to be qualified under this Act.

2) Any applicant or licensee shall provide all information required by the Act and satisfy all requests for information pertaining to qualification.

3) All applicants and licensees shall have the continuing obligation to provide any assistance or information required by the Commission and to cooperate in any inquiry or investigation conducted by the Commission.

4) Each applicant shall produce such information, documentation and assurances concerning financial background and resources as may be required to establish by clear and convincing evidence the financial stability and integrity of the applicant including but not limited to bank references, business and personal income, tax returns and other reports filed with governmental agencies.

5) Each applicant shall produce such information, documentation and assurances as may be necessary to establish by clear and convincing evidence the integrity of all financial backers, investors, mortgagees, bondholders and holders of indentures, notes or other evidence of indebtedness either proposed or in effect. The integrity of financial sources shall be judged upon the same standards as the applicant. The applicant shall produce whatever information documentation and assurances as may be required to establish the adequacy of financial resources to both construct and operate the casino hotel.

6) Each applicant shall produce such information, documentation and assurances as may be required to establish by clear and convincing evidence the applicant's good character, honesty and integrity. Such information shall include but not be limited to family habits, character, reputation, criminal and arrest record, business activities, financial affairs, professional and business associates covering a 10 year period immediately proceeding the filing of the application.

7) Each applicant shall produce such information, documentation and assurances to establish by clear and convincing evidence that the applicant has sufficient business ability and casino experience to establish the likelihood of the creation and maintenance of a successful casino operation.

B) DISQUALIFICATION CRITERIA

The Commission shall deny a casino license to any applicant who is disqualified on the basis of the following:

1) Failure of the applicant to prove by clear and convincing evidence that the applicant is qualified in accordance with the provisions of the Act.

2) Failure of the applicant to provide information, documentation or assurances required by the Act or requested by the Commission or failure of the applicant to reveal any fact material to qualification or the supplying of information which is untrue or misleading as to any material fact.

3) Conviction of the applicant or any person required to be qualified, of any offense in any jurisdiction which would be:

6 CMC 1101	Murder
6 CMC 1203	Aggravated Assault and Battery
6 CMC 1301	Rape
6 CMC 1309	Rape by object
6 CMC 1311	Sexual Abuse of a child
6 CMC 1323	Child pornography
6 CMC 1411	Robbery
6 CMC 1421	Kidnapping
6 CMC 1432	Usurping control of aircraft
6 CMC 1433	Mutiny on a vessel
6 CMC 1601(b)(1)	Theft of property or services in excess of $20,000.00 or more
6 CMC 1603	Theft by deception
6 CMC 1604	Theft by extortion
6 CMC 1606	Receiving stolen property
6 CMC 1607	Theft of services
6 CMC 1608	Theft by failure to make required disposition of funds received
6 CMC 1701	Forgery
6 CMC 1705	Deceptive business practices
6 CMC 1707	Counterfeiting
6 CMC 1802	Arson and related offenses
6 CMC 2141(a)and(b)1	Offenses and penalties for illegal drug use
6 CMC 2143	Commercial offenses - drugs offenses
6 CMC 2144	Fraud offenses - manufacture/ distribution penalties
6 CMC 2145	Attempt and conspiracies drug offenses
6 CMC 2147	Distribution to persons under 18
6 CMC 3155	Gambling offenses prohibited
6 CMC 3201	Bribery
6 CMC 3302	Obstructing justice
6 CMC 3303	Obstructing justice - interference of services
6 CMC 3304	Tampering with judicial records or process
6 CMC 3305	Tampering with jury
6 CMC 3366	Perjury

Conspiracies or attempts in conjunction with any offense listed above shall be disqualifying.

4) Any other offenses under CNMI, Federal Law or any other jurisdiction which indicates that licensure of the applicant would be inimical to the policy of the Act and to casino operations; however, that the automatic disqualification provisions of the subsection shall not apply with regard to any conviction which did not occur within the 10 year period immediately proceeding the application for licensure or any conviction which has been the subject of a judicial order of expongement or sealing.

5) Current prosecution or pending charges in any jurisdiction of the applicant or of any person who is required to be qualified under this Act for any of the offenses enumerated above; provided, however that at the request of the applicant or person charged, the Commission shall defer discussion upon such application during the pendancy of such charge.

6) The identification of the applicant or any person who is required to be qualified under this Act as a career offender or a member of a career offender cartel or an associate of a career offender or career offender cartel in such a manner which creates a reasonable belief that the association is of such a nature as to be inimical to the policies of the Act and a casino operations. For purposes of this section, career offender shall be defend as any person whose behavior is pursued in an occupational manner or context for the purpose of economic gain, utilizing such methods as are deemed criminal of the public policy of the Commonwealth. A career offender cartel shall be defined as any group of persons who operate together is career offenders.

7) The Commission by the applicant or any person who is required to be qualified under this Act as a condition of a casino license of any act or acts which would constitute any offense under Sections 3 or 4, even if such conduct has not or may not be prosecuted under the criminal laws of the Commonwealth.

SUBCHAPTER 5 STATEMENTS OF COMPLIANCE

Chapter 1 Subchapter 5, Statement of Compliance, Sections 1:5.1, 1:5.2 and 1:5.3 is hereby amended to add 1:5.1, 1:5.2, 1:5.3, 1:5.4, 1:5.5, 1:5.6, 1:5.7, 1:5.8, 1:5.9, 1:5.10 and 1:5.11.

1:5.1 General provisions

The Commission may, in its sole and absolute discretion, issue a revocable Statement of Compliance to an applicant for any license certifying that all requirements relating to a particular specified eligibility criterion or stage in the license consideration process have been complied with at any time the Commission is satisfied that any such requirements have been established by the applicant in accordance with the Act and regulations of the Commission.

1:5.2 Petition

(a) A request for a Statement of Compliance shall be initiated by a petition. One (1) original copy signed by the petitioner and six (6) photocopies of the

petition shall be filed with the Commission. The petition shall include, at a minimum, the following items:

(i) The eligibility criteria for which the Statement of Compliance is requested;

(ii) The person(s) whose compliance is requested to be considered;

(iii) The facts and circumstances underlying the request, including the reason for the request; and

(iv) Subject to the limitations contained in Section 1:5.6 of this Subchapter, the period for which the Statement of Compliance is requested to be effective.

(b) Each petition for a Statement of Compliance must also contain the following undertakings:

(i) Petitioner understands that any Statement of Compliance issued pursuant to the petition is revocable by the Commission;

(ii) Petitioner understands that any Statement of Compliance issued pursuant to the petition does not create a property right in the petitioner;

(iii) Petitioner understands that the issuance of a Statement of Compliance is not an issuance of a license; and

(iv) Petitioner understands that no license shall be issued unless every qualification as of the time of the issuance of a license shall have first been established in accordance with the Tinian Casino Gaming Control Act of 1989 and regulations of the Tinian Casino Gaming Control Commission.

1:5.3 Filing date

A petition requesting a Statement of Compliance may be filed at the time of or subsequent to the filing of a License Application. However, no petition shall be considered until the Division of Enforcement has completed its investigation of the matter(s) which the Statement of Compliance is requested to address.

1:5.4 Petition filing fee and investigation costs

(a) Except as otherwise provided herein, all fees and costs incurred in conjunction with the investigation of any petition for a Statement of Compliance must be paid by the petitioner in the manner prescribed by this Section 1:5.4.

(b) Each petition for a Statement of Compliance must be accompanied by a non-refundable filing fee in the amount of $5,000, which amount shall be applied toward the fee payable by the petitioner under Section 1:5.7 of this Subchapter 5.

(c) In addition to the non-refundable filing fee, the Commission may require a petitioner to pay such supplementary investigative fees and costs as may be determined by the Commission. At any time or times during the pendency of a petition, the Commission may estimate the supplementary investigative fees and costs and require a deposit or deposits to be paid by the petitioner in advance as a condition precedent to beginning or continuing an investigation.

(d) The Commission will not take final action on a petition unless all filing and investigative fees and costs have been paid in full. It shall be grounds for denial of the petition if the petitioner has failed or refused to pay all filing and investigative fees and costs required hereunder.

(e) After all supplementary investigative fee and costs have been paid by a petitioner, and after all actions on behalf of the Commission have been taken with respect to the petition, the Commission shall refund to the person who made the required deposit any balance remaining in the investigative account of the petitioner.

(f) Upon final action on the petition, the Commission shall give to the petitioner an itemized accounting of the investigative fees and costs incurred.

(g) The Commission may, in its sole and absolute discretion, waive payment of an investigative fee or cost.

1:5.5 Hearing

All hearings pursuant to a petition for a Statement of Compliance shall be subject to Section 2:7.1 of these regulations of the Commission.

1:5.6 Effective period

(a) A Statement of Compliance shall be effective upon payment of the fee provided under Section 1:5.7 of this Subchapter 5 and shall expire according to the terms contained therein or until revoked by the Commission; provided, however, the effective period of a Statement of Compliance shall not exceed one (1) year.

(b) A Statement of Compliance may be revoked by the Commission upon a finding that a change of circumstances has affected such compliance, that the subject of the statement has otherwise failed to qualify for licensure, that the subject of the statement has failed to comply with any conditions imposed by the Commission or that any other reason for revocation exists.

1:5.7 Statement of Compliance fee

(a) Upon the issuance of a Statement of Compliance, a fee shall be paid by the petitioner as follows:

1. The fee for a Statement of Compliance which addresses the suitability or qualification of an applicant for a casino license (or persons associated, physically or by conduct, in ownership of an applicant for a casino license), the financial sources of an applicant for a casino license or persons associated in the administration or

management of the operations or business of an applicant for a license shall be:

i. $166,666 if the Statement of Compliance addresses the suitability or qualification of an applicant for a casino license (or persons associated, physically or by conduct, in the ownership of an applicant for a casino license); plus

ii. $166,666 if the Statement of Compliance addresses the suitability and qualifications of the financial sources of an applicant for a casino license; plus

iii. $166,666 if the Statement of Compliance addresses the suitability and qualifications of persons associated in the administration or management of the operations or business of an applicant for a casino license.

2. The fee for all other Statements of Compliance shall be $_____.

(b) The fee shall be prorated for any effective period specifically described in the Statement of Compliance as less than one (1) year. The fee shall not be refunded if the Statement of Compliance is revoked by the Commission.

(c) The total fee shall be reduced by the amount of the filing fee paid by the petitioner under Section 1:5.1 of this Subchapter 5.

(d) If a casino license is issued prior to the expiration of the effective period of the Statement of Compliance, a prorated portion of the fee shall be applied to the annual license fee required under Section 50(2) (b) of the Act.

1:5.8 Contents

(a) Every Statement of Compliance shall:

1. Specify the particular criterion or stage complied with and indicate that such applicant has qualified for licensure in relation to the criterion or stage specified;

2. Set forth, as its date of issuance, the date as of which such compliance existed;

3. Set forth its date of expiration;

4. Indicate that it may be revoked by the Commission action as of the day following its date of expiration;

5. Indicate that it may be revoked by the Commission upon a finding that a change of circumstances has affected such compliance, that the applicant has otherwise filed to qualify for licensure, that the applicant has failed to comply with any conditions imposed by the Commission or that any other reason for revocation exists;

6. Indicate that it does not create a property right in the recipient;

7. Indicate that it is not a license; and

8. Indicate that no license shall be issued unless every qualification as of the time of the issuance of a license shall have first been established in accordance with the Act and regulations of the Commission.

1:5.9 Issuance of licenses

No plenary license shall be issued to any person to whom a Statement of Compliance has been issued unless every qualification of such person as of the time of the issuance of such license shall have first been established in accordance with the Act and regulations of the Commission.

1:5.10 Reservation of casino license

(a) If requested in the petition, upon the issuance of a Statement of Compliance which indicates the satisfactory competition of the suitability and qualification requirements of the Act and the Commission's regulations by an applicant for a casino license and persons associated, physically or by conduct, in the ownership of an applicant for a casino license, the Commission may reserve one (1) casino license, if a license is available, which license shall be issued to the applicant only upon full compliance and satisfaction of all license requirements under the Act and regulations of the Commission. The license shall be reserved only during the effective period of the Statement of Compliance. The reservation shall expire automatically without further action by the Commission upon the termination of the effective period of the Statement of Compliance.

(b) The reservation of a casino license is not a license and does not create a property right in the person(s) for which a license is reserved.

1:5.11 Persons to be qualified

Nothing in this Subchapter 5 shall limit or define the types of persons who must be found suitable or qualified under the Act or the regulations of the Commission.

SUBCHAPTER 6 INFORMATION

1:6.1 Affirmative responsibility to establish qualifications

It shall be the affirmative responsibility and continuing duty of each applicant and licensee to produce such information, documentation and assurances as may be required to establish by clear and convincing evidence his qualifications in accordance with the Act and regulations of the Commission. No application shall be granted to any applicant who fails to so prove his qualifications.

1:6.2 Duty to disclose and cooperate

It shall be the affirmative responsibility and continuing duty of each applicant, licensee, and person required to be qualified to provide all information, documentation and assurances pertaining to qualifications required or requested by the Commission and to cooperate with

the Commission in the performance of its duties. Any refusal by any such person to comply with a formal request for information, evidence or testimony shall be a basis for denial, revocation or disqualification. No application shall be granted to any applicant who fails to provide information, documentation and assurances required by the Act or requested by the Commission or who fails to reveal any fact material to qualification.

1:6.3 Disposition of property of a casino licensee or applicant for a casino license

(a) It shall be an affirmative responsibility of each casino licensee or applicant for a casino license, as this term is defined in (b) below, to:

1. Submit to the Commission a copy of all agreements regarding the lease or purchase of, or the option to lease or purchase, any residential, or other property in Tinian licensee or applicant, or any affiliate of the license or applicant. Such submission shall be provided within two days of the execution of the agreement:

1:6.4 Duty to promptly furnish information

It shall be the duty of each applicant or licensee to promptly furnish all information, documentation, assurances, consents, waivers, fingerprint impressions, photographs, handwriting exemplars or other materials required or requested by the Commission. Failure to furnish same within five days after receipt of request therefore shall constitute grounds for delaying consideration of the application.

1:6.5 Consent to inspections, searches and seizures

Each applicant, licensee, holding company and intermediary company shall consent in writing to inspections, searches and seizures authorized by law.

1:6.6 Waiver of liability for disclosure of information

Each applicant, licensee, and person required to be qualified shall, in writing, waive liability as to Tinian and its instrumentalities and agents for any damages resulting from any disclosure or publication of any during any inquiries, investigations or hearings.

1:6.7 Consent to examination of accounts and records

Each applicant and licensee shall, in writing, consent to the examination of all accounts, bank accounts and records in his possession or under his control and authorize all third parties in possession or with control of such accounts or records to allow such examination thereof as may be deemed necessary by the Commission.

1:6.8 Fingerprinting

Each applicant, licensee, and person required to be qualified shall be fingerprinted without charge and in duplicate on fingerprint impression card forms provided by the Commission and marked "noncriminal". One of the said forms shall be filed with the Commission and one shall be filed with the Municipal Police Department.

1:6.9 Photographing

Each applicant, licensee, and person required to be qualified shall be photographed without charge and in duplicate . One set of the said photographs shall be filed with the Commission and one shall be filed with the Municipal Police Department.

1:6.10 Handwriting exemplars

Each applicant, licensee, intermediary company, holding company and person required to be qualified shall, in writing, consent to he supplying of handwriting exemplars in the form and manner directed upon the request of the Commission.

1:6.11 Oath or affirmation and attorney certification

All applicant, registration, business enterprise disclosure and personal history disclosure forms and all other papers relating thereto submitted to the Commission by or on behalf of an applicant shall be sworn to or affirmed and subscribed and dated by the applicant and, if different, the author of the said form or paper before a person legally competent to take an oath or affirmation, who shall himself subscribe and date the signature of the affiant and indicate the basis of his authority to take oaths or affirmations. The following statement shall immediately precede the signature of the affiant: "I swear (or affirm) that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment". The affiant, if requested, shall again swear to or affirm and subscribe and date any such paper in the presence of a representative of the Commission. All such forms and papers shall also be signed by the applicant's attorney of record, if any, which shall constitute a certification by him that he has read the said paper and that, to the best of his knowledge, information and behalf, its contents are true.

1:6.12 Untrue information

The Commission shall deny a license or registration to any applicant who shall supply information to the Commission which is untrue or misleading as to a material fact pertaining to the qualification criteria.

1:6.13 Signatures

(a) All application, business enterprise disclosure and personal history disclosure forms shall be signed by each of the following persons:

1. If of a corporation, by its president, its chairman of the board, any other chief executive officer thereof, its secretary and its treasurer;

2. If of a partnership, by each of its partners; if a limited partnership, only by each of its general partners;

3. If of any other business enterprise, organization or association or of a governmental agency, by its chief executive officer, its secretary and its treasurer; and

4. If of a natural person, by the person himself..

1:6.14 Form of signature

All signatures shall be signed in ink and dated on all original papers, but may be photographed, typed, stamped or printed on any copies of such papers. The name and address of the signatory shall be typed, stamped or printed beneath each signature.

1:6.15 Form of application

Each applicant, licensee, or person required to be qualified shall provide all information in a form specified by the Commission and shall complete and submit all appropriate application, registration, business enterprise disclosure and personal history disclosure forms as directed by the Commission.
NOTE: These forms, the statement and the proposal, are not reproduced herein, but can be obtained from:

Tinian Casino Gaming Control Commission
P.O. Box 143
San Jose Village
Tinian, MP 96952

1:6.16 Format of papers

All application papers submitted to the Commission shall be on paper approximately 8 1/2 by 11 inches in size, of customary weight and quality and bound on the left margin or upper left corner in volumes not to exceed 150 sheets. Where larger sheets are required for exhibits, they shall be folded substantially to the size indicated. All such papers, unless printed, shall be typed in a type size of pica or larger and double-spaced with margins of at least one inch. Copies may be reproduced by any method capable of providing plainly legible copies.

1:6.17 Number of copies

(a) All original applications and other original papers relating thereto submitted to the Commission by the applicant, shall be accompanied by the following number of conformed copies:

1. In the case of a casino applicant and applicants for a gaming school license, four conformed copies of all personal history disclosure forms relating thereto and five conformed copies of all remaining documents;

2. In the case of an applicant for a casino service industry license, four conformed copies of all applications and papers submitted as a part thereof;

3. In the case of an applicant for a casino key employee license, two conformed copies of all applications and papers submitted as a part thereof;

4. In the case of an applicant for a casino employee license, one conformed copy of each application and papers submitted as a part thereof.

(b) Additional conformed copies of any such papers shall be supplied upon request of the Chairman.

SUBCHAPTER 7 APPLICATION

1:7.1 Receipt

All application papers, unless otherwise directed by the Chair, shall initially be submitted to and received by the Chair, or such members of the Commission staff as the Chair may designate, who shall cause to be endorsed thereon the date of such receipt.

1:7.2 Filing

(a) The Chair, or such members of the Commission staff as the Chair may designate, shall determine the date of filing as to each application received and shall cause to be endorsed thereon the date of such filing. No application shall deemed filed until the applicant shall satisfy the Chair or his or her designee:

1. That all papers presented conform to all requirements relating to format, signature, oath or affirmation, attorney certification and copies;

2. That all appropriate application, business enterprise disclosure and personal history disclosure forms have been properly completed and presented;

3. That all required consents, waivers, fingerprint impressions, photographs and handwriting exemplars have been properly presented;

4. That all other information, documentation, assurances and other materials required or requested at that preliminary stage pertaining to qualifications have been properly presented; and

5. That all required fees have been properly paid and all required bonds have been properly furnished.

1:7.3 Processing

(a) Upon a determination that all prerequisites for filing have been met the Chair, or such members of the Commission staff as the Chair shall designate, shall:

1. Accept the application for filing and cause same to be docketed by the Executive Director of the Commission;

2. Notify the applicant or his attorney, if any, in writing, of the fact that the application has been accepted for filing and docketed, the date of such acceptance for filing and the docket number thereof and of the further fact that such expectance for filing and docketing of the application shall constitute no evidence whatsoever that any requirement of the act or of the regulations of the Commission have been satisfied;

3. Direct the staff of the Commission to analyze, obtain and evaluate such information of either a factual nature or otherwise as may be

necessary to determine the qualifications of the applicant and any other matter relating to the application;

1:7.4 Public inspection of information

No information in the possession of the Commission relating to any application shall be made available for public inspection prior to the time that the said application shall be accepted for filing and docketed in accordance with the regulations of the Commission.

1:7.5 Amendment

It shall be the duty of each applicant to promptly file with the Chair, or such members of the Commission staff as the Chair shall designate, a written amendment to his or her application explaining any changed facts or circumstances whenever any material or significant change of facts or circumstances shall occur with respect to any matter set forth in the application or other papers relating thereto. Any applicant may be permitted by the Chair or his or her designee to file any other amendment to his application at any time prior to final action thereon by the Commission.

1:7.6 Withdrawal

(a) Except as otherwise provided in (b) below, a written notice of withdrawal of application may be filed by an applicant at any time prior to final Commission action. No application shall be permitted to be withdrawn, however, unless the applicant shall have first established to the satisfaction of the Commission that withdrawal of the application would be consistent with the public interest and the policies of the Act. The Commission shall have the authority to direct that any applicant so permitted to withdraw his application shall not be eligible to apply again for licensure or approval until after the expiration of one year from the date of such withdrawal. Unless the Commission shall otherwise direct, no fee or other payment relating to any application shall become refundable by reason of withdrawal of the application.

(b) Where a hearing on an application has been requested by a party or directed by the Commission, the Commission shall not permit withdrawal of said application after:

1. The application matter has been assigned to any other hearing examiner authorized by law to hear such matter; or

2. The Commission has made a determination to hear the application matter directly.

(c) Notwithstanding the foregoing, the Commission may accept and consider a written notice of withdrawal after the time specified herein if extraordinary circumstances so warrant.

1:7.7 Reapplication by natural person after denial or revocation

(a) Any natural person required to be licensed, qualified or approved under the provisions of the Act or regulations of the Commission whose licensure, qualifications, or approval is either denied or revoked by the Commission

on the basis of that person's failure to satisfy the affirmative qualification criteria of the Act, or due to a Commission finding that such person is disqualified under the criteria of the Act, or both, may not, except as otherwise provided in (b), (f) and (g) below, reapply for licensure, qualification or approval until five years have elapsed from the date of said denial or revocation.

(b) Any natural person whose licensure, qualification or approval is denied or revoked by the Commission on the basis of any of the following enumerated provisions of the Act or regulations of the Commission may reapply, in accordance with the procedure set forth in (c) below, for licensure, qualification or approval upon satisfaction of the conditions specified herein:

1. Lack of financial stability: Reapplication is permitted upon said person achieving status of financial stability.

2. Lack of business ability and casino experience: reapplication is permitted upon said person acquiring the requisite business ability and casino experience.

3. Failure to satisfy age requirement: Reapplication is permitted upon said person attaining the requisite age or upon a Commission finding that such age will be attained prior to the completion of the processing of said reapplication.

4. Conviction of statutory disqualifier or inimical offenses: Reapplication is permitted after the lapse of five years from the date of denial or upon the issuance of a judicial order of expungement or sealing, whichever occurs first.

5. Prosecution or pending charges related to statutory disqualifier: Reapplication is permitted upon the disposition of the prosecution or pending charges against such person.

(c) If the licensure, qualification or approval of any natural person has been denied or revoked on the basis of two or more statutory or regulatory provisions, reapplication shall only be permitted upon compliance with the requirements of this regulation as to each statutory or regulatory provision which the Commission found to be a basis for such denial or revocation.

(d) This regulation applies with equal force and effect to the denial of any application by a natural person for licensure, qualifications or approval, and to any denial of any reapplication for licensure, qualification or approval permitted under the provisions of this regulation.

SUBCHAPTER 8. FEES AND DEPOSITS (revised)

1:8.1 General description of fee and deposit policy

(a) Operations of the Commission shall be financed exclusively from fees charged each fiscal year to applicants and licensees and shall not be funded from CNMI or Municipality General Funds. Generally, the Act divides fees into two broad categories: those pertaining to casino licenses and those pertaining to all other forms of licensure or approval. The Commission shall establish, by regulation, fees for the application, issuance and renewal of all licenses.

(b) The differing treatment of these license categories reflects a recognition and judgment that casino applicants and licensees benefit directly or indirectly from all aspects of the regulatory process and are best suited to bear the largest share of the costs incurred by the Commission in implementing that process. Moreover, the actual cost of investigating and considering applications for individual employee licenses and casino service industry licenses will frequently exceed the amount which those applicants and licensees may fairly be required to pay as fees. The fee structure established by these regulations is designed to respond to these policies and problems.

(c) To the extent reasonably possible, each applicant or licensee should pay the investigatory or regulatory costs attributable to their application or license. However, since individual employees and casino service industry enterprises cannot always be expected to cover the full amount expended and since a portion of the costs incurred by the Commission pertain to the industry generally, there will be an amount of the annual budget which will not be recoverable through specified fees for particular services.

(d) Given the mandate of the Act to recover the cost of maintaining control and regulatory activities from license fees and given the fact that all such activities are undertaken for the direct or indirect benefit or protection of casino operations, the obligation to supply additional funds necessary to recover the otherwise uncollected expenditures of the Commission should be spread among the licensed casino facilities or applicants for casino licenses. By their nature the agency activities generating the otherwise uncollected expenditures are not attributable to any specific casino operation and they produce benefits for all such operations, for example, by creating a pool of licensed individuals to employ and enlarging the class of licensed casino service industries to contract with for goods and services. Thus, it is reasonable to apportion the otherwise uncollected costs equally among the licensed casino facilities and applicants for casino licenses subject to appropriate adjustment where a particular facility is not licensed for an entire fiscal year or where a change of ownership or control of casino operations occurs during the fiscal year which necessitates additional investigation.

1:8.2 Fiscal year

For purpose of this subchapter, a fiscal year shall be the period commencing on October 1 and ending the subsequent September 30.

1:8.3 License renewal general provisions

(a) All classes of gaming licenses, except casino licenses which remain in force until cancelled, suspended or surrendered, are subject to renewal as provided herein. Pursuant to Section 49 of the Act, no license, other than a casino license, may be renewed later than the date of expiration of the current license.

(b) Any license, other than a casino license, which is not renewed prior to expiration will be considered as forfeited. Reinstatement of such a forfeited license will require processing as a new license application including payment of the proper fees associated with initial license issuance as prescribed herein.

1:8.4 **Payment of fees and deposits**

(a) No application shall be accepted for filing or processed by the Chairman except upon the proper and timely payment of all required fees and deposits in accordance with the Act and these regulations. Any portion of an application fee or deposit which is incurred or determined after the filing of the application or which is estimated in accordance with this subchapter shall be payable upon demand made by the Commission. Failure to promptly remit any amount so demanded shall be deemed a failure to timely pay the required fee unless the Commission finds cause to permit an extension of time in which to remit the demanded amount.

(b) Except as otherwise provided in the Act and these regulations, failure to timely remit fees or deposits required under this subchapter shall result in suspension of the affected license or application until such time as the full amount of such fee or deposit is paid unless the Commission finds cause to permit an extension of time in which to remit the amount due. Except as otherwise provided, failure to remit the full amount of a fee or deposit required under this section within 30 calendar days of the date such fee becomes due shall result in permanent forfeiture of the affected license or application unless the licensee or applicant shall show cause for nonforfeiture acceptable to the Commission.

(c) All fees payable under this subchapter shall be paid by check or money order made payable to the "Tinian Municipal Treasurer" and presented to the Commission at its offices. No check so presented shall be deemed payment until the Commission shall be satisfied that sufficient funds are contained in the account against which it is drawn. All casino license application fees and licensing cost deposits shall be payable only by cashier's check, certified check or money order.

1:8.5 **Casino license fees and deposits**

(a) No application for the issuance of a casino license shall be accepted for filing by the Commission unless a nonrefundable application fee of $200,000 and a deposit against licensing costs of $150,000 shall first have been paid in full to the Commission.

(b) No conditional or plenary casino license shall be issued or renewed unless the applicant shall first have paid in full an annual license fee of $500,000 or prorated portion thereof for an initial license issuance. Pursuant to Section 50 (2)(b) of the Act, the license year for all casino licenses shall be a fiscal year which ends on September 30.

1:8.6 **Special fee assessments for general operations of the Commission**

(a) To the extent possible, funding for general operations of the Commission shall be derived from annual casino license fees, other license fees and casino license application fees. However, when amounts received from these set fees are insufficient to fund Commission operations, the provisions of this section shall apply.

(b) One month prior to the beginning of each new calendar quarter, the Commission shall determine previously received funds, not including licensing cost deposits described in 1:8.7, estimated to be available to fund operations of the Commission during the next quarter. Simultaneously, an estimate of operational funds required for the next quarter, not including license application processing costs, shall be prepared from the Commission's approved budget. When a funding shortfall is projected, the deficit shall be shared equally by all current casino license holders and applicants in the form of a special fee assessment.

(c) The Commission shall advise each license holder and applicant of the special fee assessment not later than the tenth day of the month preceeding the beginning of a new calendar quarter. Payment of said special fee shall then be due and payable at the office of the Commission no later than the last working day of the month preceeding the beginning of the new calendar quarter.

(d) Initial implementation of this section may result in these special fee assessments being made at times other than as specified in subsection (c), as the Commission will attempt to phase in these provisions as determined appropriate. However, any special fee assessed for general operations shall allow a minimum of twenty (20) calendar days for

remittance and, within six months of implementation, the regular quarterly cycle described in subsections (b) and (c) shall be fully implemented.

(e) For purposes of this section, a calendar quarter is any consecutive three month period which begins with the first day of January, April, July or October.

1:8.7 **Costs of processing a casino license application**

(a) The Commission shall cause all actual costs associated with investigation, hearing and licensing of a each casino license application, as determined necessary by the Commission, to be paid from licensing cost deposits submitted by the affected applicant. With respect to the applicant, officers, principals, shareholders, financiers, contract operators or any other parties which, in the sole view of the Commission, are subject to licensing standards pursuant to the Act, actual licensing costs shall include but not be limited to the following:

i. Professional fees and expenses incident to investigation of all parties subject to licensing standards;

ii. Expenses incident to preparation and conduct of a licensing hearing including expert witnesses or other testimony or evidence considered by the Commission to be relevant to deciding the casino license application; and

iii. An hourly charge, including a reasonable allowance for overhead, for all time expended by individual TCGCC Commissioners and staff directly on processing of the affected license application, participation in investigation, report preparation, hearing preparation, hearing participation and any other matter for which the time expended would not have been necessary were it not for the existence of the particular casino license application.

(b) If the Commission determines that actual costs of processing a casino license application will exceed the licensing cost deposit, the applicant will be notified to submit an additional deposit in an amount to be determined by the Commission based on an estimate of the amount of investigation and other expenses remaining. Such notification shall establish a date by which the additional deposit amount is to be remitted which allows a reasonable time of not less than fifteen (15) days in which to comply.

(c) When the Commission determines that the processing of a casino license application is concluded due to issuance or denial of the license, acceptance of the applicant's withdrawal of the application or for other reasons, any unexpended portion of the licensing cost deposit, including additional amounts required by the Commission subsequent to the initial filing, shall be refunded to the applicant along with a generalized accounting of expenses paid from deposited funds. To protect the confidentiality of investigation methodologies, such accounting to the applicant shall be limited to dates of payments, payees and amounts paid.

(d) Prior or subsequent to issuance of a license, if a licensee or applicant proposes a change to the ownership, capitalization or organizational structure of the licensee or applicant which, pursuant to the Act and in the sole judgement of the Commission, requires that additional investigation be undertaken, the Commission will notify the applicant of an amount and due date for remittance of a licensing cost deposit based on the estimated cost of additional investigation and other expenses. The disposition of this additional deposit amount shall be in accordance with other provisions of this section.

1:8.8 **Licensing costs of pending casino license applications**

(a) For purposes of payment of investigation and other licensing related costs, the provisions of this section shall apply to any casino license application which is pending at the time of adoption of this subchapter and, in connection with which, fees and deposits of $300,000 or more have previously been remitted to the Commission.

(b) The $200,000 application fee and the $100,000 licensing cost deposit referred to in Subsection 1:8.5(a) shall be deemed to have been timely paid from amounts previously remitted.

(c) As investigations undertaken by the Commission prior to adoption of this subchapter have resulted in preliminary investigative reports being received on all pending applications and the considerable actual costs paid by the Commission for such investigations have exceeded the aggregate licensing cost deposits of all pending applicants, all such deposits of pending applicants shall be considered as having been fully depleted. Pending applicants shall have no further liability with regard to the cost of investigative efforts expended through the filing of the preliminary investigative reports.

(d) Any additional licensing investigation or processing costs incurred or expected to be incurred with respect to a pending application after the filing of the preliminary report shall be individually assessed by the Commission and paid by the affected applicant in accordance with the provisions of Section 1:8.7.

1:8.9 **Slot machine fees**

RESERVED

1:8.10 **Casino service industry license fees**

RESERVED

1:8.11 **Casino key employee license fees**

RESERVED

1:8.12 **Casino employee license fees**

RESERVED

1:8.13 **Obligation to pay fees; nonrefundable nature of fees**

(a) Any fee or deposit obligation arising in accordance with the Act or this subchapter shall be due and payable notwithstanding the withdrawal or abandonment of any application or the termination in any manner of an existing license. Each party to an agreement to lease the casino hotel or the land thereunder, to jointly own a casino hotel or the land thereunder, or to manage a casino shall also be liable for any amounts chargeable to the casino licensee or applicant.

(b) Unless otherwise provided, amounts actually paid by an applicant or licensee in accordance with the Act and this subchapter shall not be refundable.

1:8.14 **Powers and duties of the Commission**

Nothing in this subchapter shall be construed to limit the powers and duties of the Commission as provided in the Act or the regulations of the Commission.

TINIAN CASINO GAMING CONTROL COMMISSION

Municipality of Tinian and Aguiguan
Commonwealth of the Northern Mariana Islands

CERTIFICATION

I, William M. Cing, Executive Director of the Tinian Casino Gaming Control Commission of San Jose, Tinian, which is promulgating the Rules Regarding Applications herein set forth, by signature below hereby certify that such Rules are a true, complete and correct copy of the Rules Regarding Applications formally adopted by the Tinian Casino Gaming Control Commission.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on the 2nd day of December, 1993, at Tinian, Commonwealth of the Northern Mariana Islands.

William M. Cing
Executive Director

P.O. Box 143 San Jose Village, Tinian, MP 96952 • Tel: (670) 433-9288/9292 • Fax: (670) 433-9290

NOTICE OF AMENDMENT TO PROPOSED RULES AND REGULATIONS
FOR THE OPERATION OF THE CNMI LOTTERY
AND NOTICE OF ADOPTION OF THE RULES AND REGULATIONS
FOR THE OPERATION OF THE CNMI LOTTERY

WHEREAS, on an emergency basis the CNMI Lottery Commission unanimously approved and adopted, on October 14, 1993, the "Rules and Regulations for the Operation of the Commonwealth of the Northern Mariana Islands Lottery" (hereinafter "Lottery Rules"); and,

WHEREAS, the Lottery Rules were published in the CNMI Commonwealth Register of October 15, 1993 (Volume 15, No. 10 at pages 10895 - 10985); and,

WHEREAS, contemporaneous is with the publication of the Lottery Rules, a Notice and solicitation of public comment was also published in the Commonwealth Register; and,

WHEREAS, the CNMI Lottery Commission has considered all comments received regarding the proposed Lottery Rules and good cause appearing, the CNMI Lottery Commission has unanimously voted to amend the Lottery Rules by adding thereto Section 10.1 which shall read as follows:

> 10.1 Provided that they otherwise comply with any and all other applicable CNMI laws and/or applicable CNMI Rules and Regulations, a merchant shall be exempt from the requirements of Sections 10(b) through 10(g) hereinabove set forth if the value of all prizes awarded pursuant to such gift enterprise lottery undertaking does not exceed a total retail value of $2,500.00; and, provided further that the merchant conducting such gift enterprise lottery which is otherwise exempted from the requirements of Rule 10(b) through 10(g) hereinabove set forth not buy-back, repurchase, or award a cash equivalent for any merchandise prize so awarded; and, provided further that the merchant conducting such gift enterprise lottery shall, at the discretion of the CNMI Lottery Commission, comply with the requirements of Sections 10.2, 10.3 and 10.4 of the Lottery Rules and Regulations as hereinafter set forth.

By signature below the Executive Secretary of the CNMI Lottery Commission gives notice that, as hereinabove amended, the CNMI Lottery Commission has unanimously adopted, on a permanent basis, the "Rules and Regulations for the Operation of the Commonwealth of

the Northern Mariana Islands Lottery" originally adopted on an emergency basis October 14, 1993..

Dated this 30th day of December, 1993.

Eloy S. Inos
Executive Secretary
CNMI Lottery Commission

CERTIFICATION OF THE ADOPTION OF THE RULES AND REGULATIONS FOR THE OPERATION OF THE CNMI LOTTERY

I, Eloy S. Inos, Director of the Director of Finance am also Executive Secretary of the CNMI Lottery Commission which Commission has promulgated the Rules and Regulations for the Operation of the CNMI Lottery and, by signature below, do hereby certify that such Rules and Regulations for the Operation of the CNMI Lottery, as hereinabove amended, are a true, complete and correct copy of the Rules and Regulations adopted by the CNMI Lottery Commission to govern the operation of the CNMI Lottery.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on the 30th day of December, 1993 on the island of Saipan, Commonwealth of the Northern Mariana Islands.

Eloy S. Inos
Executive Secretary
CNMI Lottery Commission

Filed by: SOLEDAD B. SASAMOTO
Registrar of Corporations
01/12/94
Date

Filed by: DONNA J. CRUZ
Governor's Office
01/12/94
Date