CERTIFICATION OF ENROLLMENT

SENATE BILL 5042

Chapter 80, Laws of 2007

60th Legislature
2007 Regular Session

INSURANCE

EFFECTIVE DATE: 07/22/07

Passed by the Senate March 5, 2007
YEAS 45 NAYS 0

BRAD OWEN
President of the Senate

Passed by the House April 4, 2007
YEAS 95 NAYS 0

FRANK CHOPP
Speaker of the House of Representatives

Approved April 18, 2007, 9:40 a.m.

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is SENATE BILL 5042 as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN
Secretary

CERTIFICATE

FILED

April 18, 2007

CHRISTINE GREGOIRE
Governor of the State of Washington

SECRETARY OF STATE
State of Washington

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.111.020 and 2006 c 36 s 3 are each amended to read as follows:

(1) A person shall not act as, or offer to act as, or hold himself or herself out to be a home heating fuel service contract provider in this state, nor may a home heating fuel service contract be sold to a consumer in this state, unless the contract provider has a valid registration as a home heating fuel service contract provider issued by the commissioner.

(2) Applicants to be a home heating fuel service contract provider shall make an application to the commissioner upon a form to be furnished by the commissioner. The application must include or be accompanied by the following information and documents:
(a) All basic organizational documents of the home heating fuel service contract provider, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, bylaws, and other applicable documents, and all amendments to those documents;

(b) The identities of the contract provider's executive officer or officers directly responsible for the contract provider's home heating fuel service contract business;

(c) Annual financial statements or other financial reports acceptable to the commissioner for the two most recent years which prove that the applicant is solvent and any information the commissioner may require in order to review the current financial condition of the applicant;

(d) An application fee of one hundred dollars, which must be deposited into the general fund; and

(e) Any other pertinent information required by the commissioner.

(3) The commissioner may refuse to issue a registration if the commissioner determines that the home heating fuel service contract provider, or any individual responsible for the conduct of the affairs of the contract provider under subsection (2)(b) of this section, is not competent, trustworthy, or financially responsible.

(4) A registration issued under this section is valid, unless surrendered, suspended, or revoked by the commissioner, or not renewed for so long as the service contract provider continues in business in this state and remains in compliance with this chapter. A registration is subject to renewal annually on July 1st upon application of the home heating fuel service contract provider and payment of a fee of twenty-five dollars, which must be deposited into the ((insurance commissioner's regulatory account under RCW 48.02.190)) general fund. If not so renewed, the registration expires on ((July 31st of that year)) June 30th next preceding.

(5) A home heating fuel service contract provider shall keep current the information required to be disclosed in its registration under this section by reporting all material changes or additions within thirty days after the end of the month in which the change or addition occurs.
Sec. 2. RCW 48.12.010 and 1977 ex.s. c 180 s 2 are each amended to read as follows:

In any determination of the financial condition of any insurer there shall be allowed as assets only such assets as belong wholly and exclusively to the insurer, which are registered, recorded, or held under the insurer's name, and which consist of:

1. Cash in the possession of the insurer or in transit under its control, and the true balance of any deposit of the insurer in a solvent bank or trust company;

2. Investments, securities, properties, and loans acquired or held in accordance with this code, and in connection therewith the following items:
   a. Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.
   b. Declared and unpaid dividends on stocks and shares unless such amount has otherwise been allowed as an asset.
   c. Interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon.
   d. Interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets if such interest is in the judgment of the commissioner a collectible asset.
   e. Interest due or accrued on a mortgage loan, in amount not exceeding in any event the amount, if any, of the difference between the unpaid principal and the value of the property less delinquent taxes thereon; but if any interest on the loan is in default more than ((eighteen months)) one hundred eighty days, or if any interest on the loan is in default and any taxes or any installment thereof on the property are and have been due and unpaid for more than ((eighteen months)) one hundred eighty days, no allowance shall be made for any interest on the loan.
   f. Rent due or accrued on real property if such rent is not in arrears for more than three months.

3. Premium notes, policy loans, and other policy assets and liens on policies of life insurance, in amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

4. The net amount of uncollected and deferred premiums in the case
of a life insurer which carries the full annual mean tabular reserve liability;

(5) Premiums in the course of collection, other than for life insurance, not more than ninety days past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States government or any of its instrumentalities;

(6) Installment premiums other than life insurance premiums, in accordance with regulations prescribed by the commissioner consistent with practice formulated or adopted by the National Association of Insurance Commissioners;

(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon and unless otherwise required by regulation prescribed by the commissioner;

(8) Reinsurance recoverable subject to RCW 48.12.160;

(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from any suspended banking institution, to the extent deemed by the commissioner available for the payment of losses and claims and at values to be determined by him;

(11) Electronic and mechanical machines constituting a data processing and accounting system if the cost of such system is at least twenty-five thousand dollars, which cost shall be amortized in full over a period not to exceed ((ten)) three calendar years; and

(12) Other assets, not inconsistent with the foregoing provisions, deemed by the commissioner available for the payment of losses and claims, at values to be determined by him.

Sec. 3. RCW 48.21.200 and 1993 c 492 s 282 are each amended to read as follows:

(1) (No individual or group disability insurance policy, health care service contract, or health maintenance agreement which provides benefits for hospital, medical, or surgical expenses shall be delivered or issued for delivery in this state which contains any provision
whereby the insurer, contractor, or health maintenance organization may reduce or refuse to pay such benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under any disability insurance policy, health care service contract, or health maintenance agreement.

(2) No individual or group disability insurance policy, health care service contract, or health maintenance agreement providing hospital, medical or surgical expense benefits and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses ((exclusive of copayments, deductibles, and other similar cost-sharing arrangements)).

((3))) (2) The commissioner shall by rule establish guidelines for the application of this section, including:

(a) The procedures by which persons covered under such policies, contracts, and agreements are to be made aware of the existence of such a provision;

(b) The benefits which may be subject to such a provision;

(c) The effect of such a provision on the benefits provided;

(d) Establishment of the order of benefit determination;

(e) Exceptions necessary to preserve policy, contract, or agreement requirements for use of particular health care facilities or providers; and

(f) Reasonable claim administration procedures to expedite claim payments and prevent duplication of payments or benefits under such a provision.

Sec. 4. RCW 48.36A.260 and 1987 c 366 s 26 are each amended to read as follows:

(1) Every domestic society ((transacting business in this state)) shall annually, on or before the first day of March, unless for cause shown such time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year and pay a fee of ten dollars for filing. The statement shall be in general form and context
as approved by the national association of insurance commissioners for
fraternal benefit societies and as supplemented by additional
information required by the commissioner.

(2) All domestic, foreign, and alien societies transacting business
in this state shall annually, on or before March 1st of each year, file
with the national association of insurance commissioners a copy of its
annual statement convention blank in electronic form.

(3) As part of the required annual statement, each society shall,
on or before the first day of March, file with the commissioner a
valuation of its certificates in force on December 31st last preceding,
provided the commissioner may, in the commissioner's discretion for
cause shown, extend the time for filing the valuation for not more than
two calendar months. The valuation shall be done in accordance with
the standards specified in RCW 48.36A.250. The valuation and
underlying data shall be certified by a qualified actuary or, at the
expense of the society, verified by the actuary of the department of
insurance of the state of domicile of the society.

(4) A society neglecting to file the annual statement in
the form and within the time provided by this section shall forfeit one
hundred dollars for each day during which the neglect continues, and,
upon notice by the commissioner, its authority to do business in this
state shall cease while the default continues.

NEW SECTION. Sec. 5. A new section is added to chapter 48.11 RCW
to read as follows:

For the purposes of this code other than as to chapter 48.19 RCW
"ocean marine and foreign trade insurances" shall include only:

(1) Insurances upon vessels, crafts, hulls, and of interests
therein or with relation thereto;

(2) Insurance of marine builders' 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 definition;

(4) Insurance of personal property and interests therein, in course
of exportation from or importation into any country, or in course of
transportation coastwise, including transportation by land, water, or
air from point of origin to final destination, in respect to,
appertaining to, or 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, storage,
transshipment, or reshipment incident thereto.

Sec. 6. RCW 48.13.120 and 1993 c 92 s 7 are each amended to read
as follows:
(1) An investment made pursuant to the provisions of RCW 48.13.110
shall not exceed seventy-five percent of the fair value of the
particular property at the time of investment. However, if the loan is
secured by a first mortgage or other first lien upon real property
improved with a single-family residential building, the terms of such
loan provide for monthly payments of principal and interest sufficient
to effect full repayment of the loan within the remaining useful life
of the building as estimated in the appraisal for the loan, or thirty
years and two months, whichever is less, the principal so loaned or the
entire note or bond issue so secured, plus the amount of the liens of
any public bond, assessment, or tax assessed upon the property, ((may))
shall not exceed eighty percent of the market value of the real
property, or of the real property together with the improvements which
are taken as security. This restriction shall not apply to purchase
money mortgages or like securities received by an insurer upon the sale
or exchange of real property acquired pursuant to RCW 48.13.160.
(2) The extent to which a mortgage loan made under RCW 48.13.110
(3) or (4) is guaranteed or insured by the Federal Housing
Administration or guaranteed by the Administrator of Veterans' Affairs
may be deducted before application of the limitations contained in
subsection (1) of this section.

Sec. 7. RCW 48.13.265 and 1957 c 193 s 8 are each amended to read
as follows:
An insurer shall not invest or have invested at any one time more
than sixty-five percent of its assets in investments in real estate,
real estate contracts, and notes, bonds and other evidences of debt
secured by mortgage on real estate, as described in RCW 48.13.110 and
48.13.160. Any insurer which, on June 13, 1957, has in excess of
sixty-five percent of its assets so invested shall not make any further
such investments while such excess exists. All investments in
mortgage-backed securities qualifying under the secondary mortgage
market enhancement act of 1984 (98 Stat. 1691; 15 U.S.C. Sec. 77r-l et seq.) are included in determining if an insurer has exceeded the sixty-five percent limit.

Sec. 8. RCW 48.13.275 and 1993 c 92 s 6 are each amended to read as follows:

(Notwithstanding the provisions of RCW 48.13.050,)) An insurer may invest its funds in obligations rated by the securities valuation office. Investments in obligations that are rated one or two by the securities valuation office shall be subject to the limitations contained in RCW 48.13.030.

Sec. 9. RCW 48.24.070 and 1973 1st ex.s. c 163 s 9 are each amended to read as follows:

The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established by two or more employers or by two or more employer members of an employers' association, or by one or more labor unions, or by one or more employers and one or more labor unions, or by one or more employers and one or more labor unions whose members are in the same or related occupations or trades, which trustees shall be deemed the policyholder, to insure employees or members for the benefit of persons other than the employers or the unions, subject to the following requirements:

(1) If the policy is issued to two or more employer members of an employers' association, such policy may be issued only if (a) the association has been in existence for at least five years and was formed for purposes other than obtaining insurance and (b) the participating employers, meaning such employer members whose employees are to be insured, constitute at date of issue at least fifty percent of the total employers eligible to participate, unless the number of persons covered at date of issue exceeds six hundred, in which event such participating employers must constitute at least twenty-five percent of such total employers in either case omitting from consideration any employer whose employees are already covered for group life insurance.

(2) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof determined by conditions pertaining to
their employment, or to membership in the unions, or to both. The policy may provide that the term "employees" shall include the individual proprietor or partners if an employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are connected with such trusteeship. The policy may provide that the term "employees" shall include retired employees. 

(3) The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or partly or wholly from funds contributed by the insured persons, or any combination thereof. A policy on which all or part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force if the eligible persons elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as to whom evidence of insurability is not satisfactory to the insurer.

(4) The policy must cover at least twenty persons at date of issue.

(5) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions.

Sec. 10. RCW 48.31.045 and 1993 c 462 s 77 are each amended to read as follows:

(1) A court in this state before which an action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for ninety days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he or she deems necessary in the interests of justice and for the protection of
creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) A statute of limitations or defense of laches does not run with respect to an action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. An action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered or the petition is denied. ((The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon a cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which the order is entered.)) The rehabilitator may institute an action or proceeding pursuant to an order of rehabilitation, within the later of two years following entry of the order or two years of the date the rehabilitator discovers, or in the exercise of reasonable care should have discovered, the injury from which the action or proceeding arose and its cause. However, actions against former directors, officers, and employees brought pursuant to an order of rehabilitation for the benefit or the protection of subscribers, policy beneficiaries, or the general public is subject to the limitations period of RCW 4.16.160.

(3) A guaranty association or foreign guaranty association covering life or health insurance or annuities has standing to appear in a court proceeding concerning the rehabilitation of a life or health insurer if the association is or may become liable to act as a result of the rehabilitation.

Sec. 11. RCW 48.31.131 and 1993 c 462 s 63 are each amended to read as follows:

(1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, an action at law or equity or in arbitration may not be brought against the insurer or liquidator, whether in this state or elsewhere, nor may such an existing action be maintained or further presented after issuance of
the order. The courts of this state shall give full faith and credit
to injunctions against the liquidator or the company when the
injunctions are included in an order to liquidate an insurer issued
under laws in other states corresponding to this subsection. Whenever,
in the liquidator's judgment, protection of the estate of the insurer
necessitates intervention in an action against the insurer that is
pending outside this state, the liquidator may intervene in the action.
The liquidator may defend an action in which he or she intervenes under
this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation,
within two years or such other longer time as applicable law may
permit, institute an action or proceeding on behalf of the estate of
the insurer upon a cause of action against which the period of
limitation fixed by applicable law has not expired at the time of the
filing of the petition upon which the order is entered. Where, by an
agreement, a period of limitation is fixed for instituting a suit or
proceeding upon a claim, or for filing a claim, proof of claim, proof
of loss, demand, notice, or the like, or where in a proceeding,
judicial or otherwise, a period of limitation is fixed, either in the
proceeding or by applicable law, for taking an action, filing a claim
or pleading, or doing an act, and where in such a case the period had
not expired at the date of the filing of the petition, the liquidator
may, for the benefit of the estate, take such an action or do such an
act, required of or permitted to the insurer, within a period of one
hundred eighty days after the entry of an order for liquidation, or
within such further period as is shown to the satisfaction of the court
not to be unfairly prejudicial to the other party)) institute an action
or proceeding pursuant to an order of rehabilitation, within the later
of two years following entry of the order or two years of the date the
liquidator discovers, or in the exercise of reasonable care should have
discovered, the injury from which the action or proceeding arose and
its cause. However, actions against former directors, officers, and
employees brought pursuant to an order of rehabilitation for the
benefit or the protection of subscribers, policy beneficiaries, or the
general public is subject to the limitations period of RCW 4.16.160.

(3) A statute of limitation or defense of laches does not run with
respect to an action against an insurer between the filing of a
petition for liquidation against an insurer and the denial of the
petition. An action against the insurer that might have been commenced
when the petition was filed may be commenced for at least sixty days
after the petition is denied.

(4) A guaranty association or foreign guaranty association has
standing to appear in a court proceeding concerning the liquidation of
an insurer if the association is or may become liable to act as a
result of the liquidation.

Sec. 12. RCW 48.31.155 and 1993 c 462 s 68 are each amended to
read as follows:

Unclaimed funds subject to distribution remaining in the
liquidator's hands when he or she is ready to apply to the court for
discharge, including the amount distributable to a person who is
unknown or cannot be found, shall be deposited with the state
(treasurer) department of revenue as unclaimed funds, and shall be
paid without interest to the person entitled to them or his or her
legal representative upon proof satisfactory to the state ((treasurer))
department of revenue of his or her right to them. An amount on
deposit not claimed within six years from the discharge of the
liquidator is deemed to have been abandoned and shall be escheated
without formal escheat proceedings and be deposited with the state
treasurer.

Sec. 13. RCW 48.43.018 and 2004 c 244 s 3 are each amended to read
as follows:

(1) Except as provided in (a) through ((e)) (d) of this
subsection, a health carrier may require any person applying for an
individual health benefit plan to complete the standard health
questionnaire designated under chapter 48.41 RCW.

(a) If a person is seeking an individual health benefit plan due to
his or her change of residence from one geographic area in Washington
state to another geographic area in Washington state where his or her
current health plan is not offered, completion of the standard health
questionnaire shall not be a condition of coverage if application for
coverage is made within ninety days of relocation.

(b) If a person is seeking an individual health benefit plan:

(i) Because a health care provider with whom he or she has an
established care relationship and from whom he or she has received
(b) Either (i) Treatment within the past twelve months is no longer part of the carrier's provider network under his or her existing Washington individual health benefit plan; and

(ii) His or her health care provider is part of another carrier's provider network; and

(iii) Application for a health benefit plan under that carrier's provider network individual coverage is made within ninety days of his or her provider leaving the previous carrier's provider network; then completion of the standard health questionnaire shall not be a condition of coverage.

(c) If a person is seeking an individual health benefit plan due to his or her having exhausted continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of exhaustion of continuation coverage. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such continuation coverage if application is made within ninety days prior to the date the continuation coverage would be exhausted and the effective date of the individual coverage applied for is the date the continuation coverage would be exhausted, or within ninety days thereafter.

(d) ((If a person is seeking an individual health benefit plan due to his or her receiving notice that his or her coverage under a conversion contract is discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility under the conversion contract would be discontinued and the effective date of the individual coverage applied for is the date eligibility under the conversion contract would be discontinued, or within ninety days thereafter.)) If a person is seeking an individual health benefit plan and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not
be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

(2) If, based upon the results of the standard health questionnaire, the person qualifies for coverage under the Washington state health insurance pool, the following shall apply:

(a) The carrier may decide not to accept the person's application for enrollment in its individual health benefit plan; and

(b) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the person's application for enrollment to both the person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, and shall include information about the Washington state health insurance pool and an application for such coverage. If the carrier does not provide or postmark such notice within fifteen business days, the application is deemed approved.

(3) If the person applying for an individual health benefit plan:

(a) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (b) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire and the carrier elects to accept the person for enrollment; or (c) is not required to complete the standard health questionnaire designated under this chapter under subsection (1)(a) or (b) of this section, the carrier shall accept the person for enrollment if he or she resides within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or
situation, or the provisions of RCW 49.60.174(2). The commissioner may
grant a temporary exemption from this subsection if, upon application
by a health carrier, the commissioner finds that the clinical,
financial, or administrative capacity to serve existing enrollees will
be impaired if a health carrier is required to continue enrollment of
additional eligible individuals.

Sec. 14. RCW 48.22.030 and 2006 c 187 s 1, 2006 c 110 s 1, and
2006 c 25 s 17 are each reenacted and amended to read as follows:
(1) "Underinsured motor vehicle" means a motor vehicle with respect
to the ownership, maintenance, or use of which either no bodily injury
or property damage liability bond or insurance policy applies at the
time of an accident, or with respect to which the sum of the limits of
liability under all bodily injury or property damage liability bonds
and insurance policies applicable to a covered person after an accident
is less than the applicable damages which the covered person is legally
entitled to recover.

(2) No new policy or renewal of an existing policy insuring against
loss resulting from liability imposed by law for bodily injury, death,
or property damage, suffered by any person arising out of the
ownership, maintenance, or use of a motor vehicle shall be issued with
respect to any motor vehicle registered or principally garaged in this
state unless coverage is provided therein or supplemental thereto for
the protection of persons insured thereunder who are legally entitled
to recover damages from owners or operators of underinsured motor
vehicles, hit-and-run motor vehicles, and phantom vehicles because of
bodily injury, death, or property damage, resulting therefrom, except
while operating or occupying a motorcycle or motor-driven cycle, and
except while operating or occupying a motor vehicle owned or available
for the regular use by the named insured or any family member, and
which is not insured under the liability coverage of the policy. The
coverage required to be offered under this chapter is not applicable to
general liability policies, commonly known as umbrella policies, or
other policies which apply only as excess to the insurance directly
applicable to the vehicle insured.

(3) Except as to property damage, coverage required under
subsection (2) of this section shall be in the same amount as the
insured's third party liability coverage unless the insured rejects all
or part of the coverage as provided in subsection (4) of this section. Coverage for property damage need only be issued in conjunction with coverage for bodily injury or death. Property damage coverage required under subsection (2) of this section shall mean physical damage to the insured motor vehicle unless the policy specifically provides coverage for the contents thereof or other forms of property damage.

(4) A named insured or spouse may reject, in writing, underinsured coverage for bodily injury or death, or property damage, and the requirements of subsections (2) and (3) of this section shall not apply. If a named insured or spouse has rejected underinsured coverage, such coverage shall not be included in any supplemental or renewal policy unless a named insured or spouse subsequently requests such coverage in writing. The requirement of a written rejection under this subsection shall apply only to the original issuance of policies issued after July 24, 1983, and not to any renewal or replacement policy. When a named insured or spouse chooses a property damage coverage that is less than the insured's third party liability coverage for property damage, a written rejection is not required.

(5) The limit of liability under the policy coverage may be defined as the maximum limits of liability for all damages resulting from any one accident regardless of the number of covered persons, claims made, or vehicles or premiums shown on the policy, or premiums paid, or vehicles involved in an accident.

(6) The policy may provide that if an injured person has other similar insurance available to him under other policies, the total limits of liability of all coverages shall not exceed the higher of the applicable limits of the respective coverages.

(7)(a) The policy may provide for a deductible of not more than three hundred dollars for payment for property damage when the damage is caused by a hit-and-run driver or a phantom vehicle.

(b) In all other cases of underinsured property damage coverage, the policy may provide for a deductible of not more than one hundred dollars.

(8) For the purposes of this chapter, a "phantom vehicle" shall mean a motor vehicle which causes bodily injury, death, or property damage to an insured and has no physical contact with the insured or the vehicle which the insured is occupying at the time of the accident if:
(a) The facts of the accident can be corroborated by competent evidence other than the testimony of the insured or any person having an underinsured motorist claim resulting from the accident; and

(b) The accident has been reported to the appropriate law enforcement agency within seventy-two hours of the accident.

(9) An insurer who elects to write motorcycle or motor-driven cycle insurance in this state must provide information to prospective insureds about the coverage.

(10) An insurer who elects to write motorcycle or motor-driven cycle insurance in this state must provide an opportunity for named insureds, who have purchased liability coverage for a motorcycle or motor-driven cycle, to reject underinsured coverage for that motorcycle or motor-driven cycle in writing.

(11) If the covered person seeking underinsured motorist coverage under this section was the intended victim of the tortfeasor, the incident must be reported to the appropriate law enforcement agency and the covered person must cooperate with any related law enforcement investigation.

(12) The purpose of this section is to protect innocent victims of motorists of underinsured motor vehicles. Covered persons are entitled to coverage without regard to whether an incident was intentionally caused. However, a person is not entitled to coverage if the insurer can demonstrate that the covered person intended to cause the event for which a claim is made under the coverage described in this section. As used in this section, and in the section of policies providing the underinsured motorist coverage described in this section, "accident" means an occurrence that is unexpected and unintended from the standpoint of the covered person.

(13) "Underinsured coverage," for the purposes of this section, means coverage for "underinsured motor vehicles," as defined in subsection (1) of this section.

NEW SECTION. Sec. 15. The following acts or parts of acts are each repealed:

(1) RCW 48.12.120 (Loss reserve--Workers' compensation insurance) and 1995 c 35 s 4, 1987 c 185 s 20, & 1947 c 79 s .12.12;
(2) RCW 48.12.130 (Unallocated workers' compensation loss expense) and 1995 c 35 s 5, 1987 c 185 s 21, & 1947 c 79 s .12.13; and
(3) RCW 48.14.050 ("Ocean marine and foreign trade insurances" defined) and 1947 c 79 s .14.05.

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