

Title 284 WAC

INSURANCE COMMISSIONER

Chapters

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Chapter 284-08

PRACTICE AND PROCEDURE

Reviser's note: Practice and procedure rules, WAC 284-08-010 through 284-08-590, were filed with the code reviser's office 3/22/60. They were repealed by insurance commissioner Order No. R 68-3, the pertinent portion of which reads as follows:

WAC 284-08-001 repeal of rules of PRACTICE and PROCEDURE (chapter 284-08 WAC). "1, LEE I. KUECKELHAN, insurance commissioner of the state of Washington, . . . do hereby repeal the above-entitled rules effective July 11, 1968, on the grounds that such rules and regulations are substantially contained in Title 1, Washington Administrative Code, which are intended to be the uniform rules of practice and procedure for state administrative agencies. . . ." [Order No. R 68-3 (part), filed 6/12/68.]

Chapter 284-40

REGISTRATION OF FUNERAL ESTABLISHMENTS

- 284-40-010 Purpose. [Order R 77-6, § 284-40-010, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-020 Effective date and scope. [Order R 77-6, § 284-40-020, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-030 Definitions. [Order R 77-6, § 284-40-030, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-040 Registration. [Order R 77-6, § 284-40-040, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-050 Prearrangement funeral service contract form requirements. [Order R 77-6, § 284-40-050, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-060 Requirements as to trust funds. [Order R 77-6, § 284-40-060, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-070 Annual statement requirements. [Order R 77-6, § 284-40-070, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-080 Renewal of certificate of registration. [Order R 77-6, § 284-40-080, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.

Chapter 284-02 WAC

DESCRIPTION OF INSURANCE COMMISSIONER'S OFFICE--ORGANIZATION OPERATIONS AND OBTAINING INFORMATION

WAC

- 284-02-010 Authority of insurance commissioner.
- 284-02-020 Organization and operations.
- 284-02-030 Obtaining service of process over foreign and alien insurers.

DISPOSITION OF CHAPTERS FORMERLY CODIFIED IN THIS TITLE

284-02-040	Applying for a license as agent, adjuster, broker or solicitor.
284-02-050	Application for admission as an authorized insurer, health care service contractor.
284-02-060	Filing complaint against company, agent/broker or adjuster.
284-02-070	Hearings of the insurance commissioner.
284-02-080	Publications and information available.
284-02-090	Public access to information and records.

WAC 284-02-010 Authority of insurance commissioner. (1) **The office generally.** The position of insurance commissioner was established by the legislature as an independent, elective office in 1907. The insurance commissioner's powers are set forth in chapter 48.02 RCW. To carry out the task of enforcing the insurance code the commissioner may make rules and regulations governing activities under the insurance code consistent therewith; he may conduct investigations to determine whether any person has violated any provision of the code, including formal hearings; he may take action against an insurance company and a health care service contractor by revocation or suspension of its certificate of authority; he may fine insurance companies, and he may revoke or suspend the licenses of insurance agents or fine them. In lieu of any disciplinary action he may issue a cease and desist order pursuant to the general enforcement powers granted to him by RCW 48.04.080, or pursuant to that section, he may bring an action in court to enjoin some act conducted by an individual licensed by his office.

(2) Duties and responsibilities imposed by Title 48 RCW.

(a) Title 48 RCW embraces the insurance code proper, which is defined by RCW 48.01.010 to include chapters 48.01 to 48.36 and 48.48 RCW. Chapters 48.01 to 48.36 RCW deal largely with the commissioner's regulation of insurance companies, insurance agents, brokers, solicitors and adjusters, although he also licenses and examines insurance rating organizations and examining bureaus.

(b) Chapter 48.36 RCW, relating to fraternal societies, while contained in the insurance code proper, establishes separate licensing examination and regulatory provisions for such societies. The offering of burial insurance by fraternal, benevolent associations and labor unions is, however, exempt from the operation of the insurance code by virtue of RCW 48.40.090 and 24.16.120.

(c) Chapter 48.48 RCW is the chapter governing the state fire marshal's office. The insurance commissioner is, by virtue of RCW 48.48.010, made ex officio state fire marshal. The description of that office's organization and operations is contained in WAC 212-02-010.

(d) The two remaining chapters presently in Title 48 RCW which are not part of the insurance code are chapter 48.44 RCW, which regulates health care service contractors as defined therein, and chapter 48.52 RCW, which regulates employee welfare trust funds as defined therein. The regulatory powers of the insurance commissioner over health care service contractors and employee

welfare trusts are not as extensive as his powers with organizations and individuals subject to the insurance code proper.

(e) The insurance code contains a number of substantive provisions which relate to the rights of policyholders in general and which are enforced for their benefit by the insurance commissioner. Those, for the most part, are contained in chapter 48.18 RCW, which is entitled the "insurance contract," and chapter 48.30 RCW, entitled "Unfair practices and frauds." Additional substantive provisions, however, are contained in chapters of the insurance code dealing with specific lines of insurance. For example, certain standard provisions are required to be placed in a disability insurance contract. See chapter 48.20 RCW. Similarly, substantive provisions appear in chapter 48.21 RCW, entitled "Group and blanket disability insurance," chapter 48.23 RCW, entitled "Life insurance and annuities," chapter 48.24 RCW, entitled "Group life and annuities," chapter 48.22 RCW, entitled "Casualty insurance," and chapter 48.34 RCW, entitled "Credit life insurance and credit accident and health insurance."

(3) **Additional duties of the insurance commissioner.** The state insurance commissioner is, by statute, made a member of a number of boards and commissions in addition to his regular duties. See RCW 41.40.030, 43.43.140, 43.35.010 and 41.32.040. In addition to these responsibilities he has been assigned the special duty of preparing annuity tables for calculation of the reserve fund in cases of death or permanent disability under the Workmen's Compensation Act. See RCW 51.44.070. He must also publish for use of the state courts and appraisers, tables showing the average expectancy of life, and values of annuities and life and term estates. (RCW 48.02.160.)

[Order R-68-6, § 284-02-010, filed 8/23/68, effective 9/23/68.]

WAC 284-02-020 Organization and operations. (1) **Administrative.** The insurance commissioner is the head of an agency generally referred to as the insurance commissioner's office, and as such is the chief administrative officer. He has a chief deputy who is given the same powers as are granted to the insurance commissioner himself.

(2) Examination division.

(a) The examination division is headed by a chief examiner and is divided into two sections, insurance and employee welfare trusts.

(b) The insurance section conducts examinations of each domestic company licensed in the state of Washington at least once every three years. It examines each rating organization and examining bureau licensed in this state not less than once every five years. It may examine each advisory organization and each joint underwriting or joint reinsurance group association organization as often as the commissioner deems advisable. In the case of nondomestic insurance companies the commissioner may accept a full report of the latest examination, certified by the insurance supervisory official of the state of domicile or of entry. Frequently examiners from the Washington insurance commissioner's office

participate in examination of nondomestic insurance companies under a participating arrangement of the National Association of Insurance Commissioners.

(c) The employee welfare trust fund section conducts examination of employee health and welfare funds and trusts and profit-sharing and pension trusts at least once every five years. An employee welfare trust fund is defined by RCW 48.52.010 to mean "any fund established for employees of one or more employers for providing employees, their families or dependents medical or hospital care, disability benefits, death benefits, retirement benefits, annuity benefits, health care services, or any insurance benefits, whether such benefits or services are to be paid directly from such fund or interest therefrom, or paid under contracts entered into by the trustees of the fund with an insurer or health care service contractor."

(d) Examinations by the insurance commissioner's office include analyses of the various operating accounts, physical inspection of assets, examination of records and files relating to assets and liabilities, policies and practices, surveys of the systems of internal control, accounting procedures, and determination of the financial condition as of the close of the period under examination. Close attention is paid to ascertain whether the business is conducted in conformity with the laws and regulations relating to insurance and employee welfare trusts, and with the charters and bylaws adopted by the governing board of the organization. Insurance examiners work from a manual guide prepared, and continually updated, by a committee of the National Association of Insurance Commissioners. Detailed auditing of vouchers and other records is performed only to the extent necessary for verification of assets and liabilities.

(e) Reports of examination are furnished to the organization, which then has no less than 10 days to request a hearing for the purpose of considering objections to that report. A report may not be made public until after such hearing and until such modifications deemed necessary by the commissioner have been made. Assuming no further action is to be taken, the commissioner may then make the examination report a public document; though he may withhold the report from public inspection if it is in the public interest to do so, pursuant to RCW 48.03.050.

(3) **Policyholder complaints.** Claims deputies located in offices of the insurance commissioner in Olympia, Seattle, Spokane and Yakima handle written and oral complaints by policyholders against their insurers. Additionally, once a month commissioner's deputies are available in Wenatchee, Kennewick and Vancouver to hear policyholder complaints. These sessions are announced in advance by the press in those areas. Assistance in connection with complaints against insurers is rendered by the insurance commissioner pursuant to his authority to enforce the various provisions of the insurance code and to take disciplinary action against an insurance company, pursuant to RCW 48.05.140. One of

the grounds for the insurance commissioner to take disciplinary action against an insurer pursuant to that statute is if the insurer "usually compels claimants under policies either to accept less than the amount due them or to bring suit against it to secure full payment of the amount due." (RCW 48.05.140(4)). The policyholder complaint section maintains a file on complaints against individual insurers and health care service contractors. The policyholder complaint section deals with contractual relations between an insurer and its insureds. It does not, except in connection with specific statutory violations or unusual situations, have jurisdiction in disputes between a third party and the insurer of another party. These latter disputes are considered matters for the courts to resolve.

(4) **Licensing division.** The licensing division issues the licenses to individuals, partnerships and corporate firms acting as insurance agents, brokers, solicitors and adjusters.

(5) **Company division.**

(a) Oversees admission of insurance companies, health care service contractors.

(b) Approves proxy statements of domestic stock companies pursuant to RCW 48.08.090 and commissioner's Regulation 246 (chapter 284-28 WAC).

(c) Supervises insider trading law (RCW 48.08.100 - 48.08.170).

(d) Handles certification of official documents; approval of company names.

(6) **Actuarial, rates and forms divisions.** These divisions of the insurance commissioner's office approve policy forms, other than surety bond forms and wet marine forms, as well as application forms, policy riders and endorsements, etc., pursuant to RCW 48.18.100, and may disapprove such forms pursuant to grounds set forth in RCW 48.18.110. They also approve rates for property, surety and casualty insurance (chapter 48.19 RCW), and title insurers (RCW 48.29.140). The standard for qualifying rates of property, surety, casualty and title insurers is that the rates shall not be excessive, inadequate, or unfairly discriminatory. See RCW 48.19.020. In addition, these divisions of the insurance commissioner's office may disapprove rates for disability insurance pursuant to RCW 48.18.110, and for credit life and disability insurance pursuant to RCW 48.34.100, where the rates charged are not reasonable in relation to the benefits conferred. Prima facie acceptable rates have been established for credit life and credit disability insurance in a regulation promulgated by the insurance commissioner's office.

(7) **Legal and investigative division.** A full-time assistant attorney general is assigned to the insurance commissioner's office to render legal advice, to represent the commissioner in disciplinary hearings and court cases, and to draft legislation and regulations. A full-time investigator is employed to investigate complaints against insurance agents and insurance companies for possible disciplinary action against them. For procedures, see *Hearings*, WAC 284-02-070, *infra*.

(8) **Tax and accounting division.** The taxation of both domestic and foreign insurance companies is a function

imposed on the insurance commissioner's office. Insurance companies are taxed on their gross premiums in this state, pursuant to RCW 48.14.020. This premium tax for all insurers, except title insurers, is in lieu of all other taxes except taxes on real and tangible personal property and excise taxes on the sale, purchase or use of such property. Title insurers are not taxed, pursuant to chapter 48.14 RCW, and fraternal societies are exempt from all taxation, pursuant to RCW 48.36.320. Surplus line insurers are taxed, pursuant to the provisions of RCW 48.15.120. Health care service contractors are not currently subject to taxation by the insurance commissioner. At the present time the premiums of domestic insurers are taxed at 1 percent. Premiums of foreign and alien insurers are taxed at 2 percent, except that, under the retaliatory provisions of RCW 48.14.040 the premium tax applicable to a foreign or alien insurer is the rate charged a Washington incorporated insurer by its state of incorporation, if this rate exceeds 2 percent. The taxation and accounting division also collects and accounts for fees paid by insurance companies, health care service contractors, insurance agents, brokers, etc. Fees charged by the insurance commissioner's office are listed in a fee schedule contained in RCW 48.14.010. The retaliatory provision, RCW 48.14.040, also operates with respect to fees charged by the insurance commissioner.

(9) **Insurance advisory examining board.** An insurance advisory examining board was created pursuant to chapter 150, Laws of 1967, § 14. The board has power to recommend general policy concerning the scope, content, procedure and conduct of examinations to be given for licenses as insurance agents, brokers or solicitors. The board is composed of seven members, including the commissioner who acts as ex officio chairman. Three of these members must be engaged in the life or disability fields, and the remaining three in other insurance fields.

[Order R-68-6, § 284-02-020, filed 8/23/68, effective 9/23/68.]

WAC 284-02-030 Obtaining service of process over foreign and alien insurers. Although domestic insurers are served with legal process personally, the insurance commissioner is the party on whom service of process should be made on all foreign and alien insurers, whether authorized to transact business in this state or not. The exact procedures are set forth in the applicable statutes. Service of process against authorized foreign and alien insurers, other than surplus line insurers, must be made pursuant to RCW 48.05.200 and 48.05.210. RCW 48.05.220 specifies where the proper venue is for such actions. Service of process against surplus line insurers can be made on the commissioner, pursuant to the procedures set forth in RCW 48.15.150. (A surplus lines insurer markets coverage which cannot be procured in the ordinary market from authorized insurers.) Service of process against unauthorized insurers may be made on the commissioner, pursuant to the procedures set forth in RCW 48.05.215.

[Order R-68-6, § 284-02-030, filed 8/23/68, effective 9/23/68.]

WAC 284-02-040 Applying for a license as agent, adjuster, broker or solicitor. Licensing requirements and

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procedures for obtaining a license as an insurance agent, adjuster, broker or solicitor may be obtained by writing to the licensing division in Olympia. This information is contained in a manual published by the commissioner, along with a study guide for the qualifying examination. The manual is sold at cost, contains reference sources, pertinent insurance code provisions, as well as regulations and bulletins of the insurance commissioner's office current as of the printing date of the manual.

[Order R-68-6, § 284-02-040, filed 8/23/68, effective 9/23/68.]

WAC 284-02-050 Application for admission as an authorized insurer, health care service contractor. A check list of documents required for an application for admission is available from the admissions deputy. The statutory requirements are contained in chapter 48.05 RCW (all insurance companies); chapter 48.06 RCW (domestic companies); chapter 48.07 RCW (domestic stock companies); chapter 48.09 RCW (mutual companies); chapter 48.10 RCW (reciprocal companies); chapter 48.15 RCW (surplus line companies); chapter 48.44 RCW (health care service contractors). Of particular interest are the capital and surplus requirements required of stock insurance companies. These are contained in RCW 48.05.340.

[Order R-68-6, § 284-02-050, filed 8/23/68, effective 9/23/68.]

WAC 284-02-060 Filing complaint against company, agent/broker or adjuster. A grievance against an insurance company, health care service contractor, agent, broker or adjuster may be filed with the insurance commissioner. To do so the insurance commissioner should be supplied with as many facts as possible to assist in the investigation of the complaint. This should include the correct name of the insurance company, the policy and/or claim number, the name of the agent, adjuster, date of loss and complete explanation of the loss.

[Order R-68-6, § 284-02-060, filed 8/23/68, effective 9/23/68.]

WAC 284-02-070 Hearings of the insurance commissioner. (1) Hearings of the insurance commissioner's office are conducted according to the Administrative Procedure Act (chapter 34.04 RCW), and chapter 48.04 RCW. Essentially there are two types of hearings conducted — rule-making hearings and contested cases, the latter including appeals from disciplinary actions taken by the commissioner. Under RCW 48.04.010 the commissioner is required to hold a hearing upon demand by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under the code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing. Requests for hearings must be made in writing, must specify how the person making the demand has been aggrieved by the office of insurance commissioner, and the demand must specify the grounds to be relied upon as the basis for the relief sought.

(2) "Contested cases."

(a) Provisions specifically relating to disciplinary action taken against insurance agents, brokers, solicitors or adjusters are contained in RCW 48.17.530, 48.17.540, 48.17.550, and 48.17.560. Provisions applicable to other "contested cases" are contained in chapters 34.04 and 48.04 RCW. The uniform rules of practice and procedure adopted by the code reviser's office, which appears in Title 1 of the Washington Administrative Code, govern procedures not contained in the statutes. The grounds for disciplinary action against insurance agents, brokers, solicitors and adjusters are contained in RCW 48.17.530; grounds of similar action against insurance companies are contained in RCW 48.05.140, and grounds for action against health care service contractors are contained in RCW 48.44.160. Essentially, these statutes provide that the insurance commissioner may suspend or revoke a licensee's license, or an insurer's or health care service contractor's certificate of authority. In addition, he may, under RCW 48.17.560, fine an insurance agent, broker, solicitor or adjuster, and may likewise fine an insurance company, pursuant to RCW 48.05.185; or in case of violations of the rating section (chapter 48.19 RCW), may impose a fine pursuant to RCW 48.19.430.

(b) "Contested case" hearings of the insurance commissioner are informal in nature, and formal rules of pleading and evidence are not required. Generally the commissioner or his chief deputy sit as hearing examiner, but the commissioner may appoint a special hearing examiner in technical matters, who would then prepare a decision to the commissioner for his action. A person wishing a full stenographic record of the proceeding must seasonably make a written request to the insurance commissioner. Where such requests are not made, the hearing is recorded on tape and transcribed if appeal from the commissioner's order is made to the superior court. The commissioner allows any person affected by the hearing to be present during the giving of all testimony and will allow him a reasonable opportunity to inspect all documentary evidence, to examine witnesses and to present evidence in support of his interest. Any person heard must make full disclosure of the facts pertinent to the inquiry. (The foregoing is provided by chapter 34.04 RCW.)

(c) Unless a person aggrieved by an order of the commissioner demands a hearing thereon within 90 days after receiving notice of such order, the right to such a hearing shall conclusively be deemed to have been waived. RCW 48.04.010(3).

(d) The commissioner must hold any hearing demanded within 30 days after receipt of the demand, unless postponed by mutual consent.

(3) **Rule-making hearings.** Rule-making hearings of the insurance commissioner are conducted pursuant to chapter 34.04 RCW (the Administrative Procedure Act) chapters 42.32 and 48.04 RCW. Under applicable law all interested parties must be afforded an opportunity to express their views concerning a proposed regulation of the insurance commissioner's office, either orally or in writing; provided, however, that no rule or regulation

can be adopted unless in a public meeting, as required by chapter 42.32 RCW and the Administrative Procedure Act, chapter 34.04 RCW. Notice of intention of the insurance commissioner to adopt a proposed rule or regulation is sent to the press, as required by chapter 42.32 RCW, to anyone who has requested in advance that the notice be given to them, and to all persons whom the commissioner determines would be interested in the proceeding.

[Order R-68-6, § 284-02-070, filed 8/23/68, effective 9/23/68.]

WAC 284-02-080 Publications and information available. (1) **Insurance code.** The insurance commissioner publishes a copy of Title 48 RCW, pursuant to authority of RCW 48.02.180, which is sold by this office at cost. Title 48 RCW is also available in any law library, as well as in most general libraries.

(2) **List of authorized insurers.** The insurance commissioner publishes biannually a list of all insurance companies authorized to do business in this state. Such lists are available on request from the insurance commissioner's office. An insurer not authorized to do business in the state is forbidden by law from soliciting business in this state. See RCW 48.15.020. Consistent with recent case law, the insurance commissioner's office has taken the position that solicitation by an unauthorized insurer, whether by mail or otherwise, violates the insurance code.

(3) **Annual report.** The insurance commissioner publishes an annual report, as required by RCW 48.02.170, which is available on request. The annual report not only contains a list of all insurers authorized to transact insurance in this state, showing the insurer's name, location, date of incorporation, date of admission, capital funds, and kinds of insurance transacted; but it also tabulates abstracts of the annual statements of all authorized insurers; and contains a summary of the operations of the insurance commissioner's office, including action taken against insurance companies; and recommended legislative proposals.

(4) **Policy forms and rates.** Rates of insurance companies and all policy forms required to be filed and/or approved by the insurance commissioner's office are on file in that office and are public records.

(5) **Examination reports, annual reports.** Reports of examination and annual reports of insurance companies and health and welfare trusts are likewise on file in the insurance commissioner's office and are open for public inspection.

(6) **Official actions of the insurance commissioner.** As required by chapter 34.04 RCW, Administrative Procedure Act, actions taken by the insurance commissioner's office relating to adoption of rules or the discipline of insurance companies, health care service contractors, insurance agents, brokers, solicitors or adjusters are on file in that office and are also a matter of public record.

(7) **Deposits of insurers.** Records of deposits of insurers, required by chapter 48.16 RCW and other sections of the insurance code, are on file in the insurance commissioner's office.

(8) **Articles of incorporation, bylaws of insurers.** All insurers are required to file their articles of incorporation and bylaws, and any amendments thereto, with the insurance commissioner's office. These are open for public inspection in the insurance commissioner's office.

(9) **Reports of adjusters.** Adjusters investigating fire loss claims must report to the commissioner pursuant to RCW 48.17.440. Any facts or circumstances indicating fraud may have been committed or attempted and full information on claims adjusted on any policy issued by an unauthorized insurer.

(10) **Administrative rules and regulations, bulletins of the insurance commissioner.** Administrative rules and regulations of the insurance commissioner are available in pamphlet form on request from the state code reviser. Individual copies of rules and regulations of the insurance commissioner, and any bulletins issued by the insurance commissioner, also available on request, without charge, from the insurance commissioner's office.

[Order R-68-6, § 284-02-080, filed 8/23/68, effective 9/23/68.]

WAC 284-02-090 Public access to information and records. Notwithstanding anything contained in this chapter or this title to the contrary, access by the public to information and records of the insurance commissioner shall be governed by chapter 284-03 WAC.

[Order R-75-2, § 284-02-090, filed 5/19/75.]

Chapter 284-03 WAC PUBLIC ACCESS TO INFORMATION AND RECORDS

WAC

284-03-010	Purpose.
284-03-020	Definitions.
284-03-030	Functions—Organization—Administration.
284-03-040	Public records available.
284-03-050	Public records officer.
284-03-060	Records index.
284-03-070	Office hours.
284-03-080	Requests for public records.
284-03-090	Copying fees.
284-03-100	Exemptions.
284-03-110	Review of denials of public records request.
284-03-120	Protection of public records.
284-03-130	Consumer complaints and inquiries.
284-03-140	Adoption of forms.
284-03-990	Form 276-1—Request for inspection of records.
284-03-99001	Form 276-2—Request for photocopy of record(s).

WAC 284-03-010 Purpose. The purpose of this chapter is to provide rules implementing RCW 42.17.250—42.17.320 (§§ 25 through 32, chapter 1, Laws of 1973).

[Order R-75-1, § 284-03-010, filed 5/19/75.]

WAC 284-03-020 Definitions. (1) The definitions set forth in RCW 42.17.020 shall apply to this chapter.

(2) "Office" is the office of the insurance commissioner of the state of Washington, which includes by operation of law the office of the state fire marshal.

[Order R-75-1, § 284-03-020, filed 5/19/75.]

WAC 284-03-030 Functions—Organization—Administration. (1) For purposes of this chapter, the functions, organization and administration of the office relating to insurance matters shall be as set forth in chapter 284-02 WAC.

(2) For purposes of this chapter, the functions, organization and administration of this office relating to the state fire marshal shall be as set forth in chapter 212-02 WAC.

[Order R-75-1, § 234-03-030 (codified as WAC 284-03-030), filed 5/19/75.]

WAC 284-03-040 Public records available. Public records are available for public inspection and copying pursuant to these rules except as otherwise provided by RCW 42.17.310 and these rules.

[Order R-75-1, § 284-03-040, filed 5/19/75.]

WAC 284-03-050 Public records officer. The public records officer for the office shall be the administrative officer, as designated by the state insurance commissioner, for all records maintained by such office whether located at the central office thereof at Olympia, Washington, or at such other offices throughout the state maintained by the state insurance commissioner. The public records officer shall be located at such central office. The public records officer shall be responsible for implementation of this chapter regarding release of public records, coordinating the staff of the office in this regard, generally insuring compliance by the staff with the public records disclosure requirements of RCW 42.17.250—42.17.320, and maintaining the records index of such office as required.

[Order R-75-1, § 284-03-050, filed 5/19/75.]

WAC 284-03-060 Records index. The office has available to all persons a current index which provides identifying information as to public records received, issued, adopted or promulgated since its inception. The current index adopted by the office shall be available to all persons under the same rules and on the same conditions as are applied to public records available for inspection.

[Order R-75-1, § 284-03-060, filed 5/19/75.]

WAC 284-03-070 Office hours. Public records shall be available for inspection and copying during the customary office hours of the office. For purposes of this chapter, the customary office hours shall be from 9:00 a.m. to noon and from 1:00 p.m. to 4:00 p.m., Monday through Friday, excluding legal holidays.

[Order R-75-1, § 284-03-070, filed 5/19/75.]

WAC 284-03-080 Requests for public records. In accordance with requirements of RCW 42.17.250—42.17.320 that agencies prevent unreasonable invasions of privacy, protect public records from damage or disorganization, and prevent excessive interference with essential functions of the agency, public records may be

inspected or copied or copies of such records may be obtained, by members of the public, upon compliance with the following procedures:

(1) A request shall be made in writing upon a form prescribed by the office which shall be available at its public records officer; or to any member of the office staff, if the public records officer is not available, at the administrative office during customary office hours. The request shall include the following information:

- (a) The name of the person requesting the record;
- (b) The time of day and calendar date on which the request was made;
- (c) The nature of the request;
- (d) If the matter requested is referenced within the current index maintained by the records officer, a reference to the requested record as it is described in such current index;
- (e) If the requested matter is not identifiable by reference to the current index, an appropriate description of the record requested.

(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public records officer or staff member to whom the request is made to assist the member of the public in appropriately identifying the public record requested.

[Order R-75-1, § 284-03-080, filed 5/19/75.]

WAC 284-03-090 Copying fees. No fee shall be charged for the inspection of public records. The office will charge a per-page fee for providing copies of public records. If copies of photographs are requested, a fee will be charged for the duplication of such photographs. Copying fees will be set at amounts equal to the actual costs to the office incident to such copying, including costs of materials, machinery, and personnel. The fees charged will be reviewed periodically to assure their accuracy, and shall be modified accordingly.

[Statutory Authority: RCW 42.17.250 and 42.17.300. 79-08-024 (Order R 79-4), § 284-03-090, filed 7/12/79; Order R-75-1, § 284-03-090, filed 5/19/75.]

WAC 284-03-100 Exemptions. (1) The office reserves the right to determine that a public record requested in accordance with the procedures outlined in WAC 284-03-080 is exempt under the provisions of RCW 42.17.260 and/or such other laws as may be deemed applicable.

(2) In addition, pursuant to RCW 42.17.260 the office reserves the right to delete identifying details when it makes available or publishes any public record in any cases when there is reason to believe that disclosure of such details would be an invasion of personal privacy or as otherwise provided in WAC 284-03-040. The public records officer will fully justify such deletion in writing.

(3) All denials of requests for public records must be accompanied by a written statement specifying the reason for the denial, including a statement of the specific exemption authorizing the withholding of the record and

a brief explanation of how the exemption applies to the record withheld.

[Order R-75-1, § 284-03-100, filed 5/19/75.]

WAC 284-03-110 Review of denials of public records request. (1) Any person who objects to the denial of a request for a public record may petition for prompt review of such decision by tendering a written request for review. The written request shall specifically refer to the written statement by the public records officer or other staff member which constituted, or accompanied the denial.

(2) Immediately after receiving a written request for review of a decision denying a public record, the public records officer or other staff member denying the request shall refer it to the insurance commissioner or a designated deputy insurance commissioner. The commissioner or his designee shall immediately consider the matter and either affirm or reverse such denial or call a special meeting of the members of the office staff necessary to properly consider the matter and/or request a legal review thereof by the assistant attorney general representing the office. In any case, the request shall be returned with a final decision, within five business days following the original denial.

(3) Administrative remedies shall not be considered exhausted until the office has returned the petition with a decision or until the close of the fifth business day following denial of inspection, whichever occurs first.

[Order R-75-1, § 284-03-110, filed 5/19/75.]

WAC 284-03-120 Protection of public records. The public records officer shall to the extent practicable insure that records requested are not removed from the premises nor portions thereof removed by members of the public.

[Order R-75-1, § 284-03-120, filed 5/19/75.]

WAC 284-03-130 Consumer complaints and inquiries. Unless a consumer complainant or inquirer specifically provides to the contrary, the public records officer or other members of the office staff are authorized when deemed appropriate to forward a copy of the letter or other writings pertinent to the complaint or inquiry to the firm or person which is the subject of the complaint or to any firm or person who may provide assistance relative to the complaint or inquiry.

[Order R-75-1, § 284-03-130, filed 5/19/75.]

WAC 284-03-140 Adoption of forms. The office hereby adopts for use by all persons requesting inspection and/or copies of records the forms attached hereto entitled "Request for inspection of records" and "Request for photocopy of records."

[Order R-75-1, § 284-06-140 (codified as WAC 284-03-140), filed 5/19/75.]

WAC 284-03-990 Form 276-1--Request for inspection of records.

[Order R-75-1, Form 276-1 (codified as WAC 284-03-990), filed 5/19/75.]

Request Number

Date requested

Date provided

(For office use only)

OFFICE OF INSURANCE COMMISSIONER

Request for Inspection of Records

The information requested in Blocks 1 through 6 is not mandatory, however, the completion of these blocks will enable this office to expedite your request and contact you should the record you seek not be immediately available.

1. Name	4. Phone number
2. Address	5. Representing (if applicable)
3. Zip code	6. If urgent - date needed

Below please state what record(s) you wish to inspect and be as specific as possible. If you are uncertain as to the type or identification of specific record or records we will assist you.

I certify that the information requested from the above record(s) will not be part of a list of individuals to be used for commercial purposes.

(Signed) _____

Date _____

Insurance Commissioner
Form 276 - 1
(Page 1 of 2 - Exhibit 1)

WAC 284-03-99001 Form 276-2--Request for photocopy of record(s).

Request Number

Date Requested

Date Provided

(Office use only)

OFFICE OF INSURANCE COMMISSIONER

Request for Photocopy of Record(s)

Please state below the pages of the documents or records you wish to have photocopied. A reasonable standard fee for each page or record will be charged for this service.

I wish the following page(s) of documents or records to be photocopied and made available for my possession, I agree to pay a reasonable standard charge for this service.

I certify that the photocopies of records received as listed above will not be part of a list of individuals to be used for commercial purposes.

Signed _____

Date _____

Office use only

Number of pages copied _____ @ _____ per copy.
Total charge _____ Amount paid _____

Insurance Commissioner
Form 276 - 2
(Page 2 of 2 - Exhibit 2)

[Order R-75-1, Form 276-2 (codified as WAC 284-03-99001), filed 5/19/75.]

Chapter 284-05 WAC
WASHINGTON ACTUARIES REGULATION

WAC

284-05-010	Title.
284-05-020	Purpose.
284-05-030	Scope.
284-05-040	Restriction on signing as actuary.
284-05-050	Actuarial representation.
284-05-060	Qualified actuary defined.
284-05-070	Effective date.

WAC 284-05-010 Title. These rules, WAC 284-05-010 through 284-05-070, shall be known and may be cited as the "Washington actuaries regulation."

[Order R-72-1, § 284-05-010, filed 2/8/72, effective 7/1/72.]

WAC 284-05-020 Purpose. The purpose of this regulation is to establish standards for use of the terms "actuary" or "actuarial." It is not the purpose of this regulation to require any insurer or other person subject to the insurance code to employ an actuary except as may be otherwise required by statute or other administrative rule.

[Order R-72-1, § 284-05-020, filed 2/8/72, effective 7/1/72.]

WAC 284-05-030 Scope. This regulation shall apply to all reports, statements, and other documents filed with the insurance commissioner or issued to the public in relation to the business of insurance.

[Order R-72-1, § 284-05-030, filed 2/8/72, effective 7/1/72.]

WAC 284-05-040 Restriction on signing as actuary. No report, statement, or document shall be filed with the insurance commissioner or issued to the public in relation to the business of insurance if it is signed by a person who represents himself in such instrument to be an actuary unless such person signing as an actuary is a qualified actuary.

[Order R-72-1, § 284-05-040, filed 2/8/72, effective 7/1/72.]

WAC 284-05-050 Actuarial representation. No person in any representation made to the public or to the insurance commissioner in respect to any matter subject to this regulation shall use the word "actuary" or "actuarial" to indicate a degree of professional competence unless such representation was prepared or approved by a qualified actuary.

[Order R-72-1, § 284-05-050, filed 2/8/72, effective 7/1/72.]

WAC 284-05-060 Qualified actuary defined. (1) For the purpose of this regulation, a "qualified actuary" is an individual who in each particular case or assignment is acting within the scope of his or her training, experience and qualifications, and

(a) Is a member of the American Academy of Actuaries, or

(b) Has otherwise demonstrated his or her actuarial competence to the satisfaction of the insurance commissioner, or to the satisfaction of the insurance regulatory

official of the domiciliary state of an insurer in the case of any actuarial certification required in connection with an annual statement filed by such insurer.

(2) Insofar as activities or conduct under the Employee Retirement Income Security Act of 1974 (P.L. 93-406) may be considered to relate to the business of insurance, an "enrolled actuary" pursuant to federal regulations issued under that act shall be deemed a "qualified actuary" with respect to such activities or conduct.

[Order R-76-1, § 284-05-060, filed 2/25/76; Order R-72-1, § 284-05-060, filed 2/8/72, effective 7/1/72.]

WAC 284-05-070 Effective date. The effective date of this regulation shall be July 1, 1972.

[Order R-72-1, § 284-05-070, filed 2/8/72, effective 7/1/72.]

Chapter 284-12 WAC
AGENTS, BROKERS AND ADJUSTERS

WAC

284-12-010	Qualifications of agents of insurers authorized to transact more than one kind of insurance— Exceptions.
284-12-030	Nonresident agent, broker, or adjuster's license.
284-12-040	Adjusters' licenses, RCW 48.14.010, 48.17.050, 48.17.060, 48.17.070, 48.17.110, 48.17.120 and 48.17.380.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-12-024	Waiver of unauthorized alien insurers' financial requirements. [Statutory Authority: RCW 48.02.060. 80-06-039 (Order R-80-6), § 284-12-024, filed 5/12/80.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-025	Brokers—Surplus line—Qualifications and examination. [Rule dated 1/20/58, filed 3/22/60.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-026	Surplus line brokers—Must file power of attorney for the service of process. [Rule dated 8/2/54, filed 3/22/60.] Repealed by 79-11-079 (Order R 79-5), filed 10/22/79. Statutory Authority: RCW 48.02.060.
284-12-027	Form for surplus line insurer to designate person to receive legal process. [Statutory Authority: RCW 48.02.060. 79-11-079 (Order R 79-5), § 284-12-027, filed 10/22/79.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-028	Surplus line brokers' form to be filed; contract stamp to be used. [Statutory Authority: RCW 48.02.060. 79-11-079 (Order R 79-5), § 284-12-028, filed 10/22/79.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-100	Twisting. [Rule filed 12/1/61, effective 12/1/61.] Repealed by Order R-68-1 (part), filed 4/23/68, effective 10/1/68.

WAC 284-12-010 Qualifications of agents of insurers authorized to transact more than one kind of insurance—Exceptions. (1) Except as provided in subsection (2) of this rule, and except where the commissioner otherwise permits after good cause is shown therefor in writing, applicants for agents' licenses must take and

pass a qualifying examination for all those kinds of insurance which the appointing insurer is authorized to transact in the state of Washington.

(2) Insurers authorized to write kinds of insurance in addition to vehicle insurance or surety insurance may appoint agents to write vehicle insurance or surety insurance only, and such appointees may take a qualifying examination for vehicle insurance or surety insurance only: *Provided, however,* That the appointing insurers shall file with this office a written statement in which they agree to accept from such appointees only vehicle or surety insurance, as the case may be, until such time as these appointees have qualified to write additional kinds of insurance and the insurers have verified such qualification.

(3) Insurers making appointments limited to vehicle insurance or surety insurance only must indicate such limitation clearly on each appointment form. In the event such limited agents subsequently qualify for the additional kinds of insurance authorized to be written by their appointing insurers, these insurers must file a new appointment form for each such agent and pay the regular appointment fee for each.

(4) This rule does not apply to or affect the "limited licenses" permitted by RCW 48.17.190.

[Order R 76-6, § 284-12-010, filed 11/10/76; Rule dated 5/1/54, filed 3/22/60.]

WAC 284-12-030 Nonresident agent, broker, or adjuster's license. The insurance code of the state of Washington provides: (1) Section 17.33 (RCW 48.17.330) *Nonresident agents and brokers—reciprocity.*"(1) The commissioner may license as a life and/or disability insurance agent only, or as a broker, a person who is otherwise qualified therefor under this code but who is not a resident of or domiciled in this state, if by the laws of the state or province of his residence or domicile a similar privilege is extended to residents of or corporations domiciled in this state. (2) Any such licensee shall be subject to the same obligations and limitations, and to the commissioner's supervision as though resident or domiciled in this state, subject to RCW 48.14.040 (Retaliatory provision). (3) No such person shall be so licensed unless he files the power of attorney provided for in RCW 48.17.340 (Service of process against nonresident agent or broker), and, if a corporation, it must have complied with the laws of this state governing the admission of foreign corporations."

(2) In part in section 17.38 (RCW 48.17.380) *Adjusters—qualifications for license.* The commissioner shall license as an adjuster only an individual who has otherwise complied with this code therefor and who has furnished evidence satisfactory to the commissioner that he is qualified as follows:

- (2)is a resident of a state which will permit residents of this state to act as adjusters in such other state.

This section is also subject to RCW 48.14.040 (Retaliatory provisions).

(3) Now therefore pursuant to authority vested in me by section .02.06 (RCW 48.02.060) of the insurance

code of the state of Washington to make reasonable rules and regulations for effectuating any provision of the insurance code, the following ruling is hereby adopted.

(a) All applicants for a nonresident agent or broker's license, either as an individual, firm or corporation, must have and maintain a similar license in their state of residence except where the state of residence does not issue a resident broker's license the applicant must be licensed in that state as an agent for all classes of insurance, except title, as same are defined in the insurance code of this state and further that state of residence must reciprocate as to resident brokers and/or agents of this state.

(b) All applicants for a nonresident independent adjuster's license must have and maintain an adjuster's license in their state of residence, except that if a state of residence does not provide for the licensing of adjusters this provision will not apply if the applicant is considered to have met the requirements of his state relating to adjusters.

(c) To comply with one and two immediately above all applicants for a nonresident agent, broker or adjuster's license shall have furnished on their behalf from the appropriate official of their state of residence:

(i) Evidence as to their licensing status o.e. as agent or broker, individual, firm or corporation.

(ii) That their license is in good standing with no complaints outstanding.

(iii) The classes of insurance for which they are licensed and/or qualified.

[Rule dated 11/4/57, filed 3/22/60.]

WAC 284-12-040 Adjusters' licenses, RCW 48.14.010, 48.17.050, 48.17.060, 48.17.070, 48.17.110, 48.17.120 and 48.17.380. Pursuant to authority invested in me by the insurance code to make rules and regulations for effectuating any provisions of the code, the following regulations is hereby made pertaining to requirements of the above indicated code sections. The regulation set forth herein shall take effect immediately.

(1) RCW 48.17.050 defines adjuster to be "1. 'Adjuster' means any person who, for compensation as an independent contractor or as an employee of an independent contractor, or for fee or commission, investigates or reports to his principal relative to claims arising under insurance contracts, on behalf solely of either the insurer or the insured. An attorney-at-law who adjusts insurance losses from time to time incidental to the practice of his profession, or an adjuster of marine losses, or a salaried employee of an insurer, or of a general agent, is not deemed to be an 'adjuster' for the purposes of this article."

(2) RCW 48.17.060 provides in part "1. No person shall in this state act as or hold himself out to be an agent, broker, solicitor, or adjuster unless then licensed therefor by this state."

(3) RCW 48.17.070 provides in part that the commissioner shall not issue a license unless and until he is satisfied that the person is qualified for such license.

(4) RCW 48.17.110 provides in part that an applicant, who has been licensed within the five-year period

preceding date of application, may be issued a license and not have to take any further examination if the new license requires qualification similar to those qualifications required under his previous license. This section has been interpreted to apply also to applicants who may furnish evidence of being so licensed in another state within the last five years, in which state he has had a satisfactory record and further, if that state will extend like privileges to residents or former residents of the state of Washington.

(5) RCW 48.17.120 provides for the scope of the examination and further requires the commissioner to prepare and make available a manual to assist such prospective licensees. This provision is limited, however, to agents, brokers and solicitors; hence, no manual has been prepared or is available from this office for applicants for licenses as adjusters.

(6) RCW 48.17.380 establishes certain qualifications before an applicant may be issued or receive an adjuster's license. In summary, these requirements are that an adjuster's license may be issued only to an individual (an adjuster's license may not be issued to a corporation or a partnership, or in any name other than that of the individual himself), the licensee must be twenty-one years of age or older; the licensee must be a bona fide resident of this state, or a resident of a state which will permit residents of this state to hold nonresident licenses in their state; and be a trustworthy person. This section also provides that the applicant "4. Has had experience or special education or training with reference to the handling of loss claims under insurance contracts, of sufficient duration and extent reasonably to make him competent to fulfill the responsibilities of an adjuster. 5. Has successfully passed any examination as required under this article."

(7) As will be seen from the provisions of sections four and five immediately above RCW 48.17.380 (4) and (5), it is necessary for an applicant for license to have both passed an examination given by this department and to have had experience or special education or training. It is the intent of these regulations to establish a method in which such experience may be acquired. Subject to the following requirements persons may be employed for a limited period as "trainees", and trained in the adjustment of losses and shall be known and referred to only as "trainees."

(a) As used herein or hereafter the term "trainee" shall refer to anyone employed to receive training and experience to qualify as an adjuster. The regulations set forth herein or hereafter shall apply to all acts relative to adjustment activities performed by any trainee. Unless and until the regulations set forth herein are complied with in full the benefits of these regulations shall not be available to any person.

(b) Trainees shall at all times be under the supervision of a licensed adjuster, and all adjusting transactions shall be in the name of such licensed adjuster who shall be responsible for the acts of the trainee.

(c) Activities of the trainee shall be restricted to participation in factual investigation and tentative closing of

losses, subject always to review and final confirmation by the licensed adjuster.

(d) Both the individual trainee and his supervisory licensed adjuster shall be residents of this state. Compensation of such trainees shall be on a salary basis only. No person may be a trainee under the provisions of this regulation more than one time.

(e) Anyone employing trainees shall immediately advise the insurance commissioner by letter, of such employment, giving the exact date of employment of each trainee and enclosing an adjuster's license application form properly completed with a remittance for \$3.00 to cover the application fee.

(f) Each trainee shall, within six months from the date of his employment and in no event later than six months after receipt of his application, take and pass the adjusters examination required by the insurance commissioner. A violation of this requirement or any provision of the insurance code shall subject both the trainee and his supervisory adjuster to penalties of the code.

(8) The adjusters examination given by this office consists of 50 questions divided between the insurance code, property losses, and vehicle losses. A passing grade is 70%. Examinations are given weekly in our Olympia, Seattle and Spokane offices and monthly in Bellingham, Vancouver, Yakima, Wenatchee and Walla Walla, Washington.

(9) Fees applicable to adjusters are: Independent adjuster's license, each year, \$10.00; public adjuster's license, each year, \$10.00; examination for license, each examination, \$2.00; first application, \$3.00.

[Rule dated 11/15/55, filed 3/22/60.]

Chapter 284-14 WAC

REGULATIONS PERTAINING TO FEES AND TAXES

WAC

284-14-010 Filing fee for rates and forms.
284-14-020 Filing transmittal information.

WAC 284-14-010 Filing fee for rates and forms.

(1) Beginning November 15, 1982, the filing fee for filing insurance rates and the filing fee for filing insurance forms shall be fifteen dollars each per filing.

(2) The following definitions shall apply for the purpose of determining the proper filing fee:

(a) A rate filing is a submission at one time from one insurer or rating organization of manuals of classification and manuals of rules and rates, or any modification thereof, and rating schedules or rating plans or a request for a rate change or deviation for one or more contract forms which may logically be grouped together.

(b) A form filing pertaining to life or disability insurance is the submission at one time from one insurer of:

(i) Policy pages which define all the conditions pertaining to one basic insurance contract, together with its application if it is an integral part thereof and set forth therein; or

(ii) An application form for general use with one or more policy forms, except when it is an integral part of the policy pages and set forth therein; or

(iii) A rider form which provides optional benefits in addition to those of one or more basic insurance contracts; or

(iv) An endorsement or amendment form which alters the provisions of any insurance contract; or

(v) Any other form for general use attachable to or becoming part of an insurance contract.

(c) A form filing pertaining to all other types of insurance is the submission at one time from one insurer or rating organization of:

(i) A policy, meaning a basic contract of insurance, together with its application form, if any, or any other forms which may define, extend, limit, exclude, condition, or otherwise alter coverage under the policy; or

(ii) Each application form or other form or combination of forms, other than a policy, related to one policy or to more than one similar policies, such as a series of homeowners-type policies, which form or forms are designed to define, extend, limit, exclude, condition, or otherwise alter coverage under such policy or policies.

[Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-010, filed 10/6/82.]

WAC 284-14-020 Filing transmittal information. Each rate or form filing, as defined by WAC 284-14-010, shall be accompanied by a transmittal containing the following information:

- (1) Date of submission;
- (2) Company name;
- (3) Washington state company identification code (CIC);
- (4) National Association of Insurance Commissioners number;
- (5) Line of insurance and policy type, as appropriate, as follows:
 - (a) Life; individual or individual credit or individual separate account, group or group credit or group separate account;
 - (b) Annuity; individual or individual separate account, group or group separate account;
 - (c) Disability; individual or individual credit, group or group credit;
 - (d) Medicare supplement; individual or group;
 - (e) Property;
 - (f) Casualty;
 - (g) Other (explain);
- (6) Type of filing, indicating whether it is a:
 - (a) Rate filing; or
 - (b) Form filing. If a form filing, indicate:
 - (i) The form number and, if appropriate, the form number being replaced;
 - (ii) Whether the form is being filed for approval or as a certified filing;
- (7) The name and telephone number of the company contact person.

Sample transmittal forms, that may be used in conjunction with company letterhead, are available from the office of insurance commissioner.

[Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-020, filed 10/6/82.]

Chapter 284-15 WAC SURPLUS LINE INSURANCE

WAC	
284-15-010	Brokers—Surplus line—Qualifications and examination.
284-15-020	Surplus line broker—Solvent insurer required.
284-15-030	Surplus line brokers' form to be filed—Contract stamp to be used.
284-15-040	Form for surplus line insurer to designate person to receive legal process.
284-15-050	Surplus line—Waiver of financial requirements.

WAC 284-15-010 Brokers—Surplus line—Qualifications and examination. (1) Each applicant for initial license as a surplus line broker shall, prior to issuance of any such license, take and pass to the satisfaction of the commissioner an examination given by the commissioner. It shall be a test of his or her qualifications and competence in all areas of surplus line insurance. The examination shall be given in the same manner and under the same conditions as are prescribed for brokers in chapter 48.17 RCW, except that such surplus line examination will generally be given twice each year at times set by the commissioner.

(2) Minimum requirements to be met by an applicant before he or she will be permitted to take the examination are:

(a) An applicant must have been licensed as a casualty-property broker in accordance with RCW 48.17.150 for not less than five years preceding the date of the application, or have received the chartered property casualty underwriter (CPCU) designation with not less than five years' experience in the insurance industry preceding the date of the application, or have not less than ten years' experience as an insurance company employee, or an employee of an insurance broker's office or other related insurance industry experience preceding the date of the application, or have other equivalent experience acceptable to the insurance commissioner.

(b) Such applicants shall complete application forms supplied by the commissioner.

(3) For the purpose of this regulation "applicant" and "surplus line broker" are defined to include any individual who is to be empowered and designated in the license as authorized to exercise the powers conferred thereby.

(4) The applicant, and each surplus line broker while so licensed, must be a resident of the state of Washington.

[Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-010, filed 1/21/81.]

WAC 284-15-020 Surplus line broker—Solvent insurer required. (1) A surplus line broker shall not knowingly place surplus line insurance with financially unsound insurers.

Foreign and alien insurers must meet or exceed the minimum financial conditions required by RCW 48.15.090.

(2) A surplus line broker shall ascertain the financial condition of the unauthorized insurer and maintain written evidence thereof before placing insurance therewith.

(a) When the surplus line broker uses an alien unauthorized insurer shown on the National Association of Insurance Commissioners (NAIC) Quarterly Listing of Alien Insurers dated within three months of the placement of the risk, it shall be deemed that the insurer meets the financial requirements of RCW 48.15.090 and that its financial condition is adequately documented.

(b) When the surplus line broker uses an alien unauthorized insurer that is not shown on the NAIC Quarterly Listing of Alien Insurers, there must be documentation in the broker's files demonstrating that the requirements of subsection (1) of this section are met or exceeded.

This documentation shall include at least the following:

(i) A copy of the unauthorized insurer's most recent available annual financial statement. This shall include an English version with United States dollar equivalents; and

(ii) Any other information obtained by the broker that verifies the financial condition of the alien company.

(c) The surplus line broker must have at least the current NAIC annual statement or its equivalent on file for any foreign unauthorized insurer used.

[Statutory Authority: RCW 48.02.060, 81-03-082 (Order R 81-1), § 284-15-020, filed 1/21/81.]

WAC 284-15-030 Surplus line brokers' form to be filed--Contract stamp to be used. (1) RCW 48.15.040 requires that a surplus line broker execute an affidavit at the time of procuring insurance from an unauthorized insurer, and to file such affidavit with the commissioner within thirty days after the insurance is procured. The form for filing such affidavit shall be in substantially the following form, and may include additional information to satisfy requirements of the Surplus Line Association of Washington:

- | | |
|---------------------------|------------------------------------|
| Policy or Certificate No: | Premium, including any policy fee: |
|---------------------------|------------------------------------|
- Name and license number of filing Surplus Line Broker:
 - Name and address of producing agent or broker (if any):
 - Name(s) of unauthorized insurer(s):
 - Name and address of insured:
 - Brief statement of coverages (common trade terms may be used, e.g. "furrier's block"):

STATE OF WASHINGTON	} ss.	SURPLUS LINE BROKER'S AFFIDAVIT
----- County		

I have procured insurance from an unauthorized insurer or insurers, in accordance with the laws and regulations

of the state of Washington under my Surplus Line Broker's license. Details of such transaction are set forth above.

Such insurance could not be procured, after diligent effort was made to do so from among a majority of the insurers authorized to transact that kind of insurance in this state, and placing the insurance in such unauthorized insurer(s) was not done for the purpose of securing a lower premium rate than would be accepted by any authorized insurer.

I certify that I am duly authorized to place this coverage on behalf of the insured, that the risk has been duly accepted by the insurer(s), and that I ascertained the financial condition of the unauthorized insurer(s) before placing the insurance therewith.

(Signature of Surplus Line Broker)

Subscribed and sworn to before me this ----- day of -----, 19--

Notary Public in and for the State of Washington,
residing at -----

(2) Every insurance contract, including those evidenced by a binder, procured and delivered as a surplus line coverage pursuant to chapter 48.15 RCW shall have a conspicuous statement stamped upon its face, which shall be initialed by or bear the name of the surplus line broker who procured it, as follows:

"This contract is registered and delivered as a surplus line coverage under the insurance code of the state of Washington, enacted in 1947. It is not issued by a company regulated by the Washington state insurance commissioner and is not protected by any Washington state guaranty fund law."

[Statutory Authority: RCW 48.02.060, 81-03-082 (Order R 81-1), § 284-15-030, filed 1/21/81.]

WAC 284-15-040 Form for surplus line insurer to designate person to receive legal process. (1) RCW 48.15.150 permits service of legal process against an unauthorized insurer that is sued upon any cause of action arising in this state under any contract issued by it as a surplus line contract to be made upon the insurance commissioner. The commissioner will mail the documents of process to the insurer at its principal place of business last known to the commissioner, or to a person designated by the insurer for that purpose in the most recent document filed with the commissioner on a form prescribed by the commissioner. If such unauthorized insurer elects to designate a person to receive such legal process from the commissioner, the designation shall be filed with the commissioner in substantially the form set forth in subsection (2) of this section.

(2) DESIGNATION OF PERSON TO WHOM COMMISSIONER SHALL FORWARD LEGAL PROCESS.

To the Insurance Commissioner of the state of Washington:

Pursuant to RCW 48.15.150, the undersigned Insurer hereby designates:

Name -----

Address -----

as the person to whom the Insurance Commissioner shall forward legal process against the Insurer. This designation supersedes any similar designation heretofore made by this Insurer.

Executed at -----, this ---- day of -----, 19--

(Insurer)

By -----

(Title)

(3) The "person" designated may be an individual, firm or corporation.

(4) The commissioner shall forward process to the person designated in the most recent document filed with him.

(5) Pursuant to RCW 48.15.150, each policy issued by an unauthorized insurer as a surplus line contract must contain a provision designating the commissioner as the person upon whom service of process may be made.

[Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-040, filed 1/21/81.]

WAC 284-15-050 Surplus line--Waiver of financial requirements. The commissioner may waive the financial requirements specified in RCW 48.15.090 in circumstances where insurance cannot be otherwise procured on risks located in this state. At least the following information shall be submitted when a surplus line broker makes a request for the commissioner to waive the financial requirements:

(1) A letter of explanation for the need to waive the financial requirements;

(2) The financial condition of the proposed insurer as reported in its annual statement as of the end of the calendar year next preceding;

(3) The number of years the company has been writing the specific class of insurance;

(4) The reinsurance agreements backing up the class of coverage or the company;

(5) Written acknowledgement signed by the proposed insured to the effect that the insured is informed that the coverage is to be issued by an insurer which is not an authorized insurer in the state of Washington, that financial requirements for surplus line insurers otherwise applicable have been waived by all parties concerned to enable this coverage to be obtained, and that there is no

protection under the Washington Insurance Guaranty Association.

[Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-050, filed 1/21/81.]

**Chapter 284-16 WAC
INSURERS**

WAC

- 284-16-030 Title insurers--Defining "complete set of tract indexes."
- 284-16-050 Accounting for salvage and subrogation recoveries, annual statement.
- 284-16-060 Disability insurance--Minimum reserve standards.
- 284-16-100 Investments--Encumbrance--Interpretation of RCW 48.13.130.
- 284-16-110 F.H.A. mortgage loans and investments.
- 284-16-150 Purpose.
- 284-16-160 Definitions.
- 284-16-170 Usual valuation of stock of a subsidiary.
- 284-16-180 Other methods of valuing stock of a subsidiary.
- 284-16-190 Limitation on values.
- 284-16-200 Additional provisions.
- 284-16-210 Adjustment procedure.
- 284-16-220 Cumulative limitations.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-16-010 Health care services--Certificates of registration. [Rule made 5/25/55, filed with code reviser 3/22/60.] Repealed by Order R-68-2, filed 5/1/68.

WAC 284-16-030 Title insurers--Defining "complete set of tract indexes." (1) The phrase "a complete set of tract indexes," as used in RCW 48.29.020 and 48.29.040, is defined to mean a set of indexes from which the record ownership and condition of title to all land within the particular county can be traced and ascertained, such set of indexes to be complete from the inception of title from the United States of America.

(2) The basic component parts of such a set of indexes are:

(a) An index or indexes in which the reference is to geographic subdivisions of land, classified according to legal description (as distinguished from an index or indexes in which the reference is to the name of the title holder, commonly called a grantor-grantee index) wherein notations of or references to:

(i) All filed or recorded instruments affecting title to particularly described parcels of real property and which impart constructive notice under the recording laws; and

(ii) All judicial proceedings in the particular county affecting title to particularly described parcels of real property are posted, filed, entered or otherwise included in that part of the indexing system which designates the particular parcel of real property; provided, no reference need be made in such index to any judicial proceeding which is referred to or noted in the name index defined in subparagraph (b) below.

(b) A name index or indexes wherein notations of or references to all instruments, proceedings and other matters of record in the particular county which affect or may affect title to all real property (as distinguished from particularly described parcels of real property) of

the person, partnership, corporation or other entity named therein and affected thereby, are posted, filed, entered or otherwise included in that part of the indexing system which designates that name.

(3) The indexes prescribed in numbered subsection (2) above, may be maintained in bound books, loose-leaf books, jackets or folders, on card files, or in any other form or system, whether manual, mechanical, electronic or otherwise; or in any combination of such forms or systems.

(4) The extent to which the prescribed indexes shall be sub-divided or defined is dependent upon all relevant circumstances. The population of the particular county, the extent to which land within the particular county has been subdivided and passed into separate ownerships, and all other factors which are reasonably related to the purpose of the statutory requirement, are entitled to consideration in such determination.

[Order 127, adopted 12/12/60, filed 12/14/60.]

WAC 284-16-050 Accounting for salvage and subrogation recoveries, annual statement. (1) Each authorized insurer is required to file with the commissioner an annual statement, pursuant to RCW 48.05.250, which statement shall be in general form and context as approved by the National Association of Insurance Commissioners (NAIC). The instructions for completing fire and casualty annual statement blanks, approved by the NAIC, provide that an insurer is to make no deductions for *anticipated* salvage or subrogation recoveries. Because of that and because of the difficulty in ascertaining the value of items received as salvage and in determining the amount which might be recovered by subrogation, each insurer authorized to do business in this state shall comply with the following:

(a) It shall not take credit, in any annual statement or interim statement filed with the commissioner, for salvage or subrogation recoveries until such recoveries shall have been reduced to cash or its equivalent.

(b) It shall account for salvage or subrogation recoveries as an offset to losses paid when such recoveries are reduced to cash or its equivalent.

(2) This rule reaffirms the commissioner's long-standing express position regarding the treatment of salvage and subrogation.

[Order R-76-3, § 284-16-050, filed 7/26/76.]

WAC 284-16-060 Disability insurance--Minimum reserve standards. All insurers authorized to write disability insurance in the state of Washington shall use the recommendations in the report of the industry advisory committee adopted by the national association of insurance commissioners on December 2, 1964, as minimum reserve standards for individual accident and health policies issued on and after January 1, 1967, provided that any insurer may elect to establish and maintain said minimum reserve standards for such policies issued prior to January 1, 1967. In case of such noncancellable accident and health loss of time contracts subject to the provisions of RCW 48.12.060, all insurers authorized to write disability insurance in the state of Washington

shall use the 1964 commissioner's disability table as a minimum reserve standard, provided that the aggregate of the active and disabled life reserves according to said table is at least equal to the statutory minimum reserve.

[Order 282, filed 7/22/66.]

WAC 284-16-100 Investments--Encumbrance--Interpretation of RCW 48.13.130. With reference to RCW 48.13.130 entitled "Encumbrance" defined, it has recently come to my attention that there has been some difficulty in the application of this provision of the code with reference to restrictions and covenants, particularly the words "common to the community in which the property is located." It has been found that restrictions and covenants are different in tracts, plats, maps or other subdivisions of land in the same community. Pursuant to the authority vested in me in RCW 48.02.060, the following ruling is hereby made, interpreting RCW 48.13.130 as follows:

(1) The wording "common to the community in which the property is located" may be regarded as applying only to the tract, plat, map, or other subdivision of land in which the real property is located.

(2) Where any right of reversion is outstanding and where a specific waiver thereof is not obtainable, the lender may consider such right not to be an "encumbrance" under the code:

Provided, A title insurance company, authorized to transact such business within the state in which the real property involved is situated, shall specifically indemnify the lender against any loss or damage arising as a result of such right.

[Rule made 5/15/53, filed 3/22/60.]

Reviser's note: Subsection (1) above is an interpretation of RCW 48.13.130 before it was revised by section 2, chapter 303, Laws of 1955. The old section contained the phrase "common to the community in which the property is located."

WAC 284-16-110 F.H.A. mortgage loans and investments. Whereas, under the provisions of the insurance code of the state of Washington which became effective as of October 1, 1947, certain limitations are placed upon the amount of money which may be loaned by domestic insurers upon the security of a mortgage upon real estate with relation to the value of such real estate, and which limitations should not be made applicable to mortgages which the federal housing administrator has insured or has made a commitment to insure, and Whereas, it is desirable that domestic insurers be able to continue to exercise the privilege of investing in or making loans upon such federal housing administration insured mortgages as was permissible under laws in force immediately prior to October 1, 1947; now therefore, it is hereby ordered:

(1) That until further order of the insurance commissioner, and pursuant to the provisions of RCW 48.13.250, consent is hereby given to domestic insurers, any other provision of the insurance code notwithstanding, to invest in or loan upon the security of real estate mortgages which the federal housing administrator has insured or has made a commitment to insure, and to make

such other investments and loans, all as provided in RCW 39.60.010.

(2) That such investments or loans may be credited toward investments of minimum capital, surplus, or reserves as required by RCW 48.13.260.

[Order 1001, issued 10/2/47, filed 3/22/60.]

WAC 284-16-150 Purpose. The purpose of this regulation, WAC 284-16-150 through 284-16-220, is to implement RCW 48.12.180(3) by establishing rules for the valuation of stock of a subsidiary of an insurer.

[Order R 76-7, § 284-16-150, filed 11/30/76.]

WAC 284-16-160 Definitions. For purpose of this regulation: (1) The term "subsidiary" shall have the same meaning given it by RCW 48.31A.010;

(2) The term "book value" shall mean that value determined by dividing the amount of its capital and surplus as shown in its last annual statement or subsequent report of examination (excluding from surplus, reserves required by statute and any portion of surplus properly allocable to policyholders, rather than stockholders) less the value (par of redemption value, whichever is the greater) of all of its preferred stock, if any, outstanding, by the number of shares of its common stock issued and outstanding.

[Order R 76-7, § 284-16-160, filed 11/30/76.]

WAC 284-16-170 Usual valuation of stock of a subsidiary. The common stock of any subsidiary of an insurer may always be valued on the basis of the value of only such of the assets of such subsidiary as would constitute lawful investments for the insurer if acquired or held directly by the insurer.

[Order R 76-7, § 284-16-170, filed 11/30/76.]

WAC 284-16-180 Other methods of valuing stock of a subsidiary. If sound business judgment of an insurer's management causes it to believe that a valuation of common stock of a subsidiary pursuant to WAC 284-16-170 is inappropriate, it may value such stock on one of the following bases:

(1) "Book value," provided, however, that the common of a noninsurance company may not be valued on the basis of this subsection, and further provided that an insurer may value its holdings of stock in a subsidiary insurer at acquisition cost if acquisition cost is less than market or book value.

(2) One of the following bases appropriate to each type of subsidiary owned by it, provided, however, that an insurer shall not be required to value the stock of all its subsidiaries on the same basis:

(a) Subject to the limitations imposed under WAC 284-16-190, the net worth of a noninsurance company determined in accordance with generally accepted accounting principles, as of the end of its most recent fiscal year, provided, subject to WAC 284-16-200, that the financial statements of the company for its most recent fiscal year have been audited by an independent certified public accountant in accordance with generally accepted

auditing standards. The common stock of an insurance company may not be valued under this subsection.

(b) Subject to the limitations imposed under WAC 284-16-190, a value equal to the cost of the common stock of the subsidiary, provided such value is determined and adjusted to reflect subsequent operating results, in the case of insurance companies in accordance with statutory accounting requirements, and for other than insurance companies in accordance with generally accepted accounting principles.

(c) The market value of the common stock of the subsidiary, if the stock is listed on a national securities exchange.

(d) The value, if any, placed on the common stock of such subsidiary by the National Association of Insurance Commissioners.

(e) Any other value which the insurer can substantiate to the satisfaction of the commissioner as being a reasonable value.

[Order R 76-7, § 284-16-180, filed 11/30/76.]

WAC 284-16-190 Limitation on values. (1) With respect to values determined under WAC 284-16-180 (2)(a) or (b), amounts attributable to "good will," and other intangibles shall not in the aggregate (of all direct and indirect subsidiaries) exceed (either initially on acquisition of a subsidiary, or thereafter), 10% of the capital and surplus of an insurer, as reported in its next preceding annual statement. Such amounts shall be written off over a period not in excess of ten years.

(2) For purposes of this section, "good will" shall be defined as the amount arising at a given point in time, resulting from an arm's-length transaction involving the transfer of a business, representing the difference between the value of the consideration given and the net asset value of the properties acquired on the books of the predecessor company.

(3) Where warranted in exceptional cases, the commissioner may require a more rapid write-off of good will than is otherwise provided in this section.

[Order R 76-7, § 284-16-190, filed 11/30/76.]

WAC 284-16-200 Additional provisions. (1) Within 90 days after the effective date of this regulation, a domestic insurer using a method of valuation permitted by WAC 284-16-180 shall file with the commissioner relevant information identifying, supporting and justifying the value of, and the basis of valuation used in accordance with the provisions of this regulation for each of its subsidiaries.

(2) Within 30 days after the acquisition of a subsidiary, a domestic insurer shall file with the commissioner relevant information identifying, supporting and justifying the value of, and the basis of valuation used in accordance with the provisions of this regulation for such subsidiary.

(3) A valuation basis used for a subsidiary shall thereafter be consistently used unless a change is substantiated as reasonable and on that basis is approved in writing by the commissioner.

(4) If a subsidiary is valued on the basis of WAC 284-16-180 (2)(a) and the books of the subsidiary are not audited at the time the valuation is included in the insurer's annual statement, the insurer shall thereafter report and explain the differences, if any, between the value of the subsidiary as reported in the annual statement and the value as determined by audit. Such report and explanation shall be made as soon as possible following such audit.

(5) If any subsidiary, which is not itself an insurance company, is valued other than on the basis of market value, there shall be deducted from the otherwise determined value a sum equal to the value claimed for any of its assets which would not constitute admitted assets for the insurer if held directly by the insurer, if such assets:

(a) Are held by the subsidiary but used, under a lease arrangement or otherwise, significantly in the conduct of the insurer's business; or

(b) Were acquired from or purchased for the benefit or use of the insurer by the subsidiary under circumstances that, in the opinion of the commissioner, support a finding that the primary purpose of such acquisition or purchase was the evasion or avoidance of RCW 48.12.010 or 48.12.020.

[Order R 76-7, § 284-16-200, filed 11/30/76.]

WAC 284-16-210 Adjustment procedure. The commissioner may, after notice and opportunity to be heard, determine that the basis used for valuation of the stock of any subsidiary does not, under the specific circumstances of the case, reflect the value of the subsidiary and may order either an adjustment in valuation or the use of one of the other specified bases of valuation.

[Order R 76-7, § 284-16-210, filed 11/30/76.]

WAC 284-16-220 Cumulative limitations. Except as modified by this regulation, applicable cumulative limitations of chapter 48.13 RCW shall continue to apply.

[Order R 76-7, § 284-16-220, filed 11/30/76.]

Chapter 284-17 WAC

LICENSING REQUIREMENTS AND PROCEDURES

WAC

284-17-120	Examination procedures for agents, solicitors and adjusters.
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284-17-320	License renewal requested—Continuing education requirement not satisfied.
284-17-400	Renewal dates for agents, brokers, solicitors and adjusters.

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284-17-410	Appointment renewal and termination procedures for insurance agents.
284-17-420	Appointment, affiliation and renewal procedures for licensed persons empowered to exercise the authority conferred to a corporate or firm licensee.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-17-010	Application. [Order R-68-12, § 284-17-010, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-020	Definitions. [Order R-68-12, § 284-17-020, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-030	Prohibited actions. [Order R-68-12, § 284-17-030, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-040	Filings required. [Order R-68-12, § 284-17-040, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-045	Review not approval. [Order R-68-12, § 284-17-045, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-050	Filing precondition to solicitation. [Order R-68-12, § 284-17-050, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-060	Exclusions. [Order R-68-12, § 284-17-060, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-070	Examination powers not diminished. [Order R-68-12, § 284-17-070, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-080	Enforcement. [Order R-68-12, § 284-17-080, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-090	Severability. [Order R-68-12, § 284-17-090, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
284-17-100	Agent, solicitor or adjuster examination scheduling and fees. [Statutory Authority: RCW 48.02.060. 80-01-011 (Order R 79-6), § 284-17-100, filed 12/12/79.] Repealed by 82-10-016 (Order R 82-2), filed 4/28/82. Statutory Authority: RCW 48.02.060.
284-17-110	Reexamination after failure to pass examination. [Statutory Authority: RCW 48.02.060. 80-01-011 (Order R 79-6), § 284-17-110, filed 12/12/79.] Repealed by 82-10-016 (Order R 82-2), filed 4/28/82. Statutory Authority: RCW 48.02.060.

WAC 284-17-120 Examination procedures for agents, solicitors and adjusters. (1) The commissioner has contracted with an independent testing service for the administration of agents', solicitors', and adjusters' examinations. On and after June 1, 1982, any person desiring to take an examination for the type of license shown in subsection (2) of this section will be required to submit a registration form and the appropriate examination fee to the independent testing service. Such fee is not refundable. Registration forms and information about examinations may be obtained from the office of insurance commissioner or from the independent testing service.

(2) At least twice each month at predetermined locations, the independent testing service will conduct the examinations required for the following types of licenses:

TYPE OF LICENSE	EXAMINATION(S) REQUIRED
Life insurance agent or solicitor	Life
Disability insurance agent or solicitor	Disability
Life and disability agent or solicitor	Life, disability
Property/casualty agent or solicitor	Property, casualty
General lines agent or solicitor	Property, casualty, disability
All lines agent or solicitor	Life, disability, property, casualty

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TYPE OF LICENSE	EXAMINATION(S) REQUIRED
Vehicle only agent or solicitor	Vehicle
Surety only agent or solicitor	Surety
Credit life and disability agent or solicitor	Credit life and disability
Independent adjuster	Independent adjuster
Public adjuster	Public adjuster

(3) If an applicant fails to take a scheduled examination, a new registration form and appropriate fees must be submitted for any later examination, unless a serious emergency prevented attendance.

(4) Tests for vehicle, surety, or credit insurance and for adjusters will be graded by the insurance commissioner's licensing department which will notify applicants of the results. Other tests will be graded by the independent testing service which will provide each applicant with a score report, following examination. If the examination is passed, the score report must be forwarded to the insurance commissioner with a completed insurance license application, finger print card, the appropriate license fee and filing fee.

(5) An applicant who fails to pass the insurance agent, solicitor or adjuster examination may request re-examination at such time as the applicant believes that he or she has completed sufficient additional study. Each reexamination request must be accompanied by a new registration form and the appropriate examination fee.

[Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-120, filed 9/12/84; 82-10-016 (Order R 82-2), § 284-17-120, filed 4/28/82.]

WAC 284-17-200 Purpose. The purpose of this regulation is to implement the provisions of RCW 48.17.150 by establishing the minimum continuing education requirements that must be met prior to the renewal of an insurance agent, solicitor or brokers license.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 § 7,10. 80-04-042 (Order R 80-3), § 284-17-200, filed 3/20/80.]

WAC 284-17-210 Definitions. As used in this continuing education regulation, unless the context requires otherwise;

(1) "Course" includes courses, programs of instruction, correspondence courses and seminars.

(2) "Hours" means the time assigned by the commissioner as recognition for the satisfactory completion of an approved course. For college level work entirely on approved subjects:

(a) Twelve hours will be assigned for each quarter "credit hour."

(b) Sixteen hours will be assigned for each semester "credit hour." The number of hours assigned for other programs will normally be based upon the number of classroom contact hours or their equivalent. However, based upon the evaluation of the course content, the number of hours assigned may be less than the total amount of time spent by the student in the course.

(3) "Licensee" means each natural person licensed as a resident insurance agent, solicitor or broker to sell life,

disability, property, or casualty insurance. A credit insurance licensee is not included.

(4) "Certificate of completion" means a document signed by the course instructor or other responsible officer which shall signify satisfactory completion of the course and shall reflect hours of credit earned. Such certificates shall be in standard form as prescribed by the insurance commissioner.

[Statutory Authority: RCW 48.02.060. 82-10-016 (Order R 82-2), § 284-17-210, filed 4/28/82. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-210, filed 3/20/80.]

WAC 284-17-220 Continuing education requirement. (1) The number of hours course work required to be presented annually as a prerequisite to license renewal or reissuance shall be 12 hours.

New licensees that have been licensed for less than 6 months at the time of renewal will not be required to complete the continuing education, however anyone licensed 6 months or more at time of renewal must have completed the entire 12 hours.

The commissioner may accept licensed sales experience in another state, as comparable experience for the purpose of calculating the number of years licensed and for determining the number of continuing education hours required for each annual renewal or reissuance.

Each course to be applied toward satisfaction of the continuing education requirement must have been completed within the twenty four month period immediately preceding the licensee's assigned license renewal date and hours applied cannot have been applied in a previous year toward satisfaction of the continuing education requirement.

(2) The courses participated in and for which credit is received shall be reported to the commissioner as part of the application for license renewal and shall be subject to verification.

(3) If the home state of a nonresident agent is determined to have a continuing education program substantially comparable to that of Washington, satisfaction of the continuing education requirement of the home state may be accepted as meeting Washington's requirement.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-220, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-220, filed 3/20/80.]

WAC 284-17-230 Eligible courses--Advance approval required. (1) Courses eligible for approval for the continuing education program shall be those courses related to insurance. General education courses and sales motivation courses shall not be eligible for approval.

(2) All courses must be approved prior to the beginning of study in order to be applied toward the satisfaction of the continuing education requirement: *Provided*, That licensees who have attended and seek credit for completion of courses organized by, and conducted under the supervision of industry trade associations, national associations of agents or brokers or such other national organizations as are accepted by the commissioner, may, within 60 days of course completion, submit

supporting course materials and a request for approval of course content and hours credit to the commissioner. The licensee seeking course and hours credit approval shall have the responsibility for providing:

(a) Sufficient supporting materials regarding course content and hours to permit the commissioner to make a determination, and

(b) A "certificate of completion" signed by the instructor or person in charge of the course signifying licensee attendance at, and completion of, the course.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-230, filed 3/20/80.]

WAC 284-17-240 Courses specifically approved.

(1) The following courses are approved as they exist on the date this regulation is adopted, for the credit hours stated:

(a) Any part of the life underwriter training council life course curriculum (50 hours credit) or health course curriculum (25 hours credit).

(b) Any part of the American College "CLU" diploma curriculum (30 hours credit), and its advanced study programs; Chartered Life Underwriter Institutes conducted by the American Society of CLU.

(c) Any part of the Insurance Institute of America's program of insurance (20 hours credit).

(d) Any part of the American Institute for Property and Liability Underwriter's Chartered Property Casualty Underwriter (CPCU) professional designation program (30 hours credit).

(e) Any part of the certified insurance counselor program (25 hours credit).

(f) Insurance related courses taught by a college or university that is accredited by the Northwest Association of Schools and Colleges, for which credit is granted.

(2) Changes in the above identified courses shall be presumed to be approved by the commissioner unless the sponsoring organization is advised of disapproval.

(3) Programs for which credit hours are not shown shall receive such credit hours as are approved by the commissioner.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-240, filed 3/20/80.]

WAC 284-17-250 Courses conducted by authorized organizations. (1) Insurance companies, insurance trade associations and statewide associations of agents or brokers that have an existing formal, and demonstrable, training program may, upon request to and approval by the commissioner, be authorized to develop course content and conduct courses without the requirement for prior individual course review and approval by the commissioner.

(2) Local chapters of such an authorized statewide association of agents or brokers may submit proposed courses to the statewide organization and, upon a determination by the statewide organization that the local chapter's course meets the standards of the organization and complies with this continuing education regulation, such local chapter's course shall be considered to be a course of the statewide association of agents or brokers

and shall be presumed to be approved by the commissioner.

(3) It is the intent of this section that only organizations with a formal, full-time training program be approved to develop and conduct courses without prior individual course approval. Courses of other organizations are to be reviewed and acted on by the commissioner on a prior and individual basis.

(4) Requests for training program review, and authority to develop course content and to conduct courses without prior individual course approval must include the following information:

(a) The name of the organization.

(b) A description of the existing training program of the organization including:

(i) The titles or description of courses taught during the previous year.

(ii) The number of students taught, by course, during the previous year.

(iii) The name of the person in charge of the training program, years of full-time training program experience and years with the present organization.

(iv) Budget of the training program for the current year.

(c) A description of the manner in which courses will be developed and reviewed prior to course conduct.

(d) A statement by the responsible employee or officer of the organization agreeing to comply with regulations in developing courses and attributing hours to courses.

(e) An agreement to offer to provide, and to provide when requested, a certificate of completion and hours earned to each successful student.

(f) An agreement to maintain records of student course completion for three years.

(5) The granting of authority to an organization to develop course content and conduct courses without prior individual course approval shall be for an indefinite period, or until revoked by the commissioner. The actual conduct and performance of the training program shall be subject to review by the commissioner.

(6) Organizations that have been authorized to develop course content and conduct courses without prior individual course approval shall file a course outline for each course with the commissioner. The course outline shall include:

(a) A description of the subject matter to be taught.

(b) The method of teaching or presentation.

(c) The number of classroom contact hours.

(d) An explanation of the criteria to be applied in determining whether the course is satisfactorily completed.

(e) The number of continuing education hours credit assigned.

(f) Other relevant information.

(7) Assignment of hours to courses by organizations that have been authorized to develop course content and conduct courses without prior individual approval shall be subject to review and revision by the commissioner as necessary to ensure consistency in continuing education hours assigned to comparable courses.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-250, filed 8/31/81. Statutory Authority: RCW

48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-250, filed 3/20/80.]

WAC 284-17-260 Courses individually approved. Organizations or individuals not included in WAC 284-17-240 or 284-17-250 that desire to have courses approved may submit their request for individual course approval to the commissioner.

(1) The request for course approval shall include:

(a) A copy of the course material that is requested to be approved.

(b) An explanation of the method of teaching or presentation.

(c) The number of classroom contract hours.

(d) An explanation of the criteria to be applied in determining whether the course is satisfactorily completed.

(e) The number of continuing education hours for which approval is requested.

(f) An agreement to offer to provide, and to provide when requested, a certificate of completion and continuing education hours earned, to each successful student.

(g) An agreement by the responsible official to comply with regulations in conducting courses.

(2) A specific determination of course and hours approval will be made by the commissioner. No course for which individual course approval is required may be represented as being approved prior to actual approval.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-260, filed 3/20/80.]

WAC 284-17-270 Credit for courses. (1) No course shall be established for less than one hour of continuing education credit. Courses conducted in conjunction with other meetings must have a separate continuing education course component.

(2) The instructor of a course must maintain a positive attendance record, consisting of a sign in - sign out register, in order to qualify the course for continuing education credit.

(3) The instructor of a course shall receive twice the number of hours credit for teaching a course as is allowed for a student taking the course.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-270, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-270, filed 3/20/80.]

WAC 284-17-280 Approved courses or organizations--Loss of approval. (1) The approval of a course, or of an organization to develop and conduct courses without prior individual course approval, may be suspended or revoked by the commissioner if he determines that:

(a) The course content has been significantly changed without notice to the commissioner and the change affects the number of hours assigned to the course.

(b) A certificate of participation and hours earned is or has been issued to any individual who did not complete the course.

(c) Certificates of participation and hours earned were not offered, or were not given when requested to individuals who have satisfactorily completed the course.

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(d) The actual instruction of the course is determined by the commissioner to be inadequate.

(e) In the commissioner's discretion, the course or courses offered fail to meet the objectives of the statutes requiring continuing education for insurance agents and brokers.

(2) Reinstatement of a suspended or revoked approval shall be at the discretion of the commissioner after receipt of satisfactory proof that the conditions responsible for the suspension have been corrected.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-280, filed 3/20/80.]

WAC 284-17-290 Waiver of continuing education requirement. Any licensee, who believes that good cause exists, may request a waiver of the continuing education requirement. Requests shall be in writing, received prior to the expiration of the licensee's existing license and specify in substantive detail the reason or reasons why the licensee believes a waiver of the continuing education requirement for the current license renewal is merited.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-290, filed 3/20/80.]

WAC 284-17-300 Continuing education advisory committee. There is hereby created a continuing education advisory committee to be made up of five members appointed for staggered terms by the commissioner. The advisory committee shall, as requested by the commissioner, provide assistance and advice in the implementation of the continuing education regulation.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-300, filed 3/20/80.]

WAC 284-17-310 When continuing education requirement must be met. Each licensee, as defined in WAC 284-17-210(3), shall be required to present evidence of completing the continuing education requirement, prior to license renewal, beginning with those license renewals falling due on or after October 1, 1981.

[Statutory Authority: RCW 48.02.060. 82-10-016 (Order R 82-2), § 284-17-310, filed 4/28/82. Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-310, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-310, filed 3/20/80.]

WAC 284-17-320 License renewal requested--Continuing education requirement not satisfied. In the event that a licensed insurance agent or broker requests license renewal and fails to present evidence of completion of the continuing education requirement, the licensee shall be notified by mail of the apparent deficiency and provided with reasonable opportunity to show compliance.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-320, filed 3/20/80.]

WAC 284-17-400 Renewal dates for agents, brokers, solicitors and adjusters. New licenses will be valid for a period ending with the licensee's first birthday anniversary after the initial issue date in the case of individuals, and for a period ending with the first renewal

date after the initial issue date in the case of firms or corporations. Thereafter, such licenses will be renewed for a period of one year.

[Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-400, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-400, filed 3/20/80.]

WAC 284-17-410 Appointment renewal and termination procedures for insurance agents. (1) Appointments shall be valid for a period ending with the insurer's first renewal date after the initial issue date. Such renewal date is assigned by the office of the insurance commissioner. Thereafter, all appointments will be renewed for a period of one year.

(2) Revocations of agents' appointments by the insurer are governed by RCW 48.17.160(4).

(3) Termination of an appointment by the agent may be accomplished by the agent giving advance written notice to the insurer with a copy mailed to the insurance commissioner that, as of a date stated in such notice, the agent renounces the appointment and will no longer represent the insurer as its agent.

[Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-410, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-410, filed 3/20/80.]

WAC 284-17-420 Appointment, affiliation and renewal procedures for licensed persons empowered to exercise the authority conferred to a corporate or firm licensee. (1) Each firm or corporation licensed as an insurance agent must be appointed by an insurer or insurers as required by RCW 48.17.160 as a prerequisite to the sale of insurance: *Provided*, That individual licensees who are empowered to exercise the authority conferred by the corporate or firm license need not be individually appointed by insurers.

(2) All firms or corporations licensed as an agent, adjuster or broker shall notify the office of the insurance commissioner of all persons who are empowered to exercise the authority conferred by the firm or corporate license. For purposes of this section, such persons shall be defined as "affiliated" with the licensed firm or corporation.

(3) An affiliation by a licensed firm or corporation which is not revoked or renounced shall be valid until the firm's or corporation's first renewal date after the notice. Thereafter, each affiliation may be renewed for a period of one year, subject to the firm or corporation paying the annual affiliation renewal fee which shall be the same as the agent appointment renewal fee.

(4) When the appointment of an affiliated person is revoked by a firm or corporation, written notice of such revocation shall be given to the affiliated person and a copy of the notice of revocation shall be mailed to the commissioner.

(5) Termination of an appointment by an affiliated person may be accomplished by such person giving advance written notice to the firm or corporation with a copy mailed to the insurance commissioner that, as of a

date stated in such notice, the affiliated person renounces the appointment and will no longer act on behalf of the firm or corporation.

[Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-420, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-420, filed 3/20/80.]

Chapter 284-18 WAC

WASHINGTON INSURANCE HOLDING COMPANY REGULATION

WAC

284-18-010	Title and purpose.
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284-18-110	Instructions for use of Forms A and B.
284-18-120	Effective date.
284-18-990	Form A—Statement regarding the acquisition of control of or merger with a domestic insurer.
284-18-99001	Form B—Insurance holding company system registration statement.

WAC 284-18-010 Title and purpose. (1) This regulation, chapter 284-18 WAC, shall be known and may be cited as the "Washington insurance holding company regulation."

(2) The purpose of this regulation is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of sections 3 through 15, chapter 13, Laws of 1971 ex. sess., herein-after referred to as the "act."

[Order R-71-2, § 284-18-010, filed 7/9/71, effective 8/10/71.]

WAC 284-18-020 Definitions. As used in these rules unless otherwise required by the context: (1) "Act" means sections 3 through 15, chapter 13, Laws of 1971 ex. sess.

(2) "Executive officer" means any individual charged with active management and control in an executive capacity (including a president, vice-president, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers) of a person, whether incorporated or unincorporated.

(3) "Foreign insurer" shall include an alien insurer except where clearly noted otherwise.

(4) "Ultimate controlling person" means that person which is not controlled by any other person.

(5) Other terms found in these rules and in section 3 of the act shall retain the meaning as found in such section 3 of the act.

[Order R-71-2, § 284-18-020, filed 7/9/71, effective 8/10/71.]

WAC 284-18-030 Control acquisition of domestic insurer. Any person required to file a statement pursuant

to section 4 of the act and any person seeking to obtain "control" of a domestic insurer (as "control" is defined in section 3 of the act) shall furnish all the information requested on Form A hereto annexed which is a part of these rules. The applicant shall promptly advise the commissioner of any changes in the information so furnished arising subsequent to the date upon which such information was furnished but prior to the commissioner's disposition of the application.

[Order R-71-2, § 284-18-030, filed 7/9/71, effective 8/10/71.]

WAC 284-18-040 Registration of insurers. (1) Any insurer required to file a statement pursuant to section 8 of the act shall furnish all the information required on Form B hereto annexed which is a part of these rules.

(2) An amendment to Form B shall be filed within fifteen days after the end of any month in which the following occurs:

(a) There is a change in the control of the registrant, in which case the entire Form B shall be made current;

(b) There is a material change in the information given in Item 5 or Item 6 of Form B in which case the respective item shall be made current.

(3) Any other amendment to Form B shall be filed within ninety days after the end of each fiscal year of the ultimate controlling person of the insurance holding company system. Such amendment shall make current all information in Form B.

[Order R-71-2, § 284-18-040, filed 7/9/71, effective 8/10/71.]

WAC 284-18-050 Alternative and consolidated registrations. (1) Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under section 8 of the act. A registration statement may include information regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state.

(2) In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile: *Provided:*

(a) The statement or report contains substantially similar information required to be furnished on Form B; and

(b) The filing insurer is the principal insurance company in the insurance holding company system.

(3) The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a simple statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

(4) Any insurer may take advantage of the provisions of section 8(6) or 8(7) of the act without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration, or the public good.

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[Order R-71-2, § 284-18-050, filed 7/9/71, effective 8/10/71.]

WAC 284-18-060 Exemptions. (1) A foreign or alien insurer otherwise subject to section 8 of the act shall not be required to register pursuant to that section if it is admitted in the domiciliary state of the principal insurer (as that term is used herein in WAC 284-18-050) and in said state is subject to disclosure requirements and standards adopted by statute or rules and regulations which are substantially the same to those contained in section 8 of the act: *Provided,* That the commissioner may require a copy of the registration statement or other information filed with the domiciliary state.

(2) The state of entry of an alien insurer shall be deemed to be its domiciliary state for the purposes of these rules.

(3) Any insurer not otherwise exempt or excepted from section 8 of the Act may apply for an exemption from the requirements of the act by submitting a statement to the commissioner setting forth its basis for claiming exemption.

[Order R-71-2, § 284-18-060, filed 7/9/71, effective 8/10/71.]

WAC 284-18-070 Disclaimers and termination of registration. (1) A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

(a) The number of authorized, issued, and outstanding voting securities of the subject;

(b) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

(c) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

(d) A statement fully explaining why such person should not be considered to control the subject.

(2) A request for termination of registration shall be deemed to have been granted unless the commissioner, within sixty days after he receives the request, notifies the registrant otherwise.

[Order R-71-2, § 284-18-070, filed 7/9/71, effective 8/10/71.]

WAC 284-18-080 Extraordinary dividends and other distributions. (1) Notices of intent to declare extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

(a) The date established for payment of the dividend;

(b) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof of its cost, and its fair market value together with an explanation of the basis for valuation;

(c) The amounts and dates of all dividends (including regular dividends) paid within the period of twelve consecutive months ending on the date fixed for payment of

the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(d) A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the quarter preceding the quarter in which the notice of the dividend or other distribution is submitted;

(e) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

(2) The payment of an extraordinary dividend by an insurer whose total liabilities, as calculated for National Association of Insurance Commissioners annual statement purposes, are less than ten percent of its assets both before and after payment thereof is deemed automatically approved: *Provided*, Such dividend is paid only from earned surplus. The insurer, however, shall give written notice to the commissioner of the declaration pursuant to section 11 of the act.

[Order R-71-2, § 284-18-080, filed 7/9/71, effective 8/10/71.]

WAC 284-18-090 Additional information may be required. The commissioner, in his discretion, may require additional information from any person subject to the act and no registration, notice or filing shall be deemed complete until such additional information has been received by the commissioner.

[Order R-71-2, § 284-18-090, filed 7/9/71, effective 8/10/71.]

WAC 284-18-100 Forms. Forms A and B, annexed hereto, constitute part of the regulation.

[Order R-71-2, § 284-18-100, filed 7/9/71, effective 8/10/71.]

WAC 284-18-110 Instructions for use of Forms A and B. (1) Forms A and B are intended to be guides in the preparation of the statements required by sections 4 and 8 of the act. They are not blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are so prepared as to indicate to the reader the coverage of the items without the necessity of his referring to the text of the items or the instructions thereto. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(2) Two complete copies of each statement, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the commissioner by personal delivery or mail, addressed to: Insurance commissioner of the state of Washington, Insurance Building, Olympia, Washington 98504, Attention: Company supervision deputy. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of

any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

(3) Statements should be prepared on paper 8 1/2" x 11" or 8 1/2" x 13" in size and preferably bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency shall be converted into United States currency.

(4) Information required by any item of Form A or Form B may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document, may be incorporated by reference in answer or partial answer to any item of Form A or Form B provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. References to information contained in exhibits or in documents already on file need not be attached as exhibits; however, they shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear, or confusing.

(5) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the most important provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document on file with the commissioner and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects, except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

(6) Information required need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because the obtaining thereof would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted if

the commissioner so determines, and subject to the following conditions:

(a) The person filing shall give such information on the subject as it possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and

(b) The person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

(7) If it is impractical to furnish any required information, document, or report at the time it is required to be filed, there may be filed with the commissioner a separate document

(a) Identifying the information, document, or report in question,

(b) Stating why the filing thereof at the time required is impractical, and

(c) Requesting an extension of time for filing the information, document, or report to a specified date.

The request shall be deemed granted unless the commissioner within twenty days after receipt thereof shall enter an order denying the request.

(8) In addition to the information expressly required to be included in Form A and Form B, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer.

(9) Any amendment for Form A or Form B shall include on the top of the cover page the phrase: "Amendment No. ----- to" and shall indicate the date of the amendment and not the date of the original filing.

[Order R-71-2, § 284-18-110, filed 7/9/71, effective 8/10/71.]

WAC 284-18-120 Effective date. The effective date of this regulation shall be August 10, 1971.

[Order R-71-2, § 284-18-120, filed 7/9/71, effective 8/10/71.]

WAC 284-18-990 Form A--Statement regarding the acquisition of control of or merger with a domestic insurer.

([Original] Page 1 of 5 - Form A)

STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

Name of Domestic Insurer

BY

Name of Acquiring Person (Applicant)

Filed with the Insurance Commissioner of Washington

Dated: ----- 19--

Name, Title, address, and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

Form A

ITEM 1. INSURER AND METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each ([Original] Page 2 of 5 - Form A) person specified in such chart or listing indicate the type of organization (e.g. - corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings looking toward a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

State the following with respect to (1) the applicant if he is an individual or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual:

(a) Name and business address;

(b) Present principal business activity, occupation, or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office, or employment was carried on; if any such occupation, position, office, or employment required licensing by or registration with any federal, state, or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding, or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity to remain confidential, he must specifically request that the identity be kept confidential.

([Original] Page 3 of 5 – Form A)

ITEM 5. FUTURE PLANS FOR INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

(1986 Ed.)

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement, or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates, or any persons listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with [with] whom such contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities ([Original] Page 4 of 5 – Form A) of the insurer for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item

[Title 284 WAC—p 25]

2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto; any proposed employment, consultation, advisory or management contracts concerning the insurer; annual reports to the stockholders of the insurer and the applicant for the last two fiscal years; and any additional documents or papers required by Form A or the regulation.

ITEM 13. SIGNATURE AND CERTIFICATION

Signature and certification in the following form:

SIGNATURE

Pursuant to the requirements of chapter 13, Laws of 1971 ex. sess. and chapter 284-18 WAC

(Name of Applicant) has caused this application to be duly signed on its behalf in the City of _____, and State of _____, on the _____ day of _____, 19__.

([Original] Page 5 of 5 - Form A)

(SEAL)

Name of Applicant

By -----
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached application dated _____, 19__-, for _____ and on behalf of _____ (Name of Applicant) that he is the _____ (Title of Officer) of such company, and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information, and belief.

(Signature) -----

(Type or print name beneath)

[Form A is a part of Order R-71-2 (codified as WAC 284-18-990), filed 7/9/71, effective 8/10/71.]

WAC 284-18-99001 Form B--Insurance holding company system registration statement.

([Original] Page 1 of 5 - Form B)

Form B

INSURANCE HOLDING COMPANY SYSTEM REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Washington

By

Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

Date: _____, 19__

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

Form B

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets are equal to less than 1/2 of 1% of the total ([Original] Page 2 of 5 - Form B) assets of the ultimate controlling person within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., - corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name.
- (b) Home Office Address.
- (c) Principal executive office address.
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.
- (e) The principal business of the person.
- (f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.
- (g) If court proceedings looking toward a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

Furnish the following information for the directors and executive officers of the ultimate controlling person: The individual's name and address, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

(1986 Ed.)

ITEM 5. TRANSACTIONS, RELATIONSHIPS, AND AGREEMENTS

(a) Briefly describe the following agreements in force, relationships subsisting, and transactions currently outstanding between the registrant and its affiliates:

- (1) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the registrant or of the registrant by its affiliates;
- (2) purchases, sales or exchanges of assets;
- (3) transactions not in the ordinary course of business;
- (4) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the registrant's ([Original] Page 3 of 5 - Form B) assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;
- (5) all management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles; and
- (6) reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company.

No information need be disclosed if such information is not material. Sales, purchases, exchanges, loans or extensions of credit or investments involving one-half of 1% or less of the registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include at least the following: The nature and purpose of the transaction; the nature and amounts of any payments or transfers of assets between the parties; the identity of all parties to such transaction; and relationship of the affiliated parties to the Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding five years, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

- (a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and
- (b) Proceedings which may have or have had a material adverse effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits shall be attached to this statement as an appendix, and such financial statements and exhibits so attached shall be listed under this item.

[Title 284 WAC—p 27]

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. [[Original] Page 4 of 5 - Form B] Such financial statements may be prepared on either an individual basis, or unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended. In conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or the regulations.

SIGNATURES

Signatures and certification of the form as follows:

SIGNATURE

Pursuant to the requirements of chapter 13, Laws of 1971 ex. sess., and chapter 284-18 WAC, the Registrant has caused this registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19__.

(SEAL)

(Name of Registrant)

By -----
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

[[Original] Page 5 of 5 - Form B)

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached registration statement dated _____, 19__, for and on behalf of _____ (Name of Company); that he is the _____ (Title of Officer) of such company, and that he has authority to execute and file such instrument.

Deponent further says that he is familiar with such instrument and that the facts therein set forth are true to the best of his knowledge, information and belief.

(Signature) -----

(Type or print name beneath)

[Form B is part of Order R-71-2 (codified as WAC 284-18-99001), filed 7/9/71, effective 8/10/71.]

Chapter 284-19 WAC
WASHINGTON ESSENTIAL PROPERTY
INSURANCE INSPECTION AND PLACEMENT
PROGRAM

WAC	
284-19-010	Title.
284-19-020	Purposes of program.
284-19-030	Effective date.
284-19-040	Participation.
284-19-050	Definitions.
284-19-060	FAIR plan—Inspections and reports.
284-19-070	FAIR plan business—Distribution and placement.
284-19-080	Procedure after inspection and submission.
284-19-090	Joint reinsurance association.
284-19-100	Standard policy coverage—Coding.
284-19-110	Cancellation under this program.
284-19-120	Right of appeal.
284-19-130	Commission.
284-19-140	Administration.
284-19-150	Annual and special meetings.
284-19-160	Duties of the committee.
284-19-165	Cooperation of producers.
284-19-170	Public education and notices required.
284-19-180	Statistics, records and reports.
284-19-200	Termination of program.

WAC 284-19-010 Title. These rules and regulations shall be entitled the WASHINGTON ESSENTIAL PROPERTY INSURANCE INSPECTION AND PLACEMENT PROGRAM (hereinafter referred to as the program).

[Order R-69-1, § 284-19-010, filed 1/28/69.]

WAC 284-19-020 Purposes of program. The purposes of the program are:

- (1) To assure stability in the property insurance market of this state.
- (2) To encourage maximum use, in obtaining essential property insurance, of the available, normal insurance market provided by authorized insurers.
- (3) To make essential property insurance available where it cannot be obtained through the normal insurance market, subject to the conditions hereinafter stated.
- (4) To encourage the improvement of the condition of properties located in the urban areas of the state of

Washington and to further orderly community development generally.

(5) To establish a FAIR plan (fair access to insurance requirements), an industry placement facility and a joint reinsurance association for the equitable distribution and placement of risks among insurers in the manner and subject to the conditions hereinafter stated.

[Order R-69-1, § 284-19-020, filed 1/28/69.]

WAC 284-19-030 Effective date. (1) The program shall become effective October 28, 1968.

(2) The program is intended to conform with the applicable provisions of the Urban Property Protection and Reinsurance Act of 1968, 82 Stat. 555, Public Law 90-448, as amended, and administrative rules and regulations, and other directives adopted pursuant thereto by the Secretary, U.S. Department of Housing and Urban Development.

[Order R-73-2, § 284-19-030, filed 3/30/73; Order R-69-1, § 284-19-030, filed 1/28/69.]

WAC 284-19-040 Participation. Participation in this program shall be mandatory for all insurers and fraternal benefit societies authorized to engage in the property insurance business in this state, who have "premiums written," as defined in this chapter.

[Order R-69-1, § 284-19-040, filed 1/28/69.]

WAC 284-19-050 Definitions. (1) "Insurer" means any insurance company or other organization licensed to write and engage in writing property insurance business, including the property insurance components of multiperil policies, on a direct basis, in this state.

(2) "Essential property insurance" means the coverage against direct loss to real and tangible personal property at a fixed location that is provided in the standard fire policy and extended coverage endorsement, and shall include also the perils of vandalism and malicious mischief and such additional lines of property insurance as may be designated by the secretary, or the commissioner. Essential property insurance specifically includes insurance against direct loss to property which is being constructed or rehabilitated (builder's risk coverage). It does not include automobile insurance; nor, unless designated by the secretary, insurance on farm or manufacturing risks.

(3) "Industry placement facility" (hereinafter referred to as the facility) means the organization formed by insurers to assist applicants in urban areas in securing essential property insurance and to administer the FAIR plan and the joint reinsurance association.

(4) "Inspection bureau" means the Washington surveying and rating bureau.

(5) "Urban area" includes the following municipalities and counties and such additional counties, municipalities, and definitive political subdivisions therein as may be added from time to time by the commissioner or the secretary:

- Pasco - All
- King County - All
- Tacoma - All

(6) "Premiums written" means gross direct premiums (excluding that portion of premiums on risks ceded to the joint reinsurance association) charged during the second preceding calendar year with respect to property in this state on all policies of property insurance and property insurance components of all multiperil policies, as defined and computed by the facility, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

(7) A "service insurer" shall be any company designated by the facility and approved by the commissioner to issue policies under this program.

(8) "Commissioner" means the commissioner of insurance of the state of Washington.

(9) "Secretary" means the Secretary, U.S. Department of Housing and Urban Development.

(10) "The act" means the Urban Property Protection and Reinsurance Act of 1968, 82 Stat. 555, Public Law 90-448, as amended.

[Order R-73-2, § 284-19-050, filed 3/30/73; Order R-70-1, § 284-19-050, filed 7/31/70; Order R-69-1, § 284-19-050, filed 1/28/69.]

WAC 284-19-060 FAIR plan--Inspections and reports. (1) Any person having an insurable interest in real or tangible personal property at a fixed location in an urban area shall be entitled, upon application therefor to the facility, to an inspection of the property by the inspection bureau at no cost to the applicant. The inspection may be requested by the property owner or his representative, the insurer or the insurance producer and need not be in writing. Requests for inspections shall be transcribed on a form approved by the facility. A deposit premium shall not be required as a precondition to inspection.

(2) The owner of the building need not be present for a tenant to obtain an inspection, but the inspection bureau must be provided full access to the property for which insurance is sought.

(3) An inspection report shall be made for each property inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. A representative photograph of the property may be taken during the inspection.

(4) During the inspection, the inspector shall point out features of structure and occupancy to the applicant or his representative, if present, and shall indicate those features which may result in condition charges if the risk is accepted. The inspector shall have no authority to advise whether any insurer will provide the coverage.

(5) After the inspection a copy of the completed inspection report, and any photograph, indicating the pertinent features of building, construction, maintenance, occupancy and surrounding property shall be sent within five business days to the facility for distribution to a service insurer. The person requesting the inspection report may designate the service insurer to which the inspection report is to be referred.

(6) Included with the report shall be a rate make-up statement, including any condition charges or surcharges imposed by inspection or under the program, or under

any substandard rating plan approved by the commissioner. A copy of the inspection report shall be made available to the applicant or his agent upon request.

[Order R-69-1, § 284-19-060, filed 1/28/69.]

WAC 284-19-070 FAIR plan business--Distribution and placement. (1) The facility may not require, as a precondition to the placement of business under the FAIR plan, that the applicant make a showing that he is unable to obtain insurance in the normal market, but the facility may require an agent or broker to furnish the facility with copies of documents or information showing what effort was made by such agent or broker to obtain insurance in the normal market, and the facility shall forward to the commissioner the names of such agents or brokers who fail to cooperate or who appear to fail to make reasonable efforts on behalf of applicants for insurance to obtain insurance in the normal market.

(2) Thereafter, the facility, upon receipt of an application for coverage and the corresponding inspection report from the inspection bureau, shall assign such application to the service insurer designated by the applicant or by his agent; or if no service insurer is so designated, it shall assign the application to a service insurer, keeping the assignments evenly distributed, based on the volume of property insurance writings in this state of the various service insurers.

(3) Assessments upon each insurer participating in this program shall be levied by the facility on the same percentage allocation basis as such insurer's premiums written bears to the total of all premiums written by all insurers participating in the program.

(a) The maximum limit of liability which may be placed through this program on any one property at one location is \$1,500,000. The facility shall undertake the responsibility of seeking to place that portion of a risk which exceeds \$1,500,000.

(b) The term "at one location" as used herein refers to real and personal property consisting of and contained in a single building, or consisting of and contained in contiguous buildings under one ownership.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.18.480, and 48.30.020. 79-08-019 (Order R 79-3), § 284-19-070, filed 7/11/79; Order R-69-1, § 284-19-070, filed 1/28/69.]

WAC 284-19-080 Procedure after inspection and submission. (1) Any service insurer to which a risk is referred by the facility shall, within three business days after receipt of the inspection report and application, complete an action report and return the same to the facility advising that:

- (a) The risk is acceptable; or
- (b) The risk will be acceptable if the improvements noted in the action report are made by the applicant and confirmed by reinspection; or
- (c) The risk is not acceptable for the reasons stated in the action report.

(2) If the risk is accepted by the designated service insurer, and upon receipt of premium, the policy or binder shall be delivered within two business days. No producer shall have authority to bind the facility or any

service insurer for any risk eligible for this program until acceptance of the risk and payment of premium.

(3) In the event a risk is declined because it fails to meet reasonable underwriting standards, the facility will so notify the applicant and the commissioner. Reasonable underwriting standards shall include, but not be limited to, the following:

(a) Physical condition of the property, such as its construction, heating, wiring, evidence of previous fires or general deterioration;

(b) its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials;

(c) other specific characteristics of ownership, condition, occupancy or maintenance which are violative of public policy and result in unreasonable exposures to loss. Neighborhood or area location or any environmental hazard beyond the control of the property owner shall not be deemed to be an acceptable criterion for declining a risk.

(4) In the event the risk is conditionally declined because the property does not meet reasonable underwriting standards, but can be improved to meet such standards, the facility shall promptly advise the applicant and the commissioner what improvements noted in the action report should be made to the property. Upon completion of the improvements by the applicant or property owner, the facility, when so notified, will have the property promptly reinspected and furnish the new inspection report to the previously designated service insurer.

(5) If the inspection of the property reveals that there are one or more substandard conditions, surcharges may be imposed in conformity with the substandard rating plan approved by the commissioner. In this event, the facility shall advise the applicant of what improvements, if any, he may make to bring his property to insurable condition at uncharged rates.

(6) Any insurer, which is a member of a group of insurers under the same management or ownership, to which a referral is made under the program, may apply in behalf of the group for a combined distribution and placement quota under the program. Such group shall have the option of designating the insurer within the group to which the risk shall be referred.

[Order R-69-1, § 284-19-080, filed 1/28/69.]

WAC 284-19-090 Joint reinsurance association. (1) A joint reinsurance association (hereinafter referred to as the association: Is hereby created consisting of all insurers.

(2) The association shall be authorized to assume reinsurance on behalf of insurers and cede reinsurance on behalf of insurers on eligible risks written by insurers through the FAIR plan. The reinsurance assumed by the association shall be for 100% of each risk written under this program under \$1,500,000.

(3) Each insurer shall participate in the total writings, expenses, profits and losses of the association in proportion to its premiums written.

(4) In the event any reinsuring member fails, by reason of insolvency, to pay its proportion of any expense or of any loss as an assuming reinsurer incurred by the facility under the program, such unpaid loss or expense shall be paid by the remaining members, each contributing in the manner provided for the distribution of expenses and losses under the program, deleting therefrom the proportion of the defaulting member. The facility shall be subrogated to the rights of the remaining members in any liquidation proceeding and shall have full authority on their behalf to exercise such rights in any action or proceeding.

[Order R-69-1, § 284-19-090, filed 1/28/69.]

WAC 284-19-100 Standard policy coverage--Coding. All policies issued shall be for essential property insurance on standard policy forms, shall be separately coded, and shall be issued for a term of one year, at rates promulgated by the inspection bureau under filings approved by the commissioner. Individual company deviation filings shall not apply to risks written under this program.

[Order R-69-1, § 284-19-100, filed 1/28/69.]

WAC 284-19-110 Cancellation under this program.

(1) No insurer shall cancel a policy or binder issued under this program except for:

- (a) Cause which would have been grounds for nonacceptance of the risk under the program had such cause been known to the insurer at the time of acceptance; or
- (b) For nonpayment of premium; or
- (c) With the approval of the governing committee.

(2) Notice of cancellation, together with a statement of the reason therefor, shall be sent to the insured with a copy sent to the facility.

(3) Any cancellation notice to the insured shall be accompanied by a statement that the insured has a right of appeal as hereinafter provided.

[Order R-69-1, § 284-19-110, filed 1/28/69.]

WAC 284-19-120 Right of appeal. (1) Any applicant or insurer shall have a right of appeal to the committee, including the right to appear in person before the committee, if requested by the party seeking appeal.

(2) A decision of the committee may be appealed to the commissioner.

(3) Each denial of insurance under this program shall be accompanied by a statement setting forth the provisions of this section (WAC 284-19-120).

(4) Notification of appeal may be made to the committee through the manager of the facility or any member of the committee.

(5) All appeals to the committee or to the commissioner shall be in writing and must indicate in what respect the applicant feels aggrieved.

(6) Decisions of the committee on appeals to it shall be reduced to writing and shall be rendered within at least 15 business days after notification of appeal is received, unless delayed by mutual consent. The majority

of committee members (3) must concur in all decisions adverse to the party seeking appeal.

(7) Appeals to the commissioner under this program shall, in all other respects not set forth herein, be handled in accordance with chapters 48.04 and 34.04 RCW (Administrative Procedure Act).

[Order R-69-1, § 284-19-120, filed 1/28/69.]

WAC 284-19-130 Commission. Commission under this program shall be 10 per cent on the policy premium and shall be paid to the licensed producer designated by the applicant.

[Order R-69-1, § 284-19-130, filed 1/28/69.]

WAC 284-19-140 Administration. (1) This program shall be administered by a governing committee (hereinafter referred to as the committee) of the facility, subject to the supervision of the commissioner, and operated by a manager appointed by the committee.

(2) On and after September 1, 1979, the committee shall consist of nine members, including five insurers, one of which shall be elected from each of the following:

American Insurance Association, Alliance of American Insurers, National Association of Independent Insurers, all other stock insurers, and all other nonstock insurers. A sixth member shall be the insurer designated as the service insurer under the program (or, if there be more than one service insurer, the sixth member shall be such service insurer as the commissioner designates as the member). The other three members shall be individuals who are appointed by the commissioner to so serve, none of whom shall be interested, directly or indirectly in any insurer except as a policyholder. The individual members shall serve for a period of one year or until their successors are appointed. Not more than one insurer in a group under the same management or ownership shall serve on the committee at the same time. One of the six insurers on the governing committee shall be a domestic insurer.

[(3) The governing committee is hereby empowered to issue operating procedures and other directives to carry out the purposes of this plan, the act, and directives of the secretary and the commissioner pursuant thereto.]

[(4) Each person serving on the committee or any subcommittee thereof, each Member of the facility, and each officer and employee of the facility shall be indemnified by the facility against all costs and expenses actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the committee, or a member or officer or employee of the facility except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful misconduct in the performance of his or its duties as a member of such committee, or a member or officer or employee of the facility. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the program. Indemnification hereunder shall not be exclusive of other rights to which such member or officer may be entitled as a matter of law.]

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.18.480, and 48.30.020. 79-08-019 (Order R 79-3), § 284-19-140, filed 7/11/79; Order R-69-1, § 284-19-140, filed 1/28/69.]

Reviser's note: RCW 34.04.058 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 284-19-150 Annual and special meetings. (1) There shall be an annual meeting of the insurers on a date fixed by the committee. The three aforementioned associations shall designate or elect their representatives to the committee. The two nonassociation groups of companies shall elect their respective representatives by a majority vote counted on a weighted basis in accordance with each insurer's premiums written and the aggregate premiums written for all insurers in the respective groups of companies. Representatives on the committee shall serve for a period of one year or until successors are elected or designated.

(2) A special meeting may be called at such time and place designated by the committee or upon the written request to the committee of any ten insurers, not more than one of which may be a group under the same management or ownership.

(3) Twenty days' notice of such annual or special meeting shall be given in writing by the committee to the insurers. A majority of the insurers shall constitute a quorum. Voting by proxy shall be permitted. Notice of any meeting shall be accompanied by an agenda for such meeting.

(4) Any matter, including amendment of this program, may be proposed and voted upon by mail, provided such procedure is unanimously authorized by the members of the committee present and voting at any meeting of the committee. If so approved by the committee, notice of any proposal shall be mailed to the insurers not less than twenty days prior to the final date fixed by the committee for voting thereon.

(5) At any regular or special meeting at which the vote of the insurers is or may be required on any proposal, including amendment to this program, or any vote of the insurers which may be taken by mail on any proposal, such votes shall be cast and counted on a weighted basis in accordance with each insurer's premiums written. A proposal shall become effective when approved by at least two-thirds of the votes cast on such weighted basis, except amendments to this program which will require administrative action by the commissioner.

[Order R-69-1, § 284-19-150, filed 1/28/69.]

WAC 284-19-160 Duties of the committee. (1) The committee shall meet as often as may be required to perform the general duties of the administration of the program or on the call of the commissioner. Three insurers of the committee shall constitute a quorum.

(2) The committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds and perform all other duties provided herein or necessary or incidental to the proper administration of the

program. The adoption of or substantive changes in pension plans or employee benefit programs shall be subject to approval of the insurers. Assessments upon each insurer shall be levied on the basis of its premiums written.

(3) Annually the manager shall prepare an operating budget which shall be subject to approval of the committee. Such budget shall be furnished to the insurers after approval. Any contemplated expenditure in excess of or not included in the annual budget shall require prior approval by the committee.

(4) The committee shall furnish to all insurers and to the commissioner a written report of operations annually in such form and detail as the committee may determine.

[Order R-69-1, § 284-19-160, filed 1/28/69.]

WAC 284-19-165 Cooperation of producers. All licensed insurance agents and brokers shall provide full cooperation in carrying out the aims and the operation of the FAIR plan.

[Order R-69-1, § 284-19-165, filed 1/28/69.]

WAC 284-19-170 Public education and notices required. (1) All insurers shall undertake a continuing public education program in cooperation with producers and others, to assure that the essential property insurance inspection and placement program receives adequate public attention.

(2) All insurers shall give any policyholder eligible for coverage under this program 30 days' notice of cancellation or refusal to renew (except in the case of nonpayment of premium or evidence of incendiarism), and shall explain the procedure for making application under this program in or accompanying such notice.

[Order R 77-1, § 284-19-170, filed 3/24/77; Order R-69-1, § 284-19-170, filed 1/28/69.]

WAC 284-19-180 Statistics, records and reports. (1) **Statistics.** The facility shall maintain separate statistics on business written in accordance with this plan, and shall make the following quarterly report to the commissioner and to the secretary, and such additional reports as may be required by the commissioner.

- (a) Number of requests for inspections,
- (b) Number of risks inspected,
- (c) The number of risks accepted, total and average premiums charged, high and low premiums,
- (d) The number of risks declined, and
- (e) The number of reinspections made on conditionally declined risks.

(2) **Records.** In addition to statistics, the facility shall maintain complete and separate records of all business transactions, including copies of all policies and endorsements issued in accordance with this plan.

(3) **Reports to members.** Regular reports of the facility's operations shall be submitted to all members by the committee, such reports to include, but not necessarily to be limited to, premiums written and earned, losses, including loss adjustment expense, paid and incurred, all other expenses incurred and outstanding liabilities.

[Order R-69-1, § 284-19-180, filed 1/28/69.]

filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.

WAC 284-19-200 Termination of program. This program shall terminate on October 31, 1988. However, from November 1, 1987, through October 31, 1988, no insurance policy under the program shall be issued or renewed, thereby allowing the program to expire in an orderly manner. The act having expired, the facility, association and governing committee shall continue to function in conformity with chapter 284-19 WAC except with respect to references to the act or the secretary as the same become inapplicable. No obligations incurred by the association shall be impaired by the termination of the program and such association shall be continued for the purpose of performing such obligations.

[Statutory Authority: RCW 48.02.060. 86-20-039 (Order R 86-4), § 284-19-200, filed 9/25/86; 84-23-006 (Order R 84-5), § 284-19-200, filed 11/8/84; Order R 77-1, § 284-19-200, filed 3/24/77; Order R-73-2, § 284-19-200, filed 3/30/73; Order R-69-1, § 284-19-200, filed 1/28/69.]

Chapter 284-20 WAC INSURANCE POLICIES

WAC

284-20-006	Washington Insurance Examining Bureau, Inc.—Audits to test adherence to rate filings.
284-20-010	Standard fire policies.
284-20-020	Time of inception and expiration.
284-20-030	Purpose.
284-20-040	Classification of risks and coverages.
284-20-050	Excluded coverages.
284-20-070	Catastrophe coverage.
284-20-100	Modification of form filing requirements.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-20-005	Washington Insurance Examining Bureau, Inc.—Rates and adhering to filings. [Statutory Authority: RCW 48.02.060. 80-04-018 (Order R 80-2), § 284-20-005, filed 3/13/80; Order R-68-4, § 284-20-005, filed 7/3/68, effective 9/1/68; Order 179, filed 3/10/64; Original Order 179, filed 1/8/63.] Repealed by 82-02-024 (Order R 81-9), filed 12/30/81. Statutory Authority: RCW 48.02.060.
284-20-031	Resolution and plan of National Association of Insurance Commissioners. [Adopted 7/31/53, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-060	Replacement or depreciation insurance—Policy and general rules effective December 20, 1947. [Order 12/17/47, effective 12/20/47, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-061	Replacement or depreciation insurance—General rules promulgated June 4, 1951. [Rules dated 6/1/51; made and filed in the commissioner's office 6/4/51, filed with code reviser 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-062	Replacement or depreciation insurance—Construction to allow coverage to be written in a separate policy. [Rule construing WAC 284-20-210; made 2/13/52, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-063	Replacement or depreciation insurance—General rules promulgated May 15, 1952. [General rules of 5/15/52, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-064	Replacement or depreciation insurance—May be written as a surplus line subject. [Order of 12/26/47,

WAC 284-20-006 Washington Insurance Examining Bureau, Inc.—Audits to test adherence to rate filings.

(1) In performing the duty of ascertaining that lawful premiums are being charged, the commissioner finds that it is not reasonable or necessary, with regard to any kind of insurance, to mandate that data relating to all policies issued be submitted for examination. He does find, however, that as to all kinds of insurance falling within the scope of chapter 48.19 RCW occasions may arise where, in order to ascertain that lawful rates are being charged, documents with respect to certain policies should be submitted for examination, and that such required submission should, in some instances, be on a random audit basis, and in some instances, by designation of certain specific policies.

(2) Based on the foregoing and pursuant to RCW 48.19.410, with respect to policies having an effective date on and after February 1, 1982, every insurer authorized to write property or casualty insurance in the state of Washington:

(a) May submit to the Washington Insurance Examining Bureau, Inc., for examination, any policies and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, which relate to property insurance as defined in RCW 48.11.040;

(b) Shall make available to the Washington Insurance Examining Bureau, Inc. a specifically identified policy and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, when directed to do so by the commissioner; and

(c) Shall make available to the Washington Insurance Examining Bureau, Inc. such policies and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, as may be required by the commissioner for purposes of random audits designed to test the companies' adherence to rate filings.

[Statutory Authority: RCW 48.02.060. 82-02-024 (Order R 81-9), § 284-20-006, filed 12/30/81.]

WAC 284-20-010 Standard fire policies. (1) This regulation is promulgated pursuant to RCW 48.18.120(1) to define and effect reasonable uniformity in all basic contracts of fire insurance.

(2) All policies which include coverage against loss or damage by fire are hereby defined to be basic contracts of fire insurance unless they come within the scope of insurance code provisions, or regulations adopted by the commissioner, providing that they may be regarded as marine, inland marine, vehicle, or casualty policies.

(3) Except for the provisions of the next succeeding three paragraphs, no company shall issue any basic contract of fire insurance covering property or interest therein in this state other than on the form known as the 1943 New York Standard Fire Insurance Policy, herein

referred to as the "standard fire policy": *Provided, however*, That such form shall be modified to conform to RCW 48.18.290 with respect to the number of day's notice of cancellation required. In addition, such form shall be modified as necessary to conform to WAC 284-20-020 with respect to inception and expiration times. Such modifications may be by endorsement.

(a) Insurers issuing a standard fire policy pursuant to this regulation are hereby authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy: *Provided, however*, That nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination provided such assumption clause has been filed with and approved by the commissioner in accordance with RCW 48.18.100.

(b) The pages of the standard fire policy issued pursuant to this regulation may be renumbered and the format rearranged for convenience in the preparation of individual contracts, and to provide space for the listing of rates and premiums for coverages insured thereunder or under endorsement attached to or printed thereon, and such other data as may be conveniently included for duplication on daily reports for office records.

(c) As an alternative form, a form written in clear, understandable language, which provides terms, conditions and coverages not less favorable to the insured than the "standard fire policy," may be used. Such alternative form may be incorporated in or integrated within a form providing other or additional coverages, as, for example, a homeowners policy or a special multi-peril policy. The intent of this subsection is to permit understandable plain language policies and package policies without diminishing any rights an insured would have under the 1943 New York Standard Fire Insurance Policy.

(d) By use of such alternative form, an insurer certifies that it is not less favorable to the insured than the "standard fire policy." If, in the adjustment of claims, any provision of the "standard fire policy" applicable to such claims is found to be more favorable to the insured than the alternative form used, then provisions of the "standard fire policy" shall govern.

[Order R 77-2, § 284-20-010, filed 4/28/77; Rule 128, filed 3/14/61.]

WAC 284-20-020 Time of inception and expiration. Until January 1, 1978, any contract of insurance containing a basic contract of fire insurance shall provide that its time of inception and expiration are either noon or 12:01 a.m. standard time. Every such contract issued on or after January 1, 1978, shall provide only 12:01 a.m. standard time as the time of inception and expiration. Such contract, by endorsement or otherwise, shall also contain language in substance as follows: "To the extent that coverage contained in this policy replaces coverage in another policy terminating at a different

hour on the effective date of this policy, this policy shall be effective at the same hour as the termination hour of the other policy."

[Order R 77-2, § 284-20-020, filed 4/28/77.]

WAC 284-20-030 Purpose. (1) The purpose of this regulation, WAC 284-20-030 through 284-20-050, is to describe the kinds of risks and coverages which may be classified under the insurance code as marine, inland marine or transportation insurance, but does not include all of the kinds of risks and coverages which may be written, classified or identified under marine, inland marine or transportation insuring powers, nor shall it be construed to mean that the kinds of risks and coverages are solely marine, inland marine or transportation insurance in all instances.

(2) This regulation shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.

[Order R 77-3, § 284-20-030, filed 5/20/77; Rule made 7/31/53, filed 3/22/60.]

WAC 284-20-040 Classification of risks and coverages. Marine and/or transportation policies may cover under the following conditions:

(1) IMPORTS.

(a) Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

(b) An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such, so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:

(i) Sold and delivered by the importer, factor or consignee; or

(ii) Removed from place of storage and placed on sale as part of importer's stock in trade at a point of sale-distribution; or

(iii) Delivered for manufacture, processing or change in form to premises of the importer or of another used for any such purposes.

(2) EXPORTS.

(a) Exports may be covered wherever the property may be without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

(b) An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this ruling respecting domestic shipments shall apply, provided, however, that this provision shall not apply to long established methods of insuring certain commodities, e.g., cotton.

(3) DOMESTIC SHIPMENTS.

(a) Domestic shipments on consignment, for sale, distribution, exhibit, trial, approval or auction, while in transit, while in the custody of others, and while being returned, provided that in no event shall the policy afford coverage on premises owned, leased or operated by the consignor.

(b) Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by insured or purchaser.

(4) BRIDGES, TUNNELS AND OTHER instrumentalities of transportation and communication (excluding buildings, their improvements and betterments, furniture and furnishings, fixed contents and supplies held in storage). The foregoing includes:

(a) Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto.

(b) Piers, wharves, docks, slips, dry docks and marine railways.

(c) Pipelines, including on-line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.

(d) Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.

(e) Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus.

(f) Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.

(5) PERSONAL PROPERTY FLOATER RISKS covering individuals and/or generally:

(a) Personal effects floater policies.

(b) The personal property floater.

(c) Government service floaters.

(d) Personal fur floaters.

(e) Personal jewelry floaters.

(f) Wedding present floaters for not exceeding ninety days after the day of the wedding.

(g) Silverware floaters.

(h) Fine arts floaters covering paintings, etchings, pictures, tapestries, art glass windows, and other bonafide works of art of rarity, historical value or artistic merit.

(i) Stamp and coin floaters.

(j) Musical instrument floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(k) Mobile articles, machinery and equipment floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use) covering identified property of a mobile or floating nature pertaining to or usual to a household. Such policies shall

not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

(l) Installment sales and leased property policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest.

(m) Live animal floaters.

(6) COMMERCIAL PROPERTY FLOATER RISKS covering property pertaining to a business, profession or occupation, as follows:

(a) Radium floaters.

(b) Physicians' and surgeons' instrument floaters. Such policies may include coverage of such furniture, fixtures and tenant insured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the insured in the practice of his profession.

(c) Pattern and die floaters.

(d) Theatrical floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.

(e) Film floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.

(f) Salesmen's samples floaters.

(g) Exhibition policies on property while on exhibition and in transit to or from such exhibitions.

(h) Live animal floaters.

(i) Builders risks and/or installation risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repairing. Such policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.

(i) Such coverage shall be limited to builders risks or installation risks where perils in addition to fire and extended coverage are to be insured.

(ii) If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverages shall terminate when the interest of the seller or contractor ceases.

(j) Mobile articles, machinery and equipment floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semitrailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use), covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

(k) Property in transit to or from and in the custody of bailees (not owned, controlled or operated by the bailor.) Such policies shall not cover bailee's property at his premises.

(l) Installment sales and leased property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This section is not intended to include machinery and equipment under certain "lease-back" contracts.

(m) Garment contractors floaters.

(n) Furriers or fur storer's customer's policies (i.e., policies under which certificates or receipts are issued by furriers or fur storers) covering specified articles the property of customers.

(o) Accounts receivable policies, valuable papers and records policies.

(p) Floor plan policies, covering property for sale while in possession of dealers under a floor plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:

(i) Such merchandise is specifically identifiable as encumbered to the bank or lending institution.

(ii) The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.

(iii) Such policies cover in transit and do not extend beyond the termination of the dealer's interest.

Such policies shall not cover automobiles or motor vehicles, nor merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.

(q) Sign and street clock policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.

(r) Fine arts policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bonafide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.

(s) Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under inland marine policies including:

(i) Musical instrument dealers policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(ii) Camera dealers policies, covering property consisting principally of cameras and their accessories.

(iii) Furrier's dealers policies, covering property consisting principally of furs and fur garments.

(iv) Equipment dealers policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural

equipment and accessories therefor; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.

(v) Stamp and coin dealers covering property of philatelic and numismatic nature.

(vi) Jewelers' block policies.

(vii) Fine arts dealers policies.

Such policies may include coverage of money in locked safes or vaults on the insured's premises. Such policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insured's interest in improvements of buildings.

(t) Wool growers floaters.

(u) Domestic bulk liquids policies, covering tanks and domestic bulk liquids stored therein.

(v) Difference in conditions coverage excluding fire and extended coverage perils.

(w) Electronic data processing policies.

[Order R 77-3, § 284-20-040, filed 5/20/77; Rule made 7/31/53, filed 3/22/60.]

WAC 284-20-050 Excluded coverages. Unless otherwise permitted, nothing in WAC 284-20-030 or 284-20-040 shall be construed to permit marine or transportation policies to cover:

(1) Storage of insured's merchandise, except as hereinbefore provided.

(2) Merchandise in course of manufacture, the property of and on the premises of the manufacturer.

(3) Furniture and fixtures and improvements and betterments to buildings.

(4) Monies and/or securities in safes, vaults, safety deposit vaults, bank or insured's premises, except while in course of transportation.

[Order R 77-3, § 284-20-050, filed 5/20/77; Rule made 1/31/56, filed 3/22/60.]

WAC 284-20-070 Catastrophe coverage. See WAC 284-24-050.

WAC 284-20-100 Modification of form filing requirements. Pursuant to RCW 48.18.100(6), the commissioner rules and hereby orders that all insurance documents and forms pertaining to surplus line coverages placed in this state pursuant to chapter 48.15 RCW are exempt from the requirements of RCW 48.18.100, hereby confirming the long-standing practice in this state.

[Statutory Authority: RCW 48.02.060 (3)(e). 86-24-043 (Order R 86-7), § 284-20-100, filed 11/26/86.]

Chapter 284-21 WAC STANDARD FORMS

WAC

284-21-010

Loss payable and mortgagee endorsements.

284-21-990

Appendix—Form—Loss payable endorsement.

WAC 284-21-010 Loss payable and mortgagee endorsements. After March 1, 1968, no new policy of automobile physical damage insurance or property insurance covering property located in the state of Washington shall be endorsed with a long form loss payable or mortgagee clause, other than:

(1) For automobile physical damage insurance, the form attached to this regulation, which is here designated Form REG-335.

(2) For property insurance, either:

(a) What is now called Standard Forms Bureau Form 372 (Nov. 1950) or the NS version of the same form, which may be adapted for use with insurance on personal property by typing over or deleting from the form the phrase "on buildings only;" or

(b) What is now called Form 438 BFU (May 1, 1942), as approved by the Board of Fire Underwriters of the Pacific and California Bankers Association Insurance Committee, or the NS version of the same form, which may be adopted for use with insurance on personal property by typing over or deleting from the form the phrase "on buildings only;" or

(c) Form REG-335 (see appendix [codified as WAC 284-21-990] at end of this chapter).

Specimens of the above forms may be obtained without cost by calling or writing to the Office of Insurance Commissioner, Insurance Building, Olympia, Washington.

[Order R-68-5, § 284-21-010, filed 7/9/68.]

WAC 284-21-990 Appendix--Form--Loss payable endorsement.

LOSS PAYABLE ENDORSEMENT

This form is identical to that promulgated in Washington State Insurance Commissioner's Regulation No. 335, pursuant to section 1, chapter 12, Laws of 1967, ex. sess., State of Washington.

1. Loss or damage, if any, under this policy shall be payable first to the loss payee or mortgagee (hereinafter called secured party), and, second, to the insured, as their interests may appear; Provided, That, upon demand for separate settlement by the secured party, the amount of said loss shall be paid directly to the secured party to the extent of its interest.

2. This insurance as to the interest of the secured party shall not be invalidated by any act or neglect of the insured named in said policy or his agents, employees or representatives, nor by any change in the title or ownership of the insured property: Provided, however, That, the conversion, embezzlement or secretion by the named insured or his agents, employees or representatives is not covered under said policy unless specifically insured against and premiums paid therefor.

3. In applying the pro rata provisions of the policy, the amount payable to the secured party shall be reduced only to the extent of pro rata payments receivable by the secured party under other policies.

4. The company reserves the right to cancel the policy at any time as provided by its terms, but in such case the company shall mail to the secured party a notice stating

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when such cancellation shall become effective as to the interest of said secured party. The amount and form of such notice shall be not less than that required to be given the named insured, by law or by the policy provisions, whichever is more favorable to the secured party.

5. If the insured fails to render proof of loss within the time granted in the policy conditions, such secured party shall do so within sixty days after having knowledge of a loss, in form and manner as provided by the policy, and, further, shall be subject to the provisions of the policy relating to appraisal and the time of payment and bringing suit.

6. Whenever the company shall pay the secured party any sum for loss or damage under policy and shall claim that, as to the insured, no liability exists, the company shall, to the extent of such payment, be thereupon legally subrogated to all the rights of the party to whom such payment shall be made, under all collateral held to secure the debt, or may, at its option, pay to the secured party the whole principal due or to grow due on the mortgage or other security agreement, with interest, and shall thereupon receive a full assignment and transfer of the mortgage or other security agreement and of all collateral held to secure it; but no subrogation shall impair the right of the secured party to recover the full amount due it.

7. All terms and conditions of the policy remain unchanged except as herein specifically provided.

8. All notices sent to the secured party shall be sent to its last reported address, which must be stated in the policy or in this endorsement below.

9. The following item shall be completed if this endorsement is not referred to by number in the policy to which this endorsement is attached:

The foregoing is attached to and forms a part of Policy No. _____ of _____ Insurance Company, issued to _____ Endorsement effective date _____, 19...

10. If the secured party and its address is not designated in the policy to which this endorsement is attached, the following line(s) shall be completed:

Secured Party Secured Party
Address: Address:
By Agent

[Order R-68-5 (codified as WAC 284-21-990), filed 7/9/68; Order 335, filed 1/3/68.]

Chapter 284-23 WAC

WASHINGTON LIFE INSURANCE REGULATIONS

WAC

284-23-010	Title and purpose.
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284-23-040	Form and content of advertisements.
284-23-050	Disclosure requirements.
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284-23-070	Solicitation beyond license limits and status of insurer.
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284-23-090	Advertising file to be maintained.
284-23-100	Conflict with other rules.
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284-23-320	Scope.
284-23-330	Contract summary, contents.
284-23-340	Contract summary, requirements.
284-23-350	Disclosure requirements.
284-23-360	General rules.
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284-23-400	Purpose.
284-23-410	Definition of replacement.
284-23-420	Other definitions.
284-23-430	Exemptions.
284-23-440	Duties of agents.
284-23-450	Duties of replacing insurers.
284-23-460	Duties of insurers with respect to direct-response sales.
284-23-470	Duties of the existing insurer.
284-23-480	Penalties.
284-23-490	Effective date, supersedes prior regulation.
284-23-500	Form to be used where the existing and proposed policies are written by different companies.
284-23-510	Form to be used where the existing and proposed policies are written by the same company.
284-23-520	Form to be used regarding replacement in a direct-response sale.
284-23-530	Form for comparative information.

WAC 284-23-010 Title and purpose. (1) This regulation, WAC 284-23-010 through 284-23-130, shall be known and may be cited as the "Washington life insurance advertising regulation."

(2) The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

[Order R-75-3, § 284-23-010, filed 8/22/75, effective 11/1/75.]

WAC 284-23-020 Definitions. (1) For the purpose of this regulation:

(a) "Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

(b) "Insurer" shall include any organization or person which issues life insurance or annuities in this State and is engaged in the advertisement of a policy.

(c) "Advertisement" shall be material designed to create public interest in life insurance or annuities or in an insurer, or to induce the public to purchase, increase, modify, reinstate, or retain a policy including:

(i) Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, bill-boards and similar displays;

(ii) Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters;

(iii) Material used for the recruitment, training and education of an insurer's sales personnel, agents, solicitors and brokers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate or retain a policy;

(iv) Prepared sales talks, presentations and material for use by sales personnel, agents, solicitors and brokers.

(2) "Advertisement" for the purpose of this regulation shall not include:

(a) Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(b) Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy;

(c) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

[Order R-75-3, § 284-23-020, filed 8/22/75, effective 11/1/75.]

WAC 284-23-030 Applicability. (1) This regulation shall apply to any life insurance or annuity advertisement intended for dissemination in this state.

(2) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer for whom such advertisements are prepared.

[Order R-75-3, § 284-23-030, filed 8/22/75, effective 11/1/75.]

WAC 284-23-040 Form and content of advertisements. (1) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

(2) Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(3) No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

[Order R-75-3, § 284-23-040, filed 8/22/75, effective 11/1/75.]

WAC 284-23-050 Disclosure requirements. (1) The information required to be disclosed by these rules shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(2) No advertisement shall omit material information or use words, phrases, statements, references or illustrations if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(3) In the event an advertisement uses "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, such terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions.

(4) An advertisement shall not use as the name or title of a life insurance policy or an annuity any phrase which does not include the words "life insurance" or "annuity" unless accompanied by other language clearly indicating it is life insurance or an annuity.

(5) An advertisement shall prominently describe the type of policy advertised.

(6) An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no agent or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the insurance commissioner prior to use.

(7) An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage

decreases or increases with age or duration, such fact shall be prominently disclosed.

(8) An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

(9) With respect to dividends:

(a) An advertisement shall not utilize or describe dividends in a manner which is misleading or has the capacity or the tendency to mislead.

(b) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends are illustrated, they must be based on the insurer's current dividend scale and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of dividends to be paid in the future.

(c) An advertisement shall not state or imply that illustrated dividends under a participating policy and/or pure endowments will be or can be sufficient at any future time to assure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains what benefits or coverage would be provided at such time and under what conditions this would occur.

(10) An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

(11) With respect to testimonials or endorsements by third parties:

(a) Testimonials used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced. In using a testimonial the insurer makes as its own all of the statements contained therein, and such statements are subject to all the provisions of this regulation.

(b) If the individual making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be disclosed in the advertisement.

(c) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the insurer, or receives any payment or other consideration from the insurer for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

(12) An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

(13) With respect to introductory, initial, or special offers and enrollment periods:

(a) An advertisement of an individual policy or combination of such policies shall not state or imply that

such policy or combination of such policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(b) An advertisement shall not state or imply that only a specific number of policies will be sold or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(c) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which over-emphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised.

(d) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than ten days and not more than forty days following the date on which such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals used by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This rule does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this rule shall be applied separately to each such sponsoring organization.

(14) An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group or quasi-group and as such enjoy special rates, dividends or underwriting privileges, unless such is the fact.

(15) An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or

rates of other insurers. An advertisement shall not falsely or unfairly describe other insurers, their policies, services or methods of marketing.

[Order R-75-3, § 284-23-050, filed 8/22/75, effective 11/1/75.]

WAC 284-23-060 Identity of insurer. (1) The full name and home office of the insurer shall be clearly identified, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, or in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

(2) No advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

[Order R-75-3, § 284-23-060, filed 8/22/75, effective 11/1/75.]

WAC 284-23-070 Solicitation beyond license limits and status of insurer. (1) An advertisement which reasonably is expected to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond such limits.

(2) An advertisement may state that an insurer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers may not be so licensed.

(3) An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claim, or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

[Order R-75-3, § 284-23-070, filed 8/22/75, effective 11/1/75.]

WAC 284-23-080 Statements about the insurer. An advertisement shall not contain statements, pictures or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

[Order R-75-3, § 284-23-080, filed 8/22/75, effective 11/1/75.]

WAC 284-23-090 Advertising file to be maintained. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies, hereafter disseminated in this State, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance commissioner. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

[Order R-75-3, § 284-23-090, filed 8/22/75, effective 11/1/75.]

WAC 284-23-100 Conflict with other rules. It is not intended that these rules conflict with or supersede any rules currently in force or subsequently adopted in this state governing specific aspects of the sale or replacement of life insurance including, but not limited to, rules dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance and replacement of life insurance policies. Consequently, no disclosure required under any such rules shall be deemed to be an advertisement within the meaning of this regulation.

[Order R-75-3, § 284-23-100, filed 8/22/75, effective 11/1/75.]

WAC 284-23-110 Violation defined as unfair practice. A violation of this regulation, WAC 284-23-010 through 284-23-130, is hereby defined to be an unfair method of competition and an unfair or deceptive act or practice in the conduct of the business of insurance, pursuant to RCW 48.30.010.

[Order R-75-3, § 284-23-110, filed 8/22/75, effective 11/1/75.]

WAC 284-23-120 Severability provision. If any section or portion of a section of this regulation, or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the regulation, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

[Order R-75-3, § 284-23-120, filed 8/22/75, effective 11/1/75.]

WAC 284-23-130 Effective date. The effective date of this regulation, WAC 284-23-010 through 284-23-130, shall be November 1, 1975.

[Order R-75-3, § 284-23-130, filed 8/22/75, effective 11/1/75.]

WAC 284-23-200 Purpose. (1) The purpose of this regulation is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve

the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

(2) This regulation does not prohibit the use of additional material which is not in violation of this regulation or any other statute or regulation.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-200, filed 6/25/79, effective 1/1/80.]

WAC 284-23-210 Scope. (1) Except as hereafter exempted, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This regulation shall apply to any issuer of life insurance contracts including fraternal mutual life insurers.

(2) Unless otherwise specifically included, this regulation shall not apply to:

(a) Annuities.

(b) Credit life insurance.

(c) Group life insurance whose cost is borne in whole or in part by the individual insured's employer or by an association of which the individual insured is a member.

(d) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

(e) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-210, filed 6/25/79, effective 1/1/80.]

WAC 284-23-220 Definitions. For the purposes of this regulation, the following definitions shall apply:

(1) "Buyer's guide." A buyer's guide is a document which contains, and is limited to, the language contained in WAC 284-23-270 or language approved by the commissioner.

(2) "Cash dividend." A cash dividend is the current illustrated dividend which can be applied toward payment of the gross premium.

(3) "Equivalent level annual dividend." The equivalent level annual dividend is calculated by applying the following steps:

(a) Accumulate the annual cash dividends at five percent interest compounded annually to the end of the tenth and twentieth policy years.

(b) Divide each accumulation of step (a) by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in step (a) over the respective periods stipulated in step (a). If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(c) Divide the results of step (b) by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

(4) "Equivalent level death benefit." The equivalent level death benefit of a policy or term life insurance rider is an amount calculated as follows:

(a) Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for ten and twenty years at five percent interest compounded annually to the end of the tenth and twentieth policy years respectively.

(b) Divide each accumulation of step (a) by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step (a) over the respective periods stipulated in step (a). If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(5) "Generic name." Generic name means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

(6) "Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

(a) Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.

(b) For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at five percent interest compounded annually to the end of the period selected and add this sum to the amount determined in step (a).

(c) Divide the result of step (b) (step a. for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step (b) (step a. for guaranteed cost policies) over the respective periods stipulated in step (a). If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(d) Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at five percent interest compounded annually to the end of the period stipulated in step (a) and dividing the result by the respective factors stated in step (c). (This amount is the annual premium payable for a level premium plan.)

(e) Subtract the result of step (c) from step (d).

(f) Divide the result of step (e) by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

(7) "Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

(8) "Policy summary." For the purposes of this regulation, policy summary means a written statement describing the elements of the policy including but not limited to:

(a) A prominently placed title as follows: Statement of policy cost and benefit information.

(b) The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

(c) The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

(d) The generic name of the basic policy and each rider.

(e) The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from sixty through sixty-five or maturity whichever is earlier:

(i) The annual premium for the basic policy.

(ii) The annual premium for each optional rider.

(iii) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(iv) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(v) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(vi) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. (If the policy loan interest rate is variable, the policy summary shall include the maximum annual percentage rate.)

(g) Life insurance surrender cost and life insurance net payment cost indexes for ten and twenty years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor basic policies or optional riders covering more than one life.

(h) The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

(i) A policy summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed in addition to a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

(j) A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended

use of these indexes is provided in the life insurance buyer's guide.

(k) The date on which the policy summary is prepared.

The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in item (e) of this section shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-220, filed 6/25/79, effective 1/1/80.]

WAC 284-23-230 Disclosure requirements. (1) The insurer shall provide, to all prospective purchasers, a buyer's guide and a policy summary prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least ten days or unless the policy summary contains such an unconditional refund offer, in which event the buyer's guide and policy summary must be delivered with the policy or prior to delivery of the policy. (RCW 48.23.380, requiring a 10-day free examination of policy, must be complied with.)

(2) The insurer shall provide a buyer's guide and a policy summary to any prospective purchaser upon request.

(3) In the case of policies whose equivalent level death benefit does not exceed \$5,000, the requirement for providing a policy summary will be satisfied by delivery of a written statement containing the information described in WAC 284-23-220 (8)(b), (c), (d), (e)(i), (ii) and (iii), (f), (g), (j) and (k).

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-230, filed 6/25/79, effective 1/1/80.]

WAC 284-23-240 General rules. (1) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(2) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales

situations in which an agent is not involved, the insurer shall identify its full name.

(3) Terms such as financial planner, investment advisor, financial consultant or financial counseling shall not be used by an agent unless he is generally engaged in an advisory business and receives a material part of his compensation from that source unrelated to the sale of insurance.

(4) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(5) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(6) A presentation of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are shown separately in close proximity thereto.

(7) A statement regarding the use of the life insurance cost indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(8) A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the company's current dividend scale and is not guaranteed.

(9) For the purposes of this regulation, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-240, filed 6/25/79, effective 1/1/80.]

WAC 284-23-250 Failure to comply. Failure of an insurer to provide or deliver a buyer's guide, or a policy summary as provided in WAC 284-23-230 shall constitute an unfair method of competition and an unfair act or practice, pursuant to RCW 48.30.010.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-250, filed 6/25/79, effective 1/1/80.]

WAC 284-23-260 Effective date. This regulation, WAC 284-23-200 through 284-23-270, shall apply to all solicitations of life insurance which commence on or after January 1, 1980.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-260, filed 6/25/79, effective 1/1/80.]

WAC 284-23-270 Life insurance buyer's guide, form to be used.

(The face page of the buyer's guide shall read as follows:)

Life insurance buyer's guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)
(Month and year of printing)

(The buyer's guide shall contain the following language at the bottom of page 2:)

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this guide in making a life insurance purchase.

This guide does not endorse any company or policy.

(The remaining text of the buyer's guide shall begin on page 3 as follows:)

Buying life insurance

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the right kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

- (1) Term insurance
- (2) Whole life insurance
- (3) Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term insurance

Term insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some terms insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole life insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the

kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment insurance

An endowment insurance policy pays a sum or income to you—the policyholder—if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than for the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a low cost policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. Look for policies with low cost index numbers.

What is cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What are cost indexes?

In order to compare the cost of policies, you need to look at:

- (1) Premiums
- (2) Cash values

(3) Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

- (1) **Life insurance surrender cost index.** This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
- (2) **Life insurance net payment cost index.** This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

* * *

There is another number called the equivalent level annual dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's equivalent level annual dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How do I use cost indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- (1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
- (2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a

"Shopper's guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

- (3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- (4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.
- (5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

Important things to remember - A summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare surrender cost indexes and net payment cost indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. Remember, look for policies with lower cost index numbers. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-270, filed 6/25/79, effective 1/1/80.]

WAC 284-23-300 Background. This regulation, WAC 284-23-300 through 284-23-380, is based upon

the model Annuity and Deposit Fund Disclosure Regulation adopted by the National Association of Insurance Commissioners on June 16, 1978.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-300, filed 6/25/79, effective 4/1/80.]

WAC 284-23-310 Purpose. (1) The purpose of this regulation is to require insurers to deliver to prospects for annuity contracts, or for deposit funds accepted in conjunction with life insurance policies or annuity contracts, information which helps the prospect select an annuity or deposit fund, or both, appropriate to the prospect's needs, improves the prospect's understanding of the basic features of the plan under consideration and improves the prospect's ability to evaluate the relative benefits of similar plans.

(2) This regulation does not prohibit the use of additional material which is not in violation of this regulation or any other statute or regulation.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-310, filed 6/25/79, effective 4/1/80.]

WAC 284-23-320 Scope. (1) To the extent hereinafter provided, this regulation shall apply to any solicitation, negotiation or procurement of annuity contracts, or deposit funds accepted in conjunction with individual life insurance policies or with annuity contracts which are subject to this regulation, occurring within this state. The regulation shall apply to any issuer of life policies or annuity contracts, including fraternal mutual life insurers.

(2) This regulation shall apply to:

(a) Individual deferred annuities other than: (i) Variable annuities; (ii) investment annuities; and (iii) contracts registered with the Federal Securities and Exchange Commission.

(b) Deposit funds (i.e., arrangements under which amounts to accumulate at interest are paid in addition to life insurance premiums or annuity considerations under provisions of individual life insurance policies or annuity contracts).

(3) This regulation shall not apply to:

(a) Group annuity contracts whose cost is borne in whole or in part by the annuitant's employer or by an association of which the annuitant is a member. The cost of a contract shall not be deemed to be borne by an annuitant's employer to the extent the annuitant's salary is reduced or the annuitant foregoes a salary increase.

(b) Immediate annuity contracts.

(c) Policies or contracts issued in connection with employee benefit plans as defined by Section 3(3) of the Federal Employee Retirement Income Security Act of 1974 (ERISA) as amended from time to time.

(d) A single advance payment of specific premiums equal to the discounted value of such premiums.

(e) A policyholder's deposit account established primarily to facilitate payment of regular premiums and where the anticipated balance of such account does not exceed twice the sum of the premiums payable in one

year on all policies for which premiums are being paid from such account.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-320, filed 6/25/79, effective 4/1/80.]

WAC 284-23-330 Contract summary, contents. For the purposes of this regulation, contract summary means a written statement describing the elements of the annuity contract and deposit fund, including but not limited to:

(1) A prominently placed title as follows: Statement of benefit information. (This shall be followed by an identification of the annuity contract or deposit fund, or both, to which the statement applies.)

(2) The name and address of the insurance agent or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the contract summary.

(3) The full name and home office or administrative office address of the insurer which will issue the annuity contract or administer the deposit fund.

(4) The death benefits for the deposit fund, and for the annuity contract during the deferred period, and the form of the annuity payout. In the case where a choice of annuity payout form is provided, this item shall show the payout options guaranteed and the form of annuity payout selected for subsections (6), (7) and (9) of this section.

(5) A prominent statement that the contract does not provide cash surrender values if such is the case.

(6) The amount of the guaranteed annuity payments at the scheduled commencement of the annuity, based on the assumption that all scheduled considerations are paid and there are no prior withdrawals from or partial surrenders of the contract and no indebtedness to the insurer on the contract.

(7) On the same basis as for subsection (6) except for guarantees, illustrative annuity payments not greater in amount than those based on first, the current dividend scale and the interest rate currently used to accumulate dividends under such contracts, or the current excess interest rate credited by the insurer, and second, the current annuity purchase rates. A dividend scale or excess interest rate which has been publicly declared by the insurer with an effective date not more than two months subsequent to the date of declaration shall be considered a current dividend scale or current excess interest rate.

(8) For annuity contracts or deposit funds for which guaranteed cash surrender values at any duration are less than the total considerations paid, a prominent statement that such contractor fund may result in loss if kept for only a few years, together with a reference to the schedule of guaranteed cash surrender values required by subsection (9)(c) of this section.

(9) The following amounts, where applicable, for the first five contract years and representative contract years thereafter sufficient to clearly illustrate the patterns of considerations and benefits, including but not limited to the tenth and twentieth contract years and at least one

age from sixty through sixty-five or the scheduled commencement of annuity payments, if any, whichever is earlier:

(a) The gross annual or single consideration for the annuity contract.

(b) Scheduled annual or single deposit for the deposit fund, if any.

(c) The total guaranteed cash surrender value at the end of the year, or, if no guaranteed cash surrender values are provided, the total guaranteed paid-up annuity at the end of the year. Values for a deposit fund must be shown separately from those for a basic contract.

(d) The total illustrative cash values or paid-up annuity at the end of the year, not greater in amount than that based on first, the current dividend scale and the interest rate currently used to accumulate dividends under such contracts or the current excess interest rate credited by the insurer, and second, the current annuity purchase rates. A dividend scale or excess interest rate which has been publicly declared by the insurer with an effective date not more than two months subsequent to the date of declaration shall be considered a current dividend scale or current excess interest rate.

(10) For a contract summary which includes values based on the current dividend scale or the current dividend accumulation or excess interest rate, a statement that such values are illustrations and are not guaranteed.

(11) The date on which the contract summary is prepared.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-330, filed 6/25/79, effective 4/1/80.]

WAC 284-23-340 Contract summary, requirements.

The contract summary must be a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more contract years may be represented by a single number if it is clearly indicated what amounts are applicable for each contract year. Amounts in WAC 284-23-330 (4), (6), (7) and (9) shall, in the case of flexible premium annuity contracts, be determined either according to an anticipated pattern of consideration payments or on the assumption that considerations payable will be \$1,000 per year. If not specified in the contract, annuity payments shall be assumed to commence at age 65 or 10 years from issue, whichever is later. Zero amounts shall be displayed as zero and shall not be displayed as blank spaces.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-340, filed 6/25/79, effective 4/1/80.]

WAC 284-23-350 Disclosure requirements. (1) The insurer shall provide to all prospective purchasers a contract summary prior to accepting the applicant's initial consideration for the annuity contract, or in the case of a deposit fund, prior to acceptance of the applicant's initial consideration for the associated life insurance policy

or annuity contract, unless the annuity contract or associated life insurance policy for which application is made provides for an unconditional refund period of at least ten days or unless the contract summary contains such an unconditional refund offer, in which event the contract summary must be delivered with or prior to the delivery of the annuity contract or associated life insurance policy.

(2) The insurer shall provide a contract summary to any prospective purchaser upon request.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-350, filed 6/25/79, effective 4/1/80.]

WAC 284-23-360 General rules. (1) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of at least three years following the date of its last authorized use.

(2) An agent shall inform the prospective purchaser, prior to commencing a sales presentation, that the agent is acting as a life insurance agent and shall inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(3) Terms such as financial planner, investment advisor, financial consultant, or financial counseling shall not be used by an agent unless he is generally engaged in an advisory business and receives a material part of his compensation from that source unrelated to the sale of insurance.

(4) Any reference to dividends or to excess interest credits must include a statement that such dividends or credits are not guaranteed.

(5) A presentation of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless guaranteed benefits are shown separately in close proximity thereto and with equal prominence.

(6) Sales promotion literature and contract forms shall not state or imply that annuity contracts or deposit funds are the same as savings accounts or deposits in banking or savings institutions. The use of passbooks which resemble savings bank passbooks is prohibited.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-360, filed 6/25/79, effective 4/1/80.]

WAC 284-23-370 Failure to comply. Failure of an insurer to provide or deliver a contract summary as provided in WAC 284-23-350 shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an annuity contract or of an insurance policy, and shall constitute an unfair method of competition and an unfair act or practice pursuant to RCW 48.30-.010.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-370, filed 6/25/79, effective 4/1/80.]

WAC 284-23-380 Effective date. This regulation, WAC 284-23-300 through 284-23-380, shall apply to all solicitations which commence on or after April 1, 1980.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-380, filed 6/25/79, effective 4/1/80.]

WAC 284-23-400 Purpose. The purpose of this regulation is:

(1) To regulate the activities of insurers and agents with respect to the replacement of existing life insurance;

(2) To protect the interests of life insurance policyowners by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of existing life insurance by:

(a) Assuring that the policyowner receives information with which a decision can be made in his or her own best interest;

(b) Reducing the opportunity for misrepresentation and incomplete disclosures; and

(c) Establishing penalties for failure to comply with the requirements of this regulation.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-400, filed 5/2/80, effective 10/1/80.]

WAC 284-23-410 Definition of replacement. "Replacement" means any transaction in which new life insurance is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance has been or is to be:

(1) Lapsed, forfeited, surrendered, or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding twenty-five percent of the loan value set forth in the policy.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-410, filed 5/2/80, effective 10/1/80.]

WAC 284-23-420 Other definitions. (1) "Cash dividend" means the current illustrated dividend which can be applied toward payment of the gross premium.

(2) "Conservation" means any attempt by the existing insurer or its agent to continue existing life insurance in force when the existing insurer has received a comparative information form as required by WAC 284-23-450 (3)(d) of this regulation from a replacing insurer. A

conservation effort does not include such routine administrative procedures as late payment reminders, late payment offers or reinstatement offers.

(3) "Direct-response sales" means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy.

(4) "Existing insurer" means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of "replacement."

(5) "Existing life insurance" means any life insurance in force including life insurance under a binding or conditional receipt or a life insurance policy that is within an unconditional refund period, but excluding life insurance obtained through the exercise of a dividend option.

(6) "Generic name" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

(7) "Replacing insurer" means the insurance company that issues a new policy which is a replacement of existing life insurance.

(8) "Sales proposal" means individualized, written sales aids of all kinds, excluding comparative information forms and policy summaries, which are used by an insurer, agent or broker in comparing existing life insurance to proposed life insurance in order to recommend the replacement or conservation of existing life insurance. Sales aids of a generally descriptive nature, which are maintained in the insurer's advertising compliance file, shall not be considered a sales proposal within the meaning of this definition.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-420, filed 5/2/80, effective 10/1/80.]

WAC 284-23-430 Exemptions. Unless otherwise specifically included, this regulation shall not apply to:

- (1) Annuities;
- (2) Individual credit life insurance;
- (3) Group life insurance, group credit life insurance, and life insurance policies issued in connection with a pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;
- (4) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account;
- (5) An application to the existing insurer that issued the existing life insurance when a contractual change or conversion privilege is being exercised;
- (6) Existing life insurance that is nonconvertible term life insurance policy which will expire in five years or less and cannot be renewed;
- (7) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company; or
- (8) Situations exempted by the commissioner after written request and a showing that the application of this regulation would not be appropriate under the circumstances.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-430, filed 5/2/80, effective 10/1/80.]

WAC 284-23-440 Duties of agents. (1) Each agent shall submit to the replacing insurer with or as part of each application for life insurance:

- (a) A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and
- (b) A signed statement as to whether or not the agent knows replacement is or may be involved in the transaction.

(2) Where a replacement is involved, the agent shall:

(a) Present to the applicant, not later than at the time of taking the application, a "Notice regarding replacement of life insurance" in the form as described in WAC 284-23-500 and 284-23-510 whichever is applicable, or other substantially similar form approved by the commissioner. The notice must be signed by and left with applicant.

(b) Present to the applicant, not later than at the time of taking the application, a comparative information form as described in WAC 284-23-530. (Substantially equivalent forms may be used with the prior approval of the commissioner.) If more than one existing life insurance policy is to be replaced, a separate comparative information form is to be provided for each such policy or separate information is to be provided in the comparative information form for each such policy, and a summary of all the separate policy information to the extent possible must be included. The agent must include in the comparative information form all of the information required to be in that form, except that information concerning the existing life insurance policy that cannot be obtained from that policy itself. The comparative information form must be signed by the agent and the applicant and a copy left with the applicant.

(c) Leave with the applicant the original or a copy of all sales proposals used for presentation to the applicant.

(d) Submit to the replacing insurer with the application, a copy of the "Notice regarding replacement of life insurance" signed by the applicant, a copy of the comparative information form signed by the agent and the applicant, and a copy of all sales proposals used for presentation to the applicant.

(3) Each agent who uses a sales proposal when conserving existing life insurance shall:

- (a) Leave with the applicant the original or a copy of all sales proposals used in the conservation effort; and
- (b) Submit to the existing insurer a copy of all sales proposals used in the conservation effort.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-440, filed 5/2/80, effective 10/1/80.]

WAC 284-23-450 Duties of replacing insurers. Each replacing insurer shall:

- (1) Inform its field representatives of the requirements of this regulation.
- (2) Require with or as part of each completed application for life insurance:

(a) A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and

(b) A statement signed by the agent as to whether or not he or she knows replacement is or may be involved in the transaction.

(3) Where a replacement is involved:

(a) Require from the agent with the application for life insurance a copy of the "Notice regarding replacement of life insurance" signed by the applicant, a copy of the comparative information form signed by the agent and the applicant, and a copy of all sales proposals used for presentation to the applicant.

(b) Verify the substantial accuracy of information concerning the proposed policy furnished to the applicant in the comparative information form. If the information concerning that policy is not substantially accurate, the replacing insurer must obtain a comparative information form signed by the agent and the applicant which includes substantially accurate information before it can begin to process the application for the proposed policy.

(c) Unless otherwise modified by the provisions of WAC 284-23-450 (3)(e) or (f), furnish to the applicant a policy summary in accordance with the provisions of the life insurance solicitation regulation.

(d) Send to the existing insurer a verified comparative information form as required by WAC 284-23-450 (3)(a) and (b) within three working days of the date the application and a substantially accurate comparative information form are received at its home or regional office, or the date its policy is issued, whichever is sooner.

(e) Delay, if it is not also the existing insurer, the issue of its policy for twenty days after it sends the existing insurer a copy of the policy summary, unless it provides in its "Notice regarding replacement of life insurance" and in either its policy or in a separate written notice that is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of twenty days commencing from the date of delivery of the policy, and it sends the policy summary required by this section to the existing insurer within three working days of the date its policy is issued, in which event the replacing insurer may issue its policy immediately.

(f) Provide, if it is also the existing insurer, the policyowner a policy summary for the new policy prepared in accordance with WAC 284-23-450 (3)(c), prior to accepting the applicant's initial premium or premium deposit, unless the replacing insurer provides in its "Notice regarding replacement of life insurance" and in either its policy or in a separate written notice that is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of twenty days commencing from the date of delivery of the policy, in which event, the replacing insurer must furnish the policy summary at or prior to delivery of the policy.

(g) Maintain copies of the "Notice regarding replacement of life insurance," the verified comparative information form, the policy summary, and all sales proposals

used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced, for at least three years or until the conclusion of the next succeeding regular examination by the insurance department of its state or domicile, whichever is later.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-450, filed 5/2/80, effective 10/1/80.]

WAC 284-23-460 Duties of insurers with respect to direct-response sales. Each insurer shall:

(1) Inform its responsible personnel of the requirements of this regulation.

(2) Require with or as part of each completed application for life insurance a statement signed by the applicant as to whether or not insurance will replace existing life insurance.

(3) Where no replacement is proposed by an insurer in the solicitation of a direct-response sale and a replacement is involved:

At the time the policy is mailed to the applicant, include a "Notice regarding replacement of life insurance" in a form substantially as described in WAC 284-23-520.

(4) Where a replacement is proposed by an insurer in the solicitation of a direct-response sale and a replacement is involved:

(a) Request from the applicant with or as part of the application a list of all existing life insurance to be replaced. Such existing life insurance shall be identified by name of insurer.

(b) If the applicant furnishes the names of the existing insurers, then the replacing direct-response insurer shall mail the applicant a "Notice regarding replacement of life insurance" in a form substantially as described in WAC 284-23-520 within three working days after receipt of the application and shall comply with all of the provisions of WAC 284-23-450 (3)(e), (f) and (g), except that it need not meet the requirements of this regulation concerning comparative information forms and need not maintain a replacement register required by WAC 284-23-450 (3)(g).

(c) If the applicant does not furnish the names of the existing insurers, then the replacing direct-response insurer shall at the time the policy is mailed to the applicant, include a "Notice regarding replacement of life insurance" in a form substantially as described in WAC 284-23-520.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-460, filed 5/2/80, effective 10/1/80.]

WAC 284-23-470 Duties of the existing insurer. Each existing insurer shall inform its responsible personnel of the requirements of this regulation. Each existing insurer, or such insurer's agent, that undertakes a conservation effort shall:

(1) Within twenty days from the date the comparative information form required by WAC 284-23-450 (3)(d) is received, either furnish the policyowner with the comparative information form received from the replacing insurer and include in it all of the information concerning the existing life insurance that was not completed

and correct any information that was inaccurately completed by the replacing agent, or furnish the policyowner with a policy summary for the existing life insurance. Such policy summary shall be completed in accordance with the provisions of the life insurance solicitation regulation, except that information relating to premiums, cash values, death benefits and dividends, if any, shall be computed from the current policy year of the existing life insurance. The policy summary shall include the amount of any outstanding policy indebtedness, the sum of any dividend accumulations or additions, and may include any other information that is not in violation of any regulation or statute. Life insurance cost index and equivalent level annual dividend figures need not be included in the policy summary. If index figures are included in the policy summary, the policyowner must receive written notification at the time the policy summary is delivered that such figures should only be used for comparing the relative costs of similar policies.

(2) Furnish the replacing insurer with a copy of the fully completed comparative information form or the policy summary for the existing life insurance within three working days of the date that the fully completed comparative information form or the policy summary is sent by the existing insurer to either its agent or directly to the policyowner.

(3) Maintain a file containing the following:

(a) comparative information forms required by WAC 284-23-450 (3)(d) and policy summaries required by WAC 284-23-450 (3)(e) received from replacing insurers; and

(b) Copies of fully completed comparative information forms or policy summaries prepared pursuant to WAC 284-23-470(1), and all sales proposals used to conserve the existing life insurance.

This material shall be indexed by replacing insurer and held for three years or until the conclusion of the next regular examination conducted by the insurance department of its domicile, whichever is later.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-470, filed 5/2/80, effective 10/1/80.]

WAC 284-23-480 Penalties. (1) Any insurer, agent, representative, officer or employee of such insurer failing to comply with the requirements of this regulation shall be subject to such penalties as may be appropriate under the insurance laws of Washington.

(2) This regulation does not prohibit the use of additional material other than that which is required that is not in violation of this regulation or any other Washington statute or regulation.

(3) Policyowners have the right to replace existing life insurance after indicating in or as part of the applications for life insurance that such is not their intention; however, patterns of such action by policyowners who purchase the replacing policies from the same agent shall be deemed prima facie evidence of the agent's knowledge that replacement was intended in connection with the sale of those policies, and such patterns of action shall be deemed prima facie evidence of the agent's intent to violate this regulation.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-480, filed 5/2/80, effective 10/1/80.]

WAC 284-23-490 Effective date, supersedes prior regulation. This regulation, WAC 284-23-400 through 284-23-530, is effective October 1, 1980, and shall supersede the "revised replacement regulation," WAC 284-30-100 through 284-30-200, as of that date.

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-490, filed 5/2/80, effective 10/1/80.]

WAC 284-23-500 Form to be used where the existing and proposed policies are written by different companies.

(Name, address and telephone number
of the insurance company)

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

Our agent is recommending to you that you purchase a life insurance policy from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing policy issued by another insurance company or that you may obtain a loan from that company against your policy to pay premiums on the proposed policy. Any of these actions is a replacement of life insurance. This notice must be given to you, along with a form including preliminary information comparing the proposed policy with your existing policy to be replaced. Please read this notice and the comparative information form carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a policy summary including complete information on the proposed policy no later than when that policy is delivered to you. In addition, we are required to notify the insurance company that issued your existing policy. That company may then furnish you with additional information concerning your existing policy. You may want to contact that company or its agent for further information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have received your application and notified the other insurance company you will have twenty days from the date the proposed policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

* * * * *

(Alternate paragraph if 20-day money-back guarantee is not provided.)

We are required by state regulation to delay the issuance of the policy for which you are making application for twenty days from the date on which we send your existing insurer notification that their policy will be replaced.

* * * * *

CAUTION

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

I have received and read a copy of this replacement notice.

(Signed) _____ Date _____

[Statutory Authority: RCW 48.02.060, 80-05-098 (Order R 80-5), § 284-23-500, filed 5/2/80, effective 10/1/80.]

WAC 284-23-510 Form to be used where the existing and proposed policies are written by the same company.

(Name, address and telephone number of the insurance company)

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

Our agent is recommending that you purchase a life insurance policy from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing policy issued by our company or that you may obtain a loan from our company against your existing policy to pay premiums on the proposed policy. Any of these actions is a replacement of life insurance. This notice must be given to you, along with a comparative information form which includes preliminary information comparing the proposed policy with your existing policy to be replaced. Please read this notice and the comparative information form carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a policy summary including complete information on the proposed policy no later than when the policy is delivered to you. In addition, we will, at your request, furnish you additional information concerning your existing policy. You may want to discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which our company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life.

Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

* * * * *

(Additional paragraph if twenty-day money-back guarantee is provided.)

After we have issued your policy, you will have twenty days from the date the new policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

* * * * *

CAUTION

If, after studying the information made available to you, you do decide to replace the existing life insurance with our company with a new life insurance policy issued by our company, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

I have received and read a copy of this replacement notice.

(Signed) _____ Date _____

[Statutory Authority: RCW 48.02.060, 80-05-098 (Order R 80-5), § 284-23-510, filed 5/2/80, effective 10/1/80.]

WAC 284-23-520 Form to be used regarding replacement in a direct-response sale.

(Name, address and telephone number of the insurance company)

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You have indicated that you intend to replace an existing life insurance policy or policies in connection with the purchase of our life insurance policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features

of the proposed policy and your existing insurance coverage.

You may want to contact your existing life insurance company or its agent for additional information and advice or discuss your purchase with other advisors. The information you receive should be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could (contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or)* deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

* * * * *

(Additional paragraph if direct-response insurer's solicitation proposes replacement, and a twenty-day money-back guarantee is provided by the insurer.)

After we have issued your policy, you will have twenty days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

* * * * *

CAUTION

You are urged not to take action to terminate or alter your existing life insurance coverage until you have been issued the new policy, examined it and have found it acceptable to you.

*Use bracketed language only when the application asks health questions.

[Statutory Authority: RCW 48.02.060, 80-05-098 (Order R 80-5), § 284-23-520, filed 5/2/80, effective 10/1/80.]

WAC 284-23-530 Form for comparative information.

(Name, address and telephone number of insurance company)

Comparative Information Form

Name of Proposed Insured _____ Address _____ Date of Birth _____

<u>GENERAL INFORMATION</u>	<u>EXISTING LIFE INSURANCE</u>	<u>PROPOSED LIFE INSURANCE</u>
Name of Company	_____	_____
Policy Number	_____	_____
Basic Policy Generic Name	_____	_____
Name of Basic Policy	_____	_____
Rider 1; Generic Name	_____	_____
Rider 2; Generic Name	_____	_____
Rider 3; Generic Name	_____	_____
Issue Age	_____	_____
Date of Issue	_____	_____
Contestable Period Expires	_____	_____
Suicide Clause Expires	_____	_____

<u>PREMIUM DATA/DEATH BENEFITS</u>	<u>PREMIUM MODE: AMOUNT</u>	<u>AGE PAYABLE TO</u>	<u>AGE DEATH BENEFIT</u>	<u>AGE BENEFIT CEASES</u>	<u>PREMIUM MODE: AMOUNT</u>	<u>AGE PAYABLE TO</u>	<u>AGE DEATH BENEFIT</u>	<u>AGE BENEFIT CEASES</u>
Basic Policy	\$		\$		\$		\$	
Rider 1	\$		\$		\$		\$	
Rider 2	\$		\$		\$		\$	
Rider 3	\$		\$		\$		\$	
Accidental Death Benefit	\$		\$		\$		\$	
Option to Purchase Additional Insurance	\$		\$	(Option Ages: _____)	\$		\$	(Option Ages: _____)
Waiver of Premium Benefit	\$		\$xxx		\$		\$xxx	
Disability Income Benefit	\$		\$xxx	(Monthly Income: _____)	\$		\$xxx	(Monthly Income: _____)
Total Current Premium	\$		\$		\$		\$	

<u>CASH VALUES/DIVIDENDS</u>	<u>*GUARANTEED CASH VALUE</u>	<u>*DIVIDENDS</u>	<u>*GUARANTEED CASH VALUE</u>	<u>*DIVIDENDS</u>
Currently (last policy anniversary)	\$	\$	\$	\$
1 year hence	\$	\$	\$	\$
5 years hence	\$	\$	\$	\$
10 years hence	\$	\$	\$	\$
At Age 65	\$	\$	\$	\$

- * Current Death Benefit of Div. Adds \$
- * Current Cash Value of Div. Adds \$
- * Current Accum. Div. \$
- * Current Policy Loan \$

Maximum Policy Loan Interest Rate _____%

Maximum Policy Loan Interest Rate _____%

* Dividends are based on the current (19____) scale.

* Dividends are based on the current (19____) scale.

* Dividends, policy loan and certain guaranteed cash value information concerning your existing insurance may not be known to our agent. Dividends are not guaranteed. However, they may materially reduce the cost of insurance and are an important factor to consider. Thus, if dividends or other figures have been omitted from this Comparative Information Form, you should not reach a final decision to replace your existing insurance until you have them. You may obtain the omitted figures from the company that issued your existing policy. We will notify that company of your intent to replace your existing policy.

AGENT'S STATEMENT

1. The primary reasons for my recommending the proposed replacement of existing life insurance by new life insurance are:*

2. My recommendations as to the existing insurance is that it be:

- Not Changed --Lapsed --Surrendered
--Reduced Paid-Up --Extended Term

Other (Explain) -----

Borrowed Upon (Explain and state the amount to be borrowed) -----

3. The existing life insurance does not meet the insured/buyer's needs for insurance because:*

*Specific reasons must be given. For example, if you believe the existing life insurance cannot meet the insured/buyer's needs, you must specify why you think it does not.

INSTRUCTION NOTES FOR AGENT

- 1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, alternative identification information such as an application or receipt number must be shown.
2. If the premium for the basic policy or any rider or benefit changes, indicate the changes; attach schedule, if necessary.
3. If the death benefit for the basic policy or any rider or benefit changes, indicate the changes; attach schedules, if necessary.
4. If the premium for benefits is not separable from the premium for the basic policy, insert "Included" in Basic Policy Premium.
5. If more than one existing life insurance policy is to be replaced, a separate comparative information form is to be provided for each such policy, or separate information is to be provided in one comparative information form for each such policy, and a summary of all the separate policy information must also be included to the extent possible.

AGENT'S CERTIFICATION

I hereby certify that prior to taking an application for a policy, I have provided the applicant with the Notice Regarding Replacement of Life Insurance and that the information in this comparative information form is true and correct to the best of my knowledge and belief.

(Signature of Agent) (Date)

I have received and read a copy of this comparative information form.

(Signature of Applicant) (Date)

[Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-530, filed 5/2/80, effective 10/1/80.]

Chapter 284-24 WAC
RATES

Table with 2 columns: WAC and description. Includes entries for 284-24-015 (Statistical plans), 284-24-060 (Modification of filing requirements), 284-24-070 (Suspension of filing requirements), 284-24-080 (Rate filings), and 284-24-100 (Standards for schedule rating plans).

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

Table with 2 columns: WAC and description. Lists dispositions for various WAC sections including 284-24-010, 284-24-020, 284-24-030, 284-24-035, 284-24-040, and 284-24-050.

WAC 284-24-015 Statistical plans and designation of statistical agents. Pursuant to the provisions of RCW 48.19.370, the insurance commissioner has adopted the following statistical plans for the recording and reporting of loss and expense experience, and hereby designates the particular organizations, or their successors, as statistical agents to assist the commissioner in the gathering and compilation of experience for the classes of business stated.

(1) The statistical plans of the insurance services of-
fice with respect to the following kinds of insurance:

- (a) Fire and allied lines,
- (b) Automobile physical damage,
- (c) Automobile liability,
- (d) General liability,
- (e) Burglary,
- (f) Glass,
- (g) Boiler and machinery,
- (h) Inland marine,
- (i) Homeowners, comprehensive dwelling and dwelling
policy program,
- (j) Commercial multiperil,
- (k) Businessowners, and
- (l) Medical professional liability.

(2) The statistical plans of the National Association
of Independent Insurers with respect to:

- (a) Burglary,
- (b) Businessowners,
- (c) Crop hail,
- (d) Farmowners,
- (e) Fidelity and surety,
- (f) Fire and allied lines,
- (g) General liability,
- (h) Glass,
- (i) Inland marine,
- (j) Malpractice and professional liability,
- (k) Personal lines (homeowners and dwelling fire),
- (l) Special multiperil,
- (m) Automobile liability, and
- (n) Automobile physical damage.

(3) The statistical plans of the American Association
of Insurance Services with respect to:

- (a) Homeowners,
- (b) Farmowners,
- (c) Mobile homeowners,
- (d) Inland marine,
- (e) Farm fire,
- (f) Dwelling fire,
- (g) Commercial fire,
- (h) General liability,
- (i) Burglary,
- (j) Glass,
- (k) Special multiperil,
- (l) Manufacturers output, and
- (m) Businessowners.

(4) The statistical plan of the Surety Association of
America with respect to fidelity, surety and forgery.

(5) The statistical plan of the Crop-Hail Insurance
Actuarial Association with respect to hail insurance on
growing crops and windstorm (when accompanied by
hail) insurance on growing crops.

(6) The statistical plan of the Factory Mutual Service
Bureau with respect to property insurance.

(7) The statistical plan of the Mill and Elevator Rat-
ing Bureau with respect to property insurance.

(8) The statistical plan of the Nuclear Insurance Rat-
ing Bureau with respect to nuclear physical damage
insurance.

Experience filed by individual carriers is to be kept
confidential by these statistical agents and only the con-
solidated experience will be available as public informa-
tion.

[Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), §
284-24-015, filed 3/1/82.]

**WAC 284-24-060 Modification of filing require-
ments.** (1) Pursuant to RCW 48.19.080, the commis-
sioner rules and hereby orders that the rate filing
requirements set forth in chapter 48.19 RCW are modi-
fied so that:

(a) No filings with respect to rates pertaining to sur-
plus line coverages placed in this state pursuant to chap-
ter 48.15 RCW need be made, hereby confirming the
longstanding practice in this state; and

(b) An insurer, having made its rates for commercial
insurance in full compliance with the requirements of
such chapter, may use its rates immediately upon filing
with the commissioner, provided the change in rates as
the result of the filing neither exceeds ten percent for
any single policy nor results in a change exceeding ten
percent when all filings applying to any single policy are
combined for the preceding twelve months.

(2) For purposes of this section, the following defini-
tions apply:

(a) "Commercial insurance" means insurance for
business or nonprofit interests which is not for personal,
family, or household purposes.

(b) "Filing" means the submission of rates or rating
plans to be used by an insurer when issuing policies. A
filing, as used in this section, must include:

(i) Supporting actuarial data in sufficient detail to
justify any rate level changes and statistically demon-
strate the differences and/or correlations relevant to
rating plan definitions and rate differentials; and

(ii) An exhibit comparing the proposed rates to the
previous rates stated in percentages. This exhibit must
show the date the preceding rates were submitted to the
commissioner.

(c) "Rate" means a monetary amount applied to the
units of exposure. It includes:

(i) Classification, which means the individual rating
group in which a particular risk is placed for underwrit-
ing purposes; and

(ii) Relativities, increased limit factors, territory as-
signments, or any other rating factors applied to a base
rate when calculating a premium. With respect to pack-
age policies, the insurer need only consider the package
modification factors.

[Statutory Authority: RCW 48.02.060 (3)(e). 86-24-043 (Order R
86-7), § 284-24-060, filed 11/26/86. Statutory Authority: RCW 48-
.02.060. 82-06-036 (Order R 82-1), § 284-24-060, filed 3/1/82.]

**WAC 284-24-070 Suspension of filing require-
ments—"A" rating.** (1) Pursuant to RCW 48.19.080,
the commissioner rules and hereby orders that the casu-
alty insurance rate filing requirements set forth in chap-
ter 48.19 RCW are suspended as to classes of policies:

(a) Covering risks in a class, which risks are so different from each other that no single manual rate could be representative of all,

(b) Covering risks of a classification that does not develop enough experience to warrant any creditability for ratemaking purposes, or

(c) Covering risks that involve a new product or coverage as to which there is no appropriate analogy to similar exposures for ratemaking purposes.

(2) A rate filing for such classes of policies shall consist only of a notation, in an appropriate rate manual, of the symbol "(a)" following the description of the risk, which symbol shall indicate that the risk cannot practicably be filed with the commissioner and that such risk shall be submitted to the insurer for rating.

(3) The insurer's rating of such a risk shall be based on a documented underwriting analysis of:

(a) Specific definable loss potential characteristics,

(b) Analogy to similar exposures, and

(c) Available loss frequency and severity data.

(4) Examples of appropriate "(a)" rated risks include but are not limited to:

(a) Manufacturing and construction risks, such as:

(i) Ammunition manufacturing,

(ii) Dam construction,

(iii) Irrigation works operation, and

(iv) Logging railroad—operation and maintenance.

(b) Owners, landlord and tenants risks, such as:

(i) Amusement devices, designed for small children only, not otherwise classified (NOC),

(ii) Christmas tree lots—open air,

(iii) Bleachers or grandstands,

(iv) Dude ranches,

(v) Firing ranges—indoor,

(vi) Parks or playgrounds, and

(vii) Zoos.

(c) Product risks, such as:

(i) Aircraft or aircraft parts manufacturing,

(ii) Ball or roller bearing manufacturing,

(iii) Chemical manufacturing—household—NOC,

(iv) Discontinued operations—products,

(v) Electronic component manufacturing,

(vi) Firearms manufacturing—over .50 caliber

(vii) Instrument manufacturing—NOC,

(viii) Levee construction,

(ix) Machinery or machinery parts manufacturing,

(x) Pharmaceutical or surgical goods manufacturing,

(xi) Products—NOC,

(xii) Sign manufacturing—NOC,

(xiii) Tank manufacturing—metal—not pressurized,

(xiv) Textile coating or impregnating,

(xv) Tool manufacturing—hand type—powered,

(xvi) Valves manufacturing,

(xvii) Wheels manufacturing,

(xviii) Wire goods manufacturing—NOC, and

(xix) Wood products manufacturing—NOC.

(5) Insurers writing "(a)" rated risks" shall maintain separate documentation, including loss experience, on each risk written and shall be prepared to provide such documentation to the insurance commissioner upon request.

[Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-070, filed 3/1/82.]

WAC 284-24-080 Rate filings required for certain inland marine risks. RCW 48.19.030 and 48.19.070 recognize that certain inland marine risks are by general custom of the business not written according to manual rates or rating plans. The following inland marine classes of risks are, however, by general custom of the business written according to manual rates or rating plans, and, therefore, manual rates or rating plans applicable to the following such risks shall be filed with the commissioner and may be used only after approval except as otherwise permitted by WAC 284-24-060 (1)(b):

(1) Accounts receivable and valuable papers and records,

(2) Agricultural machinery, farm equipment and livestock floaters,

(3) Bicycle floater,

(4) Cameras,

(5) Camera and musical instrument dealers,

(6) Equipment dealers,

(7) Hardware and implement dealers floater,

(8) Implement dealers stock floater,

(9) Fine arts (private collections),

(10) First class mail,

(11) Floor plan,

(12) Furriers' block,

(13) Furriers' customers,

(14) Garment contractors,

(15) Golfer's equipment floater,

(16) Musical instruments,

(17) Negative film floater,

(18) Neon signs,

(19) Personal articles floater,

(20) Personal effects,

(21) Personal furs or fur floater,

(22) Personal jewelry or jewelry floater,

(23) Personal property floater,

(24) Physicians' and surgeons' equipment floater,

(25) Registered mail,

(26) Silverware floater,

(27) Stamp and coin collection floater,

(28) Theatrical floater,

(29) Tourist baggage,

(30) Travel baggage (issued in combination with accident and sickness insurance),

(31) Wedding presents, and

(32) Boatowners' and/or boats under twenty-seven feet in length.

[Statutory Authority: RCW 48.02.060 (3)(e). 86-24-043 (Order R 86-7), § 284-24-080, filed 11/26/86. Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-080, filed 3/1/82.]

WAC 284-24-100 Standards for schedule rating plans, noncomplying filings ineffective. Pursuant to RCW 48.19.120, and to effectuate the provisions of RCW 48.19.030, the commissioner finds that existing schedule rating plans permit excessive credits or debits, commonly resulting in discrimination against insureds or inadequate premiums, and, for that reason, fail to meet the

requirements of chapter 48.19 RCW. Therefore, no filing of a schedule rating plan shall be effective or accepted after January 1, 1986, unless it meets the following standards:

(1) A plan shall apply only to those classes of insurance (monoline or packaged) commonly known as commercial vehicle, commercial general casualty, commercial inland marine, and commercial property.

(2) A plan shall provide for no more than a twenty-five percent credit (reduction) or debit (charge), excluding any expense adjustment permitted by a lawfully filed and approved expense adjustment plan.

(3) A plan must provide for an objective analysis by the insurer of the risk and be based on specific factual information supporting the rating. Items such as the following may be considered:

(a) Management capacity for loss control and risk improvement, including financial and operating performance.

(b) Condition and upkeep of premises and equipment.

(c) Location of risk and suitability of occupancy.

(d) Quality of fire and police protection.

(e) Employee training, selection, supervision, or similar elements.

(f) Type of equipment.

(g) Safety programming.

(h) Construction features and maintenance.

(i) Classification variances, including differences from average hazards.

(4) A plan must provide that when a risk is rated below average (debited), an insured or applicant, upon timely request, will be advised by the insurer of the factors which resulted in the adverse rating so that the insured or applicant will be fairly apprised of any corrective action that might be appropriate with respect to the insurance risk.

(5) A plan shall be administered equitably and applied fairly to every eligible risk which an insurer elects to insure. Records supporting the development of individual risk modifications shall be retained by the insurer for a minimum of three years or until the conclusion of the next regular examination conducted by the insurance department of its domicile, whichever is later, and made available at all reasonable times for the commissioner's examination. Such records must include copies of all documentation used in making each particular determination, even though a credit or debit may not result.

[Statutory Authority: RCW 48.02.060, 85-23-031 (Order R 85-4), § 284-24-100, filed 11/14/85.]

Chapter 284-26 WAC

INSIDER TRADING OF EQUITY SECURITIES OF A DOMESTIC STOCK INSURANCE COMPANY

WAC

284-26-010	Definition of certain terms.
284-26-020	Transactions exempted from the operation of RCW 48.08.120.
284-26-030	Filing of statements.
284-26-040	Ownership of more than ten percent of an equity security.

284-26-050	Disclaimer of beneficial ownership.
284-26-060	Exemptions from RCW 48.08.110 and 48.08.120.
284-26-070	Exemption from the act of securities purchased or sold by odd-lot dealers.
284-26-080	Certain transactions subject to RCW 48.08.110.
284-26-090	Ownership of securities held in trust.
284-26-100	Exemption for small transactions.
284-26-110	Exemption from RCW 48.08.120 of transactions which need not be reported under RCW 48.08.110.
284-26-120	Exemption from RCW 48.08.120 of certain transactions effected in connection with a distribution.
284-26-130	Exemption from RCW 48.08.120 of acquisitions of shares of stock and stock options under certain stock bonus, stock option or similar plans.
284-26-140	Exemption from RCW 48.08.120 of certain transactions in which securities are received by redeeming other securities.
284-26-150	Exemption of long term profits incident to sales within six months of the exercise of an option.
284-26-160	Exemption from RCW 48.08.120 of certain acquisitions and dispositions of securities pursuant to merger or consolidations.
284-26-170	Exemption from RCW 48.08.120 of transactions involving the deposit or withdrawal of equity securities under a voting trust or deposit agreement.
284-26-180	Exemption from RCW 48.08.120 of certain transactions involving the conversion of equity securities.
284-26-190	Exemption from RCW 48.08.120 of certain transactions involving the sale of subscription rights.
284-26-200	Exemption of certain securities from RCW 48.08.130.
284-26-210	Exemption from RCW 48.08.130 of certain transactions effected in connection with a distribution.
284-26-220	Exemption from RCW 48.08.130 of sales of securities to be acquired.
284-26-230	Arbitrage transactions under RCW 48.08.150.

WAC 284-26-010 Definition of certain terms. (1) "Insurer" means any domestic stock insurance company with an equity security subject to the provisions of sections 6 through 13, chapter 70, Laws of 1965 ex. sess., codified as RCW 48.08.100 through 48.08.170, and not exempt thereunder.

(2) "Act" means sections 6 through 13, chapter 70, Laws of 1965 ex. sess., codified as RCW 48.08.100 through 48.08.170.

(3) "Officer" means a president, vice-president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

(4) "Equity security" means any stock or similar security; or any voting trust certificate or certificate of deposit for such a security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right.

(5) Securities "held of record."

(a) For the purpose of determining whether the equity securities of an insurer are held of record by one hundred or more persons, securities shall be deemed to be "held of record" by each person who is identified as the owner of such securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

(i) In any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as such an owner on such records if they had been

maintained in accordance with accepted practice shall be included as a holder of record.

(ii) Securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person.

(iii) Securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person.

(iv) Securities held by two or more persons as co-owners shall be included as held by one person.

(v) Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if such securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of persons.

(vi) Securities registered in substantially similar names where the insurer has reason to believe because of the address or other indications that such names represent the same person, may be included as held of record by one person.

(b) Notwithstanding subsection (a) of this section:

(i) Securities held, to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in such securities; provided however, that the insurer may rely in good faith on such information as is received in response to its request from a nonaffiliated insurer of the certificates or evidences of interest.

(ii) If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the act, the beneficial owners of such securities shall be deemed to be the record owners thereof.

(iii) "Class" means all securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges.

[Order R-69-3, § 284-26-010, filed 2/7/69.]

WAC 284-26-020 Transactions exempted from the operation of RCW 48.08.120. Any acquisition or disposition of any equity security by a director or officer of an insurer within six months prior to the date on which the act shall first become applicable with respect to the equity securities of such insurer shall not be subject to the operation of RCW 48.08.120.

[Order R-69-3, § 284-26-020, filed 2/7/69.]

WAC 284-26-030 Filing of statements. Initial statements of beneficial ownership of equity securities required by RCW 48.08.110 shall be filed on Form S, to be obtained from the commissioner. Statements of changes in such beneficial ownership required by RCW 48.08.110 shall be filed on Form 4, to be obtained from the commissioner. All such statements shall be prepared

and filed in accordance with the requirements of the applicable form.

[Order R-69-3, § 284-26-030, filed 2/7/69.]

WAC 284-26-040 Ownership of more than ten percent of an equity security. In determining for the purpose of RCW 48.08.110 whether a person is the beneficial owner, directly or indirectly, of more than ten percent of any class of equity securities, such person shall be deemed to be the beneficial owner of securities of such class which such person has the right to acquire through the exercise of presently exercisable options, warrants or rights or through the conversion of presently convertible securities. The securities subject to such options, warrants, rights or conversion privileges held by a person shall be deemed to be outstanding for the purpose of computing, in accordance with WAC 284-26-030, the percentage of outstanding securities of the class owned by such person but shall not be deemed outstanding for the purpose of computing the percentage of the class owned by any other person. This paragraph shall not be construed to relieve any person of any duty to comply with RCW 48.08.110 with respect to any equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject as a class to that section of the act.

[Order R-69-3, § 284-26-040, filed 2/7/69.]

WAC 284-26-050 Disclaimer of beneficial ownership. Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that such person is, for the purpose of the act, the beneficial owner of any equity securities covered by the statement.

[Order R-69-3, § 284-26-050, filed 2/7/69.]

WAC 284-26-060 Exemptions from RCW 48.08.110 and 48.08.120. (1) During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from RCW 48.08.110 and 48.08.120:

(a) Executors or administrators of the estate of a decedent;

(b) Guardians or committees for an incompetent; and

(c) Receivers, trustees in bankruptcy, assignees for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

(2) After the twelve-month period following their appointment or qualification the foregoing persons shall be required to file reports with respect to the securities held by the estates which they administer under RCW 48.08.110 and shall be liable for profits realized from trading in such securities pursuant to RCW 48.08.120 only when the estate being administered is a beneficial owner of more than ten per cent of any class of equity security of an insurer subject to the act.

(3) Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt

from RCW 48.08.110 and 48.08.120 during the time they are held by the insurer.

[Order R-69-3, § 284-26-060, filed 2/7/69.]

WAC 284-26-070 Exemption from the act of securities purchased or sold by odd-lot dealers. Securities purchased or sold by an odd-lot dealer (1) in odd lots so far as reasonably necessary to carry on odd-lot transactions or (2) in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from the provisions of the act with respect to participation by such odd-lot dealer in such transactions.

[Order R-69-3, § 284-26-070, filed 2/7/69.]

WAC 284-26-080 Certain transactions subject to RCW 48.08.110. The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed such a change in the beneficial ownership of the security to which such privilege relates as to require the filing of a statement reflecting the acquisition or disposition of such privilege. Nothing in this section, however, shall exempt any person from filing the statements required upon the exercise of such option, put, call, spread or straddle.

[Order R-69-3, § 284-26-080, filed 2/7/69.]

WAC 284-26-090 Ownership of securities held in trust. (1) Beneficial ownership of a security for the purpose of RCW 48.08.110 shall include:

(a) The ownership of securities as a trustee where either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust,

(b) The ownership of a vested beneficial interest in a trust, and

(c) The ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(2) Except as provided in subsection (3) hereof, a beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of RCW 48.08.110 where less than twenty percent in market value of the securities having a readily ascertainable market value held by such trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from RCW 48.08.110 with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of such securities by the trust is made without prior approval by the settlor or beneficiary. No exemption pursuant to this subsection shall, however, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of RCW 48.08.110.

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(3) In the event that ten percent of any class of any equity security of an insurer is held in a trust, that trust and the trustees thereof as such shall be deemed a person required to file the reports specified in RCW 48.08.110.

(4) Not more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or ten percent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or ten per cent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file any such report so long as he relies in good faith upon an understanding that the trustee of such trust will file whatever reports might otherwise be required of such beneficiary.

(5) As used in this section the "immediate family" of a trustee means:

(a) A son or daughter of the trustee, or a descendant of either,

(b) A stepson or stepdaughter of the trustee,

(c) The father or mother of the trustee, or an ancestor of either,

(d) A stepfather or stepmother of the trustee,

(e) A spouse of the trustee.

For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of such person by blood.

(6) In determining, for the purposes of RCW 48.08.110 whether a person is the beneficial owner, directly or indirectly, of more than ten percent of any class of any equity security, the interest of such person in the remainder of a trust shall be excluded from the computation.

(7) No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under RCW 48.08.110 with respect to his indirect interest in portfolio securities held by:

(a) A pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan,

(b) A business trust with over 25 beneficiaries.

(8) Nothing in this section shall be deemed to impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date.

[Order R-69-3, § 284-26-090, filed 2/7/69.]

WAC 284-26-100 Exemption for small transactions. (1) Any acquisition of securities shall be exempt from RCW 48.08.110 where:

(a) The person effecting the acquisition does not within six months thereafter effect any disposition, otherwise than by way of gift, or securities of the same class, and

(b) The person effecting such acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of \$3,000 for any six months' period during which the acquisition occurs.

(2) Any acquisition or disposition of securities by way of gift where the total amount of such gifts does not exceed \$3,000 in market value for any six months' period, shall be exempt from RCW 48.08.110 and may be excluded from the computations prescribed in subdivision (1)(b).

(3) Any person exempted by subsection (1) or (2) of this section shall include in the first report filed by him after a transaction within the exemption a statement showing his acquisitions and dispositions for each six months' period or portion thereof which has elapsed since his last filing.

[Order R-69-3, § 284-26-100, filed 2/7/69.]

WAC 284-26-110 Exemption from RCW 48.08.120 of transactions which need not be reported under RCW 48.08.110. Any transaction which has been or shall be exempted from the requirements of RCW 48.08.110 of the act shall, insofar as it is otherwise subject to the provisions of RCW 48.08.120 be likewise exempted from RCW 48.08.120.

[Order R-69-3, § 284-26-110, filed 2/7/69.]

WAC 284-26-120 Exemption from RCW 48.08.120 of certain transactions effected in connection with a distribution. (1) Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of RCW 48.08.120, to the extent specified in this section as not comprehended within the purpose of RCW 48.08.120, upon the following conditions:

(a) The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of such business, in the distribution of such block of securities;

(b) The security involved in the transaction is (i) a part of such block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of such block of securities or (ii) a security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over-allotment or other short position created in connection with such distribution; and

(c) Other persons not within the purview of RCW 48.08.120 are participating in the distribution of such block of securities on terms at least as favorable as those on which such person is participating and to an extent as least equal to the aggregate participation of all persons exempted from the provisions of RCW 48.08.120 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

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(2) The exemption of a transaction pursuant to this section with respect to the participation therein of one party thereto shall not render such transaction exempt with respect to participation of any other party therein unless such other party also meets the conditions of this section.

[Order R-69-3, § 284-26-120, filed 2/7/69.]

WAC 284-26-130 Exemption from RCW 48.08.120 of acquisitions of shares of stock and stock options under certain stock bonus, stock option or similar plans. Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of RCW 48.08.120 if the plan meets the following conditions:

(1) The plan has been approved, directly or indirectly, (a) by the affirmative votes of the holders of a majority of the securities of such insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the state of Washington, or (b) by the written consent of the holders of a majority of the securities of such insurer entitled to vote: provided, however, that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the National Association of Insurance Commissioners, if any, in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of (i) the date the act first applies to such insurer, or (ii) the acquisition of an equity security for which exemption is claimed. Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with, or mailed for filing to, the commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this paragraph, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(2) If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified,

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restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as follows:

(a) With respect to the participation of directors—

(i) By the board of directors of the insurer, a majority of which board and a majority of the directors action in the matter are disinterested persons;

(ii) By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

(iii) Otherwise in accordance with the plan, if the plan (a) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or (b) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

(b) With respect to the participation of officers who are not directors—

(i) By the board of directors of the insurer or a committee of three or more directors; or

(ii) By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to set in the matter, all of the members of which committee are disinterested persons.

For the purpose of this paragraph, a director or committee member shall be deemed to be a disinterested person only if such person is not at the time such discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(c) The provisions of this section shall not apply with respect to any option granted, or other equity security acquired, prior to the date that RCW 48.08.110, 48.08.120, and 48.08.130 first become applicable with respect to any class of equity securities of any insurer.

(3) As to each participant or as to all participants the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination

date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

(4) Unless the context otherwise requires, all terms used in this section shall have the same meaning as in the act and in WAC 284-26-110. In addition, the following definitions apply:

(a) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

(b) The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in section 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this section, provided however, that for the purposes of this section an option which meets all of the conditions of that section, other than the date of issuance shall be deemed to be a "restricted stock option."

(c) The term "exercise of an option, warrant or right" contained in the parenthetical clause of the first paragraph of this section shall not include (i) the making of any election to receive under any plan an award of compensation in the form of stock or credits therefore, provided, that such election is made prior to the making of the award; and provided further that such election is irrevocable until at least six months after termination of employment; (ii) the subsequent crediting of such stock; (iii) the making of any election as to a time for delivery of such stock after termination of employment, provided that such election is made at least six months prior to any such delivery; (iv) the fulfillment of any condition to the absolute right to receive such stock; or (v) the acceptance of certificates for shares of such stock.

[Order R-69-3, § 284-26-130, filed 2/7/69.]

WAC 284-26-140 Exemption from RCW 48.08.120 of certain transactions in which securities are received by redeeming other securities. Any acquisition of an equity security (other than [than] a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of RCW 48.08.120 upon condition that:

(1) The equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets other than cash (or government bonds) consist of securities of the insurer issuing the equity security so acquired, and which

(a) Represented substantially and in practical effect a stated or readily ascertainable amount of such equity security,

(b) Had a value which was substantially determined by the value of such equity security, and

(c) Conferred upon the holder the right to receive such equity security without the payment of any consideration other than the security redeemed;

(2) No security of the same class as the security redeemed was acquired by the director or officer within six months prior to such redemption or is acquired within six months after such redemption;

(3) The insurer issuing the equity security acquired has recognized the applicability of subsection (1) of this section by appropriate corporate action.

[Order R-69-3, § 284-26-140, filed 2/7/69.]

WAC 284-26-150 Exemption of long term profits incident to sales within six months of the exercise of an option. (1) To the extent specified in subsection (2) of this section, the commissioner hereby exempts as not comprehended within the purposes of RCW 48.08.120 any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where such purchase is pursuant to the exercise of an option or similar right either (a) acquired more than six months before its exercise, or (b) acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

(2) In respect of transactions specified in subsection (1) the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in this section shall be deemed to enlarge the amount of profit which would inure to such insurer in the absence of this section.

(3) The commissioner also hereby exempts, as not comprehended within the purposes of RCW 48.08.120 the disposition of a security, purchased in a transaction specified in subsection (1) of this section, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in section 368(c) of the Internal Revenue Code of 1954, of a person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

(4) The exemptions proved by this section shall not apply to any transaction made unlawful by RCW 48.08.130 or by any rules and regulations thereunder.

(5) The burden of establishing market price of a security for the purpose of this section shall rest upon the person claiming the exemption.

[Order R-69-3, § 284-26-150, filed 2/7/69.]

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WAC 284-26-160 Exemption from RCW 48.08.120 of certain acquisitions and dispositions of securities pursuant to merger or consolidations. (1) The following transactions shall be exempt from the provisions of RCW 48.08.120 as not comprehended within the purpose of said section:

(a) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(b) The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(c) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by reference to their most recent available financial statements for a twelve-month period prior to the merger or consolidation;

(d) The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a twelve-month period prior to the merger or consolidation.

(2) A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

(3) Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by this section) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by this section) of a security in any other company involved in the merger or consolidation within any period of less than six months during which the merger or consolidation took place, the exemption provided by this section shall be unavailable to such officer, director, or stockholder to the extent of such purchase and sale.

[Order R-69-3, § 284-26-160, filed 2/7/69.]

WAC 284-26-170 Exemption from RCW 48.08.120 of transactions involving the deposit or withdrawal of equity securities under a voting trust or deposit agreement.

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Any acquisition or disposition of an equity security involved in the deposit of such security under, or the withdrawal of such security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing such security, shall be exempt from the operation of RCW 48.08.120 if substantially all of the assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal, as the case may be, consisted of equity securities of the same class as the security deposited or withdrawn: provided, however, that this section shall not apply to the extent that there shall have been either:

(1) A purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class, or

(2) A sale of an equity security of the class deposited and purchase of any certificate representing an equity security of such class (otherwise than in a transaction involved in such deposit or withdrawal or in a transaction exempted by any other provision of chapter 284-26 WAC within a period of less than six months which includes the date of the deposit or withdrawal.

(3) The surrender and issuance are made pursuant to provisions of a certificate of incorporation which require that the shares issued upon such surrender shall be registered upon issuance in the name of a person or persons other than the holder of the shares surrendered and may be required to be issued as of right only in connection with the public offering, sale and distribution of such shares and the immediate sale by such holder of such shares for that purpose, or in connection with a gift of such shares.

(4) Neither the shares so surrendered nor any shares of the same class, nor other shares of the same class as those issued upon such surrender, have been or are purchased (otherwise than in a transaction exempted by this section), by the person surrendering such shares, within six months before or after such surrender or issuance.

[Order R-69-3, § 284-26-170, filed 2/7/69.]

WAC 284-26-180 Exemption from RCW 48.08.120 of certain transactions involving the conversion of equity securities. (1) Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of RCW 48.08.120: *Provided, however,* That this section shall not apply to the extent that there shall have been either (a) a purchase of any equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion, or (b) a sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion (otherwise than in a transaction involved in such conversion or in a transaction exempted by any other provision of chapter 284-26 WAC)

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within a period of less than six months which includes the date of conversion.

(2) For the purpose of this section, an equity security shall not be deemed to be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with such conversion, of cash or other property (other than equity securities involved in the conversion) equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

(3) For the purpose of this section, an equity security shall be deemed convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of the security or the governing instruments.

[Order R-69-3, § 284-26-180, filed 2/7/69.]

WAC 284-26-190 Exemption from RCW 48.08.120 of certain transactions involving the sale of subscription rights. (1) Any sale of a subscription right to acquire any subject security of the same insurer shall be exempt from the provisions of RCW 48.08.120, to the extent prescribed in this section, as not comprehended with the purpose of RCW 48.08.120, if:

(a) Such subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(b) Such subscription right by its terms expires within 45 days after the issuance thereof;

(c) Such subscription right by its terms is issued on a pro rata basis to all holders of the beneficiary security of the insurer; and

(d) A registration statement under the Securities Act of 1933 is in effect as to each subject security, or the applicable terms of any exemption from such registration have been met in respect to each subject security.

(2) When used within this section the following terms shall have the meaning indicated:

(a) The term "subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security;

(b) The term "beneficiary security" means a security registered pursuant to section 12 of the Securities Exchange Act, to the holders of which a subscription right is granted;

(c) The term "subject security" means a security which is the subject of a subscription right.

(3) Notwithstanding anything contained herein to the contrary, if a person purchases subscription rights for cash or other consideration, then a sale by such person of subscription rights otherwise exempted by this section will not be so exempted to the extent of such purchases within the six-month period preceding or following such sale.

[Order R-69-3, § 284-26-190, filed 2/7/69.]

WAC 284-26-200 Exemption of certain securities from RCW 48.08.130. Any security shall be exempt from the operation of RCW 48.08.130 to the extent necessary to render lawful under RCW 48.08.130 the

execution by a broker of an order for an account in which he has no direct or indirect interest.

[Order R-69-3, § 284-26-200, filed 2/7/69.]

WAC 284-26-210 Exemption from RCW 48.08.130 of certain transactions effected in connection with a distribution. Any security shall be exempt from the operation of RCW 48.08.130 to the extent necessary to render lawful under such section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

(1) The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting-dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

(2) Other persons not within the purview of RCW 48.08.130 are participating in the distribution of such block of securities on terms at least as favorable as those on which such dealer is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of RCW 48.08.130 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

[Order R-69-3, § 284-26-210, filed 2/7/69.]

WAC 284-26-220 Exemption from RCW 48.08.130 of sales of securities to be acquired. (1) Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of RCW 48.08.130 provided that:

(a) The sale is made subject to the same conditions as those attaching to the right of acquisition, and

(b) Such person exercises reasonable diligence to deliver such security to the purchaser promptly after his right of acquisition matures, and

(c) Such person reports the sale on the appropriate form for reporting transactions by persons subject to RCW 48.08.110.

(2) This section shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when-issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition.

[Order R-69-3, § 284-26-220, filed 2/7/69.]

(1986 Ed.)

WAC 284-26-230 Arbitrage transactions under RCW 48.08.150. It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of such insurer, unless he shall include such transaction in the statements required by RCW 48.08.110 and shall account to such insurer for the profits arising from such transaction, as provided in RCW 48.08.120. The provisions of RCW 48.08.130 shall not apply to such arbitrage transactions. The provisions of the act shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than such director or officer of the insurer.

[Order R-69-3, § 284-26-230, filed 2/7/69.]

Chapter 284-28 WAC

PROXIES, CONSENTS, AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

WAC

284-28-001	Promulgation.
284-28-010	Application of regulation.
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284-28-030	Disclosure of equivalent information.
284-28-040	Definitions.
284-28-050	Information to be furnished to stockholders.
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284-28-090	Prohibition of certain solicitations.
284-28-100	Special provisions applicable to election contests.
284-28-110	Effective date.

WAC 284-28-001 Promulgation. Whereas, subsection (7), section 5, chapter 70, Laws of 1965 ex. sess. provides:

"The commissioner shall have authority to make and promulgate rules and regulations for the effectuation of this section, and in so doing shall give due consideration to rules and regulations promulgated for similar purposes by the insurance supervisory officials of other states." and,

Whereas, pursuant to RCW 34.04.020(3) a rule-making hearing was held on the fifteenth day of September, 1965, at the hour of 1:30 p.m. in the Office of the Insurance Commissioner, Insurance Building, Olympia, Washington, to receive views as to whether the above-entitled regulation should be adopted,

Now, therefore, I hereby make the following findings:

(1) On June 8, 1964, the Congress of the United States enacted the Securities Act Amendments of 1964 (Public Law 88-467) which exempts securities issued by an insurance company from the application of the federal requirement of regulation by, and periodic filings with, the Securities Exchange Commission provided that the following conditions are met:

"(I) . . .

(II) Such insurance company is subject to regulation by its domiciliary State of proxies, consents, or authorizations in respect of securities issued by such company and such regulation conforms to that prescribed by the National Association of Insurance Commissioners.

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"(III) . . .".

(2) The above-entitled regulation substantially conforms to the proposals regarding proxies, consents and authorizations of domestic stock insurers as prescribed and promulgated by the National Association of Insurance Commissioners on the third day of December, 1964.

(3) The above-entitled regulation reasonably effectuates section 5, chapter 70, Laws of 1965 ex. sess., by making the regulation of domestic stock insurers with respect to proxies, consents and authorizations complete when applied in conjunction with section 5, chapter 70, Laws of 1965 ex. sess.

Now, therefore, being fully informed, I hereby adopt the following order and regulation upon the foregoing findings and pursuant to subsection (7), section 5, chapter 70, Laws of 1965 ex. sess.

[Order R-69-2, § 284-28-001, filed 2/5/69; Regulation 246, filed 9/24/65, effective 11/1/65.]

WAC 284-28-010 Application of regulation. This regulation is applicable to each domestic stock insurer which has any class of equity security held of record by one hundred or more persons; provided, however, that this regulation shall not apply to any insurer if ninety-five percent or more of its equity securities are owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than five hundred persons. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and the applicable regulations promulgated thereunder, shall be exempt from the provisions of this regulation with respect to any class of securities subject to SEC jurisdiction.

[Order R-69-2, § 284-28-010, filed 2/5/69; Regulation 246, § 1, filed 9/24/65, effective 11/1/65.]

WAC 284-28-020 Proxies, consents, and authorizations. No domestic stock insurer, or any director, officer or employee of such insurer subject to WAC 284-28-010, or any other person, shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent or authorization in respect of any class of equity security of such insurer held of record by one hundred or more persons in contravention of this regulation and Schedules A and B hereto annexed and hereby made a part of this regulation.

[Order R-69-2, § 284-28-020, filed 2/5/69; Regulation 246, § 2, filed 9/24/65, effective 11/1/65.]

WAC 284-28-030 Disclosure of equivalent information. Unless proxies, consents or authorizations in respect of any class of equity security of a domestic insurer subject to WAC 284-28-010 are solicited by or on behalf of the management of such insurer from the holders of record of such security prior to any annual or other meeting of such security holders, such insurer shall, in accordance with this regulation and such further regulations as the commissioner may adopt, file

with the commissioner and transmit to all security holders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made. Such insurer shall transmit a written information statement containing the information specified in WAC 284-28-050(4) to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited on behalf of the management of the insurer provided, that in the case of a class of securities in unregistered or bearer form such statement need be transmitted only to those security holders whose names and addresses are known to the insurer.

[Order R-69-2, § 284-28-030, filed 2/5/69; Regulation 246, § 3, filed 9/24/65, effective 11/1/65.]

WAC 284-28-040 Definitions. (1) The definitions and instructions set out in Schedule SIS of the insurer's annual statement required to be filed pursuant to RCW 48.05.250, shall be applicable for purposes of this regulation.

(2) The terms "solicit" and "solicitation" for purposes of this regulation shall include:

(a) Any request for a proxy, whether or not accompanied by or included in a form of proxy; or

(b) Any request to execute or not to execute, or to revoke, a proxy; or

(c) The furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(3) The terms "solicit" and "solicitation" shall not include:

(a) Any solicitation by a person in respect of stock of which he is the beneficial owner;

(b) Action by a broker or other person in respect to stock carried in his name or in the name of his nominee in forwarding to the beneficial owner of such stock soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

(c) The furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

[Order R-69-2, § 284-28-040, filed 2/5/69; Regulation 246, § 4, filed 9/24/65, effective 11/1/65.]

WAC 284-28-050 Information to be furnished to stockholders. (1) No solicitation subject to this regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting

of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection one hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS of the insurers annual statement under the heading "financial reporting to the stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

(3) Two copies of each report sent to the stockholders pursuant to this section shall be mailed to the commissioner, not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the commissioner, pursuant to WAC 284-28-070(1), whichever date is later.

(4) If no solicitation is being made by management of the insurer with respect to any annual or other meeting, such insurer shall mail to every security holder of record at least twenty days prior to the meeting date, an information statement as required by WAC 284-28-030, containing the information called for by all of the Items of Schedule A, other than Items 1, 3, and 4 thereof, which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting. If such information statement relates to an annual meeting at which directors are to be elected, it shall be accompanied by an annual report to such security holders in the form provided in subsection 2 thereof.

[Order R-69-2, § 284-28-050, filed 2/5/69; Regulation 246, § 5, filed 9/24/65, effective 11/1/65.]

WAC 284-28-060 Requirements as to proxy, and information statement. (1) The form of proxy (a) shall indicate in boldface type whether or not the proxy is solicited on behalf of the management, (b) shall provide a specifically designated blank space for dating the proxy and (c) shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or stockholders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to subsection three hereof.

(2)(a) Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in boldface type how it is intended to vote the shares or authorization represented by the proxy in each such case.

(b) A form of proxy which provides both for elections to office and for action on other specified matters shall be prepared so as to clearly provide, by a box or otherwise, means by which the security holder may withhold authority to vote for elections to office. Any such form of proxy which is executed by the security holder in such

manner as not to withhold authority to vote for elections to office shall be deemed to grant such authority, provided the form of proxy so states in boldface type.

(3) A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

(4) No proxy shall confer authority (a) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

(5) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to subsection two hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

(6) The information included in the proxy statement or information statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements or information statements shall be clearly and legibly presented.

[Order R-69-2, § 284-28-060, filed 2/5/69; Regulation 246, § 6, filed 9/24/65, effective 11/1/65.]

WAC 284-28-070 Material required to be filed. (1) Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the commissioner at least ten days prior to the date definitive copies of such material are first sent or given to stockholders, or such shorter period prior to that date as the commissioner may authorize upon a showing of good cause therefor.

(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the commissioner at least two days (exclusive of Saturdays, Sundays of holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the commissioner may authorize upon a showing of good cause therefor.

(3) Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the commissioner not later than the date such material is first sent or given to the stockholders.

(4) Where any proxy statement, form of proxy or other material filed pursuant to these rules is amended

or revised, two of the copies shall be marked to clearly show such changes.

(5) Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

(6) Notwithstanding the provisions of subsections one and two hereof and of subsection five of WAC 284-28-100, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the commissioner as required by subsection three hereof not later than the date such material is used or published. The provisions of subsections one and two hereof and subsection five of WAC 284-28-100 shall apply, however, to any reprints or reproductions of all or any part of such material.

[Order R-69-2, § 284-28-070, filed 2/5/69; Regulation 246, § 7, filed 9/24/65, effective 11/1/65.]

WAC 284-28-080 False or misleading statements. No proxy statement, form of proxy, notice of meeting, information statement, or other communication, written or oral, subject to this regulation, shall contain any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading.

[Order R-69-2, § 284-28-080, filed 2/5/69; Regulation 246, § 8, filed 9/24/65, effective 11/1/65.]

WAC 284-28-090 Prohibition of certain solicitations. No person making a solicitation which is subject to this regulation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

[Order R-69-2, § 284-28-090, filed 2/5/69; Regulation 246, § 9, filed 9/24/65, effective 11/1/65.]

WAC 284-28-100 Special provisions applicable to election contests. (1) **Applicability.** This section shall apply to any solicitation subject to this regulation by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

(2) **Participant or participant in a solicitation.** (a) For purposes of this section the terms "participant" and "participant in a solicitation" include: (i) The insurer; (ii) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (iii) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(b) For the purposes of this section the terms "participant" and "participant in a solicitation" do not include: (i) A bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant; (ii) any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties; (iii) any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment; (iv) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or (v) any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

(3) **Filing of information required by Schedule B.** (a) No solicitation subject to this section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the commissioner may authorize upon a showing of good cause therefor, there has been filed, with the commissioner, by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Commissioner's comments have been received and complied with.

(b) Within five business days after a solicitation subject to this section is made by the management of an insurer, or such longer period as the commissioner may authorize upon a showing of good cause therefor, there shall be filed with the commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the commissioner, by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a), (b) and (c) of this subsection, additional persons become participants in a solicitation subject to this rule, there shall be filed with the commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as

the commissioner may authorize upon a showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the commissioner.

(f) Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the commissioner.

(4) **Solicitations prior to furnishing required written proxy statement.** Notwithstanding the provisions of subsection one of WAC 284-28-050, a solicitation subject to this section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Schedule A with respect to such solicitation, provided that—

(a) The statements required by subsection three hereof are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to stockholders prior to the time the written proxy statement required by subsection one of WAC 284-28-050 is furnished to such persons: *Provided, however,* That this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to stockholders.

(c) At least the information specified in paragraphs (b) and (c) of the statements required by subsection three hereof to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given stockholders at the earliest practicable date.

(5) **Solicitations prior to furnishing required written proxy statement—Filing requirements.** Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by subsection one of WAC 284-28-050 shall be filed with the commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the commissioner may authorize upon a showing of good cause therefor.

(6) **Application of this section to report.** Notwithstanding the provisions of subsections two and three of WAC 284-28-050, two copies of any portion of the report referred to in subsection two of WAC 284-28-050 which comments upon or refers to any solicitation subject to this section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the commissioner as proxy material subject to this regulation. Such portion of the report shall be filed with the commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to stockholders.

SCHEDULE A

INFORMATION REQUIRED IN PROXY STATEMENT

Item 1. **Revocability of proxy.** State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

Item 2. **Dissenters' rights of appraisal.** Outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such stockholders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

Item 3. **Persons making solicitations not subject to (WAC 284-28-100).** (1) If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action which he intends to oppose.

(2) If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

(3) If the solicitation is to be made by specially engaged employees or paid solicitors, state (i) the material features of any contract or arrangement for such solicitation and identify the parties, and (ii) the cost or anticipated cost thereof.

Item 4. **Interest of certain persons in matters to be acted upon.** Describe briefly any substantial interest, direct or indirect, by stockholdings or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

Item 5. **Stocks and principal stockholders.** (1) State, as to each class of voting stock of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

(2) Give the date as of which the record list of stockholders entitled to vote at the meeting will be determined. If the right to vote is not limited to stockholders of record on that date, indicate the conditions under which other stockholders may be entitled to vote.

(3) If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

Item 6. **Nominee and directors.** If action is to be taken with respect to the election of directors furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting:

(a) Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him, and indicate which persons are nominees for election as directors at the meeting.

(b) State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of stockholders at a meeting for which proxies were solicited under this regulation.

(c) If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

(d) State, as of the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such stocks make a statement to that effect.

Item 7. **Remuneration and other transactions with management and others.** Furnish the information reported or required in item one of Schedule SIS under the heading "Information regarding management and directors" if action is to be taken with respect to (a) the election of directors, (b) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, (c) any pension or retirement plan in which any such person will participate, or (d) the granting or extension to any such person of any options, warrants or rights to purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro-rata basis. If the solicitation is made on behalf of persons other than the management information shall be furnished only as to item one-A of the aforesaid heading of Schedule SIS.

Item 8. **Bonus, profit sharing and other remuneration plans.** If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) The amounts which would have been distributable under the plan during the last calendar year to (1) each person named in item seven of this schedule, (2) directors and officers as a group, and (3) to all other employees as a group, if the plan had been in effect.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph (b) of this item, the nature of such amendments should be specified.

Item 9. **Pension and retirement plan.** If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) State (1) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period; (2) the estimated annual payment to be made with respect to current services; and (3) the amount of such annual payments to be made for the benefit of (i) each person named in item seven of this schedule, (ii) directors and officers as a group, and (iii) employees as a group.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in sub-paragraph (b)(3) of this item, the nature of such amendments should be specified.

Item 10. **Options, warrants, or rights.** If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all stockholders on a pro-rata basis, furnish the following information:

(a) The title and amount of stock called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

(b) If known, state separately the amount of stock called for or to be called for by warrants received or to be received by the following person, naming each such person:

(1) Each person named in item seven of this schedule, and

(2) each other person who will be entitled to acquire five per cent or more of the stock called for or to be called for by such warrants.

(c) If known, state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11. Authorization or issuance of stock. 1. If action is to be taken with respect to the authorization or issuance of any stock of the insurer furnish the title, amount and description of the stock to be authorized or issued.

2. If the shares of stock are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

3. If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial statements comparable to those contained in the annual report.

Item 12. Mergers, consolidations, acquisitions and similar matters. 1. If action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

(a) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting stockholders in order to perfect such rights.

(b) The material features of the plan or agreement.

(c) The business done by the company to be acquired or whose assets are being acquired.

(d) If available, the high and low sales prices for each quarterly period within two years.

(e) The percentage of outstanding shares which must approve the transaction before it is consummated.

2. For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(a) A comparative balance sheet as of the close of the last two fiscal years.

(b) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earning per share after related taxes and cash dividends paid per share.

(c) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13. Restatement of accounts. If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information:

(a) State the nature of the restatement and the date as of which it is to be effective.

(b) Outline briefly the reasons for the restatement and for the selection of the particular effective date.

(c) State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item 14. Matters not required to be submitted. If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders,

state the nature of such matter, the reason for submitting it to a vote of stockholders and what action is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

Item 15. Amendment of charter, bylaws, or other documents. If action is to be taken with respect to any amendment of the insurer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

SCHEDULE B

INFORMATION TO BE INCLUDED IN STATES FILED BY OR ON BEHALF OF A PARTICIPANT (OTHER THAN THE INSURER) IN A PROXY SOLICITATION IN AN ELECTION CONTEST

Item 1. Insurer. State the name and address of the insurer.

Item 2. Identity and background. (a) State the following:

(1) Your name and business address.

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(b) State the following:

(1) Your residence address.

(2) Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

(c) State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

(d) State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item need not be included in the proxy statement or other proxy soliciting material.

Item 3. Interest in securities of the insurer. (a) State the amount of each class of stock of the insurer which you own beneficially, directly or indirectly.

(b) State the amount of each class of stock of the insurer which you own of record but not beneficially.

(c) State with respect to all securities of the insurer purchased or sold within the past two years, the dates on which they were purchased or sold and the amount purchased or sold on each such date.

(d) If any part of the purchase price or market value of any of the stock specified in paragraph (c) is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, so state and indicate the amount of the indebtedness as of the latest

practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

(e) State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so name the persons with whom such contracts, arrangements, or understandings exist and give the details thereof.

(f) State the amount of stock of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.

(g) State the amount of each class of stock of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

Item 4. **Further matters.** (a) Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

(b) Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

(c) State whether or not you or any of your associates have any arrangement or understanding with any person—

(1) With respect to any future employment by the insurer or its subsidiaries or affiliates; or

(2) With respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangements or understanding and state the names of the parties thereto.

Item 5. **Signature.** The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

(Date)

(Signature of participant or authorized representative)

[Order R-69-2, § 284-28-100, filed 2/5/69; Regulation 246, § 10, filed 9/24/65, effective 11/1/65.]

WAC 284-28-110 Effective date. This regulation is effective on the first day of November, 1965.

[Order R-69-2, § 284-28-110, filed 2/5/69; Regulation 246, filed 9/24/65, effective 11/1/65.]

**Chapter 284-30 WAC
TRADE PRACTICES**

WAC

- 284-30-300 Authority and purpose.
- 284-30-310 Scope.
- 284-30-320 Definitions.
- 284-30-330 Unfair methods of competition and unfair or deceptive acts or practices defined.
- 284-30-340 File and record documentation.
- 284-30-350 Misrepresentation of policy provisions.
- 284-30-360 Failure to acknowledge pertinent communications.
- 284-30-370 Standards for prompt investigation of claims.
- 284-30-380 Standards for prompt, fair and equitable settlements applicable to all insurers.
- 284-30-390 Standards for prompt, fair and equitable settlements applicable to automobile insurance.
- 284-30-400 Enforcement.
- 284-30-410 Effective date.
- 284-30-500 Unfair practices with respect to vehicle insurance.
- 284-30-550 Receipts to be given.
- 284-30-560 Applications and binders.
- 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed.
- 284-30-580 Policies to be delivered, not held by agents.
- 284-30-600 Unfair practices with respect to out of state group life and disability insurance.
- 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-30-005 Which regulation applicable. [Order R-71-1, § 284-30-005, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-010 Replacement of life insurance policies. [Order R-68-10, § 284-30-010, filed 10/25/68; Order R-68-1 (part), § 284-30-010, filed 4/23/68, effective 10/1/68.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-100 Title and explanation. [Order R-71-1, § 284-30-100, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-110 Purpose. [Order R-71-1, § 284-30-110, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-120 Replacement of life insurance defined. [Order R-71-1, § 284-30-120, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-130 Exemptions. [Order R-71-1, § 284-30-130, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-140 Duties of licensees. [Order R-71-1, § 284-30-140, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-150 Duties of insurers. [Order R-71-1, § 284-30-150, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-160 Enforcement. [Order R-71-1, § 284-30-160, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-170 Forms. [Order R-71-1, § 284-30-170, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-180 Supersedes prior regulation. [Order R-71-1, § 284-30-180, filed 6/15/71, effective 9/1/71.] Repealed

- 284-30-190 by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060. Severability. [Order R-71-1, § 284-30-190, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-200 Effective date. [Order R-71-1, § 284-30-200, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-990 Exhibit 1—Disclosure statement. [Exhibit 1 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-990), filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-991 Exhibit 2—Notice to applicants regarding replacement of life insurance. [Exhibit 2 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-991), filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

WAC 284-30-300 Authority and purpose. RCW 48.30.010 authorizes the commissioner to define methods of competition and acts and practices in the conduct of the business of insurance which are unfair or deceptive. The purpose of this regulation, WAC 284-30-300 through 284-30-410, is to define certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-300, filed 7/27/78, effective 9/1/78.]

WAC 284-30-310 Scope. This regulation applies to all insurers and to all insurance policies and insurance contracts. This regulation is not exclusive, and acts performed, whether or not specified herein, may also be deemed to be violations of specific provisions of the insurance code or other regulations.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-310, filed 7/27/78, effective 9/1/78.]

WAC 284-30-320 Definitions. When used in this regulation:

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

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

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

(4) "Insurance policy" or "insurance contract" mean any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer;

(5) "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer,

Lloyds insurer, fraternal mutual insurer, fraternal mutual life insurer, and any other legal entity engaged in the business of insurance, authorized or licensed to issue or who issues any insurance policy or insurance contract in this state. "Insurer" does not include health care service contractors, as defined in RCW 48.44.010, and health maintenance organizations, as defined in RCW 48.46.020;

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

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

(8) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-320, filed 7/27/78, effective 9/1/78.]

WAC 284-30-330 Unfair methods of competition and unfair or deceptive acts or practices defined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresenting pertinent facts or insurance policy provisions.

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

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

(4) Refusing to pay claims without conducting a reasonable investigation.

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

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

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

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

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

(10) Asserting to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept

settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

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

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

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failure to expeditiously honor drafts given in settlement of claims.

(16) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-330, filed 7/27/78, effective 9/1/78.]

WAC 284-30-340 File and record documentation. The insurer's claim files shall be subject to examination by the commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-340, filed 7/27/78, effective 9/1/78.]

WAC 284-30-350 Misrepresentation of policy provisions. (1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

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

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage

which contain language which release the insurer or its insured from its total liability.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-350, filed 7/27/78, effective 9/1/78.]

WAC 284-30-360 Failure to acknowledge pertinent communications. (1) Every insurer, upon receiving notification of a claim shall, within ten working days, or 15 working days with respect to claims arising under group insurance contracts, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) Every insurer, upon receipt of any inquiry from the office of the insurance commissioner respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(3) An appropriate reply shall be made within ten working days, or 15 working days with respect to communications arising under group insurance contracts, on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section shall constitute compliance with that subsection.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-360, filed 7/27/78, effective 9/1/78.]

WAC 284-30-370 Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time. All persons involved in the investigation of a claim shall provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-370, filed 7/27/78, effective 9/1/78.]

WAC 284-30-380 Standards for prompt, fair and equitable settlements applicable to all insurers. (1) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) and is made by any other

means than writing, an appropriate notation shall be made in the claim file of the insurer.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, within forty-five days from the date of the initial notification and no later than every thirty days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

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

(5) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

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

[Statutory Authority: RCW 48.02.060 and 48.30.010, 78-08-082 (Order R 78-3), § 284-30-380, filed 7/27/78, effective 9/1/78.]

WAC 284-30-390 Standards for prompt, fair and equitable settlements applicable to automobile insurance. The following standards apply to insurance claims relating to motorcycles and private passenger automobiles as defined in RCW 48.18.297: (1) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(a) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

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

(i) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.

(ii) One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.

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

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

(3) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop, or to obtain a temporary rental or loaner automobile.

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

(5) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be itemized and shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and shall, upon request, furnish to the claimant the names of repair shops convenient to the claimant that will satisfactorily complete the repairs for the estimated cost, having in mind, particularly, the problems associated with the repair of unibody vehicles.

(6) In first party claim situations, if an insurer elects to exercise a contract right to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(7) In any claim situation, an insurer shall make a good faith effort to honor a claimant's request for repairs to be made in a specific repair shop of the claimant's choice, and shall not arbitrarily deny such request. A denial of such a request solely because of the repair shop's hourly rate is arbitrary if such rate does not result in a higher overall cost of repairs. The insurer shall make an appropriate notation in its claim file setting forth the reason it has rejected a claimant's request.

(8) Deductions for betterment and depreciation are permitted only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and depreciation shall be limited to the lesser of an amount equal to the proportion that the expired life of the part to be repaired or replaced bears to the normal useful life of that part, or the amount which the resale value of the vehicle is increased by the repair or replacement. Calculations for betterment, depreciation, and normal useful life must be included in the insurer's claim file.

[Statutory Authority: RCW 48.02.060 (3)(a), 85-02-019 (Order R 84-8), § 284-30-390, filed 12/27/84. Statutory Authority: RCW 48.02.060 and 48.30.010, 78-08-082 (Order R 78-3), § 284-30-390, filed 7/27/78, effective 9/1/78.]

WAC 284-30-400 Enforcement. Violations of the standards imposed by WAC 284-30-330 through 284-30-390 shall be subject to the enforcement provisions set forth in RCW 48.30.010 and shall also constitute a failure to comply with a regulation pursuant to RCW 48.05.140(1).

[Statutory Authority: RCW 48.02.060 and 48.30.010, 78-08-082 (Order R 78-3), § 284-30-400, filed 7/27/78, effective 9/1/78.]

WAC 284-30-410 Effective date. This regulation, WAC 284-30-300 through 284-30-410, shall take effect September 1, 1978.

[Statutory Authority: RCW 48.02.060 and 48.30.010, 78-08-082 (Order R 78-3), § 284-30-410, filed 7/27/78, effective 9/1/78.]

WAC 284-30-500 Unfair practices with respect to vehicle insurance. (1) Beginning July 1, 1985, the following practices by any insurer with respect to every vehicle liability insurance policy applicable to private passenger automobiles registered or principally garaged in this state are unfair and prohibited:

(a) Failing to provide, to any insured under such policy, liability limits at least as great as those required by RCW 46.29.090, as measured at the effective date of the pertinent policy or its renewal;

(b) Denying or limiting liability coverage in such policy to less than the limits required by RCW 46.29.090, solely because the injured person is related to the insured by blood or marriage, as, for example, through use of so-called "family" or "household" exclusions;

(c) Denying or limiting liability coverage in such policy, with respect to injuries sustained by motorcycle passengers, to an amount below the bodily injury liability limits required by RCW 46.29.090.

(2) Beginning July 1, 1985, the following practices by any insurer, with respect to vehicle insurance policies applicable to private passenger vehicles registered or principally garaged in this state, are unfair and prohibited:

(a) Failing to provide a named insured under such policy an itemization of the premium costs for the coverages under the policy as to which there are identifiable separate premium charges. Such itemization shall be given no later than the time of delivery of a policy and with each offer to renew thereafter;

(b) Failing, except with respect to a motorcycle policy, to provide, to any named insured who so requests and pays the premium therefor, first party automobile benefits such as those in medical payments coverage or personal injury protection, on approved forms commonly used by the insurer in the state of Washington, with maximum benefit limits, as appropriate to the particular form, of at least:

(i) \$35,000 for medical and hospital benefits incurred within three years of the accident;

(ii) \$35,000 for one year's income continuation benefits, subject to a limit of the lesser of \$700 per week or eighty-five percent of the weekly income; and

(iii) \$40 per day for loss of services benefits, for at least a year.

(3) For purposes of this section, the definition of a "private passenger automobile" is that set forth in RCW 48.18.297, and includes a motorcycle except as otherwise specifically provided in this section.

[Statutory Authority: RCW 48.02.060 (3)(a), 85-02-019 (Order R 84-8), § 284-30-500, filed 12/27/84.]

WAC 284-30-550 Receipts to be given. (1) Beginning June 1, 1985, to effectuate RCW 48.17.470 and 48.17.480 and to eliminate unfair practices in accord with RCW 48.30.010, any agent, solicitor or other representative of an insurer who receives a contract payment or premium from or on behalf of an insured or applicant for homeowners', dwelling fire, private passenger automobile, motorcycle, individual life, or individual disability insurance shall deliver or mail a signed receipt therefor as promptly as possible, which should generally be no later than the next business day. Such receipt must be dated, identify the agent and the agent's address, identify the person by or for whom payment is made, state the amount received, identify the applicable insurer by its full legal name (or the premium finance company or Washington automobile insurance plan if payment is intended therefor), and identify the contract or policy including a brief description of the coverage for which payment is received.

(2) The receipt need not be an independent document but may be incorporated in an application or binder, if appropriate.

(3) For purposes of this section "life insurance" includes annuities.

(4) For purposes of this section "insurer" includes a health care service contractor and a health maintenance organization, and "disability insurance" includes their contracts and agreements.

(5) This section shall not apply to the receipt of checks or other instruments payable on their face to the insurer, premium finance company or the Washington Automobile Insurance Plan. It also shall not apply to payments (other than by cash) received by an agent after delivery of the policy for which payment is made, when the payment is pursuant to a premium financing arrangement with the agent or in response to a billing by the agent.

(6) A failure to comply with this section shall be an unfair practice pursuant to RCW 48.30.010, and a violation of a regulation pursuant to RCW 48.17.530.

(7) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-550, filed 12/27/84.]

WAC 284-30-560 Applications and binders. (1) Beginning June 1, 1985, every application form used in connection with homeowners', dwelling fire and vehicle insurance, shall contain a clear and conspicuous statement setting forth whether or not coverage has commenced.

(a) If coverage has commenced, the effective date shall be stated.

(b) If coverage has not commenced, there shall be an explanation as to the circumstances which will cause coverage to commence and the time when coverage will become effective.

(c) The statement concerning commencement of coverage shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the other contents of the application so as to be confusing, misleading or not readily evident.

(d) A copy of such application shall be delivered or mailed to the applicant promptly following its execution.

(2) Beginning June 1, 1985, every binder used pending the issuance of a policy of property, marine and transportation, vehicle and general casualty insurance, as those kinds of insurance are defined in chapter 48.11 RCW, shall be reduced to writing or printed form and delivered or mailed to the insured as promptly as possible, which should generally be no later than the next business day.

(a) Such binder must be dated, identify the insurer in which coverage is bound, briefly describe the coverage bound, state the date and time coverage is effective, and acknowledge receipt of the amount of any premium money received.

(b) Such binder may be incorporated in or be attached to the application for the insurance but must be clear and conspicuous.

(3) Binders should be replaced promptly with insurance policies. With few exceptions and then only in compliance with RCW 48.18.230(2), insurers must replace binders within ninety days of their effective date.

(4) It shall be an unfair practice and unfair competition for an insurer or agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-560, filed 12/27/84.]

WAC 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed.

(1986 Ed.)

Whenever an insurer is required by law to give the reason for its canceling, denying, or refusing to renew insurance, as, for example, pursuant to RCW 48.18.291, 48.18.292, or 48.30.320, it shall give the true and actual reason for its action in clear and simple language, so that the insured or applicant will not need to resort to additional research to understand the real reason for the action. It is not sufficient, for example, to state that an insured "does not meet the company's underwriting standards." The reason why the individual does not meet such underwriting standards is what must be given. If the actual reason relates to medical information, the insurer may make a broad reference thereto and limit specific disclosure of details to the applicant's or insured's physician.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-570, filed 12/27/84.]

WAC 284-30-580 Policies to be delivered, not held by agents. (1) RCW 48.18.260 requires that policies be delivered within a reasonable period of time after issuance. If an insurer relies upon its agents to make deliveries of its policies, the insurer, as well as the agent, is responsible for any delay resulting from the failure of the agent to act diligently.

(2) Insurance agents delivering insurance policies to insureds must make an actual physical delivery. It is not acceptable for an agent to merely obtain a receipt indicating a delivery and then to retain the policy, for safekeeping or otherwise, in the agent's possession.

(3) Agents may obtain policies from owners or insureds and hold such policies briefly for analysis or servicing, giving a receipt therefor in every instance, but shall promptly return any such policies to their owners or insureds. Agents shall not otherwise take custody of, or hold, insurance policies, whether for fee or at no charge, unless a family or legal relationship clearly justifies such conduct, as, for example, where a policy belonging to a minor child of the agent is held, or where the agent is acting as a legal guardian or a court appointed representative and holds a policy of a ward or of an estate.

(4) It shall be an unfair practice and unfair competition for an insurer or agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-580, filed 12/27/84.]

WAC 284-30-600 Unfair practices with respect to out of state group life and disability insurance. (1) Beginning April 1, 1985, pursuant to RCW 48.30.010, it shall be an unfair practice for any insurer to effect life or disability insurance coverage on persons in this state under a group policy which is delivered to a policyholder outside this state when:

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(a) With respect to disability insurance, the out of state group policy does not:

(i) Provide that claims will be processed in compliance with RCW 48.21.130 through 48.21.146,

(ii) Meet the requirements as to benefits and coverage mandated by chapter 48.21 RCW, and specifically those imposed by RCW 48.21.150 through 48.21.270, and

(iii) Meet the loss ratio standards applicable to group insurance pursuant to RCW 48.66.100 and 48.70.030 and WAC 284-60-060; and

(b) With respect to life insurance, the out of state group policy fails to comply with the provisions of RCW 48.24.100 through 48.24.260.

(2) This rule is applicable to insurance coverage provided by such group policies including those issued for trustee groups which would be eligible for group insurance pursuant to RCW 48.24.070, except it is not applicable to insurance coverage provided by group policies:

(a) Issued for a group which would be eligible for group insurance pursuant to RCW 48.24.020, 48.24.030, 48.24.035, 48.24.040, 48.24.050, and 48.24.095, unless the person insured pays all or substantially all of the cost of his or her coverage;

(b) Issued for an association group which would be eligible for group insurance pursuant to the requirements of RCW 48.24.045, if such association clearly has a genuine purpose and existence of significant value to its members independent of its status as the group policyholder and independent of its involvement in insurance on behalf of its members, and if, further, there is a realistic and demonstrable basis related to the situs of the association or the residencies of a substantial portion of its members justifying the issuance of the group policy in the other state; or

(c) Issued for a group which would be eligible for group insurance pursuant to RCW 48.24.060, 48.24.080, and 48.24.090.

(3) This rule is applicable whether the insurance coverage is offered by means of a solicitation through a sponsoring organization, through the mail or other mass communication media, or through licensed agents or brokers.

(4) It is further defined to be an unfair practice for any insurer effecting group insurance coverage in this state through policies issued out of state to fail with respect to such insurance:

(a) To comply with the requirements of this state relating to advertising and claims settlement practices; and

(b) To make available copies of any policy and certificates issued thereunder, and advertising materials used within this state, upon request of the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-018 (Order R 84-7), § 284-30-600, filed 12/27/84.]

WAC 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations. (1) Beginning August 1, 1985, pursuant to RCW 48.30.010, it shall be an unfair practice for any insurer transacting homeowners insurance to deny homeowners insurance to an applicant therefor, or to terminate any homeowners insurance policy covering a

dwelling located in this state, whether by cancellation or nonrenewal, for the principal reason that an insured under such policy is engaged in the operation of a day-care facility, pursuant to chapter 74.15 RCW, at the insured location.

(2) This rule does not prevent an insurer from excluding or limiting coverage with respect to liability or property losses arising out of business pursuits of an insured, specifically including those related to the operation of day-care facilities.

[Statutory Authority: RCW 48.02.060. 85-17-018 (Order R 85-3), § 284-30-700, filed 8/12/85.]

Chapter 284-32 WAC

PLAN OF OPERATION FOR WASHINGTON INSURANCE GUARANTY ASSOCIATION

WAC

284-32-010	Purpose.
284-32-020	Board of directors.
284-32-030	Officers of board.
284-32-040	Quorum, votes required, proxies.
284-32-050	Annual meetings.
284-32-060	Board's annual meeting.
284-32-070	Meeting after notice of insolvency.
284-32-080	Other meetings.
284-32-090	Expenses of board members.
284-32-100	Official address of association.
284-32-110	Bank accounts, borrowing power.
284-32-120	Board may levy fee.
284-32-130	Contract with servicing facility.
284-32-140	Claim settlements of \$25,000 or more.
284-32-150	Prevention of insolvencies.
284-32-160	Records, reports, audit.
284-32-170	Appeal.
284-32-180	Indemnification.
284-32-190	Conformity to statute.
284-32-200	Effective date.

WAC 284-32-010 Purpose. This plan of operation, hereinafter referred to as the plan, is adopted by the insurance commissioner, hereinafter called the commissioner, to assure the fair, reasonable, and equitable administration of the Washington Insurance Guaranty Association, pursuant to chapter 265, Laws of 1971 ex. sess., hereinafter referred to as the act.

[Emergency and Permanent Order R-71-3, § 284-32-010, filed 12/9/71.]

WAC 284-32-020 Board of directors. (1) The Washington Insurance Guaranty Association shall exercise its powers through a board of directors.

(a) The initial board of directors shall consist of six member insurers who have been appointed by the commissioner. The initial appointees, as designated by the commissioner, will serve staggered terms; two appointees shall serve until their successors are elected and qualified in 1973, two appointees shall serve until their successors are elected and qualified in 1974, and two appointees shall serve until their successors are elected and qualified in 1975.

(b) Succeeding members of the board of directors shall be elected by the member insurers. Such elections

shall be conducted in conjunction with the annual meeting of the board of directors and votes shall be cast by the member insurers on a weighted basis using the net direct premium volume for the kinds of insurance specified in section 2 of the act as the determining factor in the number of votes allowed each member insurer. Each member insurer shall be given at least one vote in electing a member to the board of directors and shall be permitted to vote by proxy. All elected members shall serve for a term of three years and may be reelected for succeeding terms.

(c) The board of directors shall appoint from among their members a nominating committee. This committee shall select nominees to succeed board members whose terms are to expire at the annual meeting. The names of the nominees shall first be certified to the commissioner and if he does not disapprove within ten days they shall then be provided to the members at least two months prior to the annual meeting. The previously elected board members shall serve until their successors have been duly elected and qualified to serve.

(d) Vacancies on the board of directors shall be filled by appointment by the commissioner. Such appointees shall serve until the next annual meeting of the board of directors at which time an election will be held as provided in subsection (b) of this section. The term of office for such newly-elected director shall be the remaining term of the replaced director.

[Emergency and Permanent Order R-71-3, § 284-32-020, filed 12/9/71.]

WAC 284-32-030 Officers of board. The board of directors shall elect a chairman and such other officers as may seem desirable from among the representatives of its members, each to serve for a period of one year or until his successor is elected and qualified.

[Emergency and Permanent Order R-71-3, § 284-32-030, filed 12/9/71.]

WAC 284-32-040 Quorum, votes required, proxies.

(1) A majority of the board shall constitute a quorum for the transaction of business and the acts of the majority of the board present at a meeting at which a quorum is present shall be the acts of the board: *Provided, however,* That an affirmative vote of five board members is required to:

- (a) Approve a contract with a servicing facility,
- (b) Levy an assessment or provide for a refund,
- (c) Borrow money.

(2) Each board member shall be entitled to one vote and shall be permitted to vote by proxy.

[Emergency and Permanent Order R-71-3, § 284-32-040, filed 12/9/71.]

WAC 284-32-050 Annual meetings. Beginning in 1973, member insurers and the board shall each hold an annual meeting at the office of the commissioner on the first Wednesday in February of each year, unless the board, upon proper notice, shall designate some other date or place.

(1986 Ed.)

[Emergency and Permanent Order R-71-3, § 284-32-050, filed 12/9/71.]

WAC 284-32-060 Board's annual meeting. At the board's annual meeting, the board shall:

(1) Review the plan and consider any amendments it may deem appropriate for adoption by a majority of the board members. Such amendments shall be effective upon written approval of the commissioner.

(2) Review each outstanding contract with servicing facilities and make any necessary corrections, improvements, or additions.

(3) Review operating expenses and covered claims' costs and determine if an assessment, or a refund of a prior assessment, would be appropriate and, if so, the amount thereof. The board shall levy any assessment or make any such refund in accordance with section 6 of the act. The board may waive collection from, or refuse refund to, a member insurer when the amount to be assessed or refunded is less than ten dollars.

(4) Review, consider and act on any other matters it may deem appropriate.

[Emergency and Permanent Order R-71-3, § 284-32-060, filed 12/9/71.]

WAC 284-32-070 Meeting after notice of insolvency. The board shall hold a meeting promptly after receiving notice from the commissioner of the insolvency of any member insurer. At such meeting or at any subsequent meeting the board shall consider and decide:

(1) Whether such insolvency meets the requirements of the act and is covered thereby.

(2) What method or methods shall be adopted to pay and discharge covered claims of the insolvent insurer. If the board decides to contract with a servicing facility, the board shall seek to secure the receiver's, liquidator's, or statutory successor's participation in such contract to assist the association in the performance of its legally-imposed duties. The association shall pursue all recoveries permitted to the insolvent insurer.

(3) What immediate action, if any, should be taken to assure the proper retention of the records of the insolvent insurer necessary to the prompt, economical handling by the association of the covered claims. In this effort, the board or a designated servicing facility shall work with the receiver, liquidator, or statutory successor and seek his approval of having the board, or a designated servicing facility, take direct physical control of that portion of the insolvent insurer's records deemed by the board to be necessary for the discharge of its duties imposed by law.

(4) What persons should be hired by the association to implement and carry out the directives of the board made pursuant to its statutorily-imposed duties.

(5) To what extent and in what manner the board shall review and contest settlements, releases, judgments, orders, decisions, verdicts, and findings to which the insolvent insurer or its insured were parties in accordance with section 6(d) and 16 of the act.

(6) What assessment, if any, should be levied or whether any refund should be made to member insurers.

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If such assessment or refund is determined to be necessary, the board shall levy such assessments in accordance with sections 6(1)(c) through 6(2)(g) of the act. As provided in WAC 284-32-060(3), the board may waive assessments or refuse refunds of amounts less than ten dollars.

(7) What steps permitted by law are deemed necessary and shall take such action as necessary to protect the association's rights against the estate of the insolvent insurer.

(8) Any other matters it may deem appropriate for the proper administration of the association.

[Emergency and Permanent Order R-71-3, § 284-32-070, filed 12/9/71.]

WAC 284-32-080 Other meetings. The board may schedule such other regular meetings as it may deem appropriate. Special meetings of the board may be called by the chairman, and shall be called at the request of any two board members. Not less than five days' written notice shall be given to each board member of the time, place, and purpose or purposes of any special meeting. Any board member not present may consent in writing to any specific action taken by the board. Any action approved by a majority of the board's members at such special meeting at which a quorum is present, including those consenting in writing, shall be as valid a board action as though authorized at a regular meeting of the board. At such meeting the board may consider and decide any matter it may deem appropriate.

[Emergency and Permanent Order R-71-3, § 284-32-080, filed 12/9/71.]

WAC 284-32-090 Expenses of board members. Members of the board shall serve without compensation; but they may be reimbursed for necessary expenses incurred by them as members of the board of directors. Such expenses shall be submitted to the board for approval and subsequent payment.

[Emergency and Permanent Order R-71-3, § 284-32-090, filed 12/9/71.]

WAC 284-32-100 Official address of association. The official address of the association shall be the Office of the Insurance Commissioner, Insurance Building, Olympia, Washington 98504.

[Emergency and Permanent Order R-71-3, § 284-32-100, filed 12/9/71.]

WAC 284-32-110 Bank accounts, borrowing power. The board may open one or more bank accounts for use in association business. Reasonable delegation of deposit and withdrawal authority to such accounts for association business may be made consistent with prudent fiscal policy. The board may borrow money from any person or organization, including a member insurer, or from an appointed servicing facility as the board may deem appropriate.

[Emergency and Permanent Order R-71-3, § 284-32-110, filed 12/9/71.]

WAC 284-32-120 Board may levy fee. The board may levy an equal annual fee not exceeding one hundred dollars per member insurer to cover the reasonable costs of administering the association. Such fee shall be credited against any assessment as provided for in section 6 of the act.

[Emergency and Permanent Order R-71-3, § 284-32-120, filed 12/9/71.]

WAC 284-32-130 Contract with servicing facility. The board may contract with one or more persons, firms, or corporations to act as servicing facilities should the board receive notice from the commissioner of the insolvency of a member insurer. The designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer. Such contract terms may include:

(1) Terms of payment to the servicing facility;
(2) Extent of authority delegated to the servicing facility.

(3) Procedures for giving the receiver, liquidator, or statutory successor timely notice, sufficient to protect the association's right of subrogation against him, of each and every covered claim not otherwise reported to him.

(4) Procedures contemplated for the handling of covered claims as defined in section 3(4) of the act. These procedures shall include the right to request from, or offer to, any person arbitration of his covered claim.

(5) Procedures for the printing or preparation of forms necessary for the proper handling of covered claims.

(6) Requirements of bond for faithful performance.

(7) Any other provisions deemed appropriate by the board of directors.

[Emergency and Permanent Order R-71-3, § 284-32-130, filed 12/9/71.]

WAC 284-32-140 Claim settlements of \$25,000 or more. The board shall review, and approve by majority vote, claim settlements to be made by the association or its agents of twenty-five thousand dollars or more.

[Emergency and Permanent Order R-71-3, § 284-32-140, filed 12/9/71.]

WAC 284-32-150 Prevention of insolvencies. In order to effectuate the purposes set forth in section 11 of the act concerning the prevention of insolvencies, the board may develop procedures for discovering and reporting any member that may be insolvent or in a financial condition hazardous to the policyholder's interests or the public interest. No such reports shall be considered public documents. The board of directors, at its annual meeting, or at any other meeting called for this purpose, may review the insurance code and regulations with a view towards making recommendations to the commissioner for the detection and prevention of insurer insolvency. The association may develop forms for reporting the history and cause of each insolvency processed and shall maintain a continuing file of such reports.

[Emergency and Permanent Order R-71-3, § 284-32-150, filed 12/9/71.]

WAC 284-32-160 Records, reports, audit. (1) A written record of the proceedings of each board meeting shall be made. The original of this record shall be retained by the chairman with copies being furnished to each board member, the commissioner, and, upon written request, any member insurer.

(2) The board shall make an annual report to the commissioner not later than March 30 of each year. Such report shall include a review of the association's activities and an accounting of its income and disbursements for the past year in a form approved by the commissioner.

(3) After the appointment of a receiver, liquidator, or statutory successor and the levy of an assessment by the association, the board shall, once every year, appoint certain of the member insurers to serve as an audit committee. The audit committee shall consist of three member insurers, at least two of which shall not have representatives on the board of directors. Such committee shall see to the proper auditing of all the books and records of the association and shall report its findings to the board and the commissioner.

[Emergency and Permanent Order R-71-3, § 284-32-160, filed 12/9/71.]

WAC 284-32-170 Appeal. Any member insurer aggrieved by an action of the association shall appeal, in writing, to the board before appealing to the commissioner. If such member insurer is aggrieved by the final action or decision of the board or if the board does not act on such complaint within thirty days, the member insurer may appeal to the commissioner, in writing, within thirty days after the action or decision of the board or the expiration of the thirty days.

[Emergency and Permanent Order R-71-3, § 284-32-170, filed 12/9/71.]

WAC 284-32-180 Indemnification. (1) Any person described in section 5 of the act shall be indemnified by the association against all expenses incurred in the defense of any action taken or not taken by him in the performance of his powers and duties under the Washington Insurance Guaranty Association Act, unless such person shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of his office. In the event of settlement before final adjudication, such indemnity shall be provided only if the association is advised by independent counsel that such person did not, in counsel's opinion, commit such a breach of duty.

(2) The expense of such indemnification shall be prorated and paid for by the member insurers in the proportion that the net direct written premiums of each member insurer for the calendar year preceding commencement of such action, suit or proceeding bears to the net direct written premiums of all member insurers for the preceding calendar year.

(1986 Ed.)

(3) This indemnification is intended to operate as a supplement and additional safeguard to, and not in place of, the immunity granted by section 15 of the act.

[Emergency and Permanent Order R-71-3, § 284-32-180, filed 12/9/71.]

WAC 284-32-190 Conformity to statute. The Washington Insurance Guaranty Association Act as written, and as may be amended, is incorporated as part of this plan.

[Emergency and Permanent Order R-71-3, § 284-32-190, filed 12/9/71.]

WAC 284-32-200 Effective date. This regulation, WAC 284-32-010 through 284-32-200, shall be effective as an emergency regulation on December 10, 1971, and shall be effective as a permanent regulation on January 10, 1972.

[Emergency and Permanent Order R-71-3, § 284-32-200, filed 12/9/71.]

Chapter 284-34 WAC

CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

WAC

284-34-010	Credit life insurance.
284-34-020	Credit accident and health insurance.
284-34-030	Collection and remittance of premiums.
284-34-040	Rate filings and deviations from prima facie rates.
284-34-050	Refunds.
284-34-060	Effective date—Implementation.
284-34-070	Prohibited transactions.

WAC 284-34-010 Credit life insurance. (1) Except as hereafter qualified, the following rates for decreasing term life insurance may be considered as establishing "prima facie acceptable rates" for purposes of RCW 48.34.100(2). That is, rates which are filed by any company for the indicated coverage will be deemed to be acceptable without substantiating data if they do not exceed these premium rates.

(a) Single premium of \$.60 per coverage per \$100 of initial indebtedness repayable in twelve equal monthly installments during the period of coverage.

(b) Monthly premium of \$.96 per \$1000 of outstanding balances.

(2) Single premium rates for indebtedness repayable in installments other than twelve in number shall be one-twelfth of the above premium rate multiplied by the number of full months in the period of indebtedness. Premium rates for credit life insurance not covered under subsection (1) above shall be the actuarial equivalent of rates in subsection (1).

(3) The foregoing rates are presumed to produce reasonable benefits in relation to premiums only if:

(a) The credit life insurance contract contains no exclusion other than for suicide within two years of the effective date of the insurance, and

(b) Coverage is provided or offered to all debtors regardless of age; or to all debtors not older than the applicable age limit, which shall not be less than attained age sixty-five if such limit applies to the age when the insurance attaches, or not less than attained age sixty-six years if such limit applies to the age on the scheduled maturity date of the debt.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-020 Credit accident and health insurance. (1) Except as hereafter qualified, the following rates for credit accident and health insurance may be considered as "prima facie acceptable rates" for purposes of RCW 48.34.100(2). That is, rates which are filed by any company for the indicated coverage will be deemed to be acceptable without substantiating data if they do not exceed these premium rates.

If premiums are paid in one sum for the entire duration of the indebtedness the following rates for \$100 of initial indebtedness repayable in indicated number of installments are applicable:

No. of Months Indebtedness is Repayable	Nonretroactive 14-day	Benefits 30-day	Retroactive 14-day	Benefits 30-day
6	\$1.00	\$.40	\$1.80	\$1.30
12	1.40	.80	2.20	1.70
24	2.20	1.60	3.00	2.50
36	3.00	2.40	3.80	3.30
48	3.50	2.90	4.30	3.80
60	3.90	3.30	4.70	4.20
72	4.20	3.60	5.00	4.50
84	4.40	3.80	5.20	4.70

(2) Premiums payable other than on a single premium basis, for indebtedness of monthly durations not shown above or for benefits on a basis different than illustrated above, shall be actuarially consistent with the above rates.

(3) The foregoing rates are presumed to produce reasonable benefits in relation to premiums only if:

(a) The coverage contains no exclusion for preexisting conditions except for those conditions which manifested themselves to the insured debtor by requiring medical diagnosis or treatment, or would have caused a reasonably prudent person to have sought the medical diagnosis or treatment, within six months preceding the taking of the application for insurance and which caused loss within the six months following effective date of coverage: *Provided, however,* That disability commencing thereafter resulting from such conditions shall be covered.

(b) Coverage is provided or offered to all debtors regardless of age or to all debtors not older than the applicable age limit, which shall not be less than attained age sixty-five if such limit applies to the age when the insurance attaches, or not less than attained age sixty-six years if such limit applies to the age on the scheduled maturity date of the debt.

(4) Any contract to which the foregoing rates apply may contain provisions excluding or restricting coverage in the event of pregnancy, intentionally and self-inflicted injury, foreign travel or residence, flight in nonscheduled aircraft, or war or military service. (Except in unusual cases such insurance should not be sold to military persons, since their pay continues through periods of disability.) If more restricted coverage is to be provided there must be an appropriate reduction in the foregoing premium standards.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-030 Collection and remittance of premiums. A creditor may remit and an insurer may collect premiums on either a single premium basis or on a monthly outstanding balance basis, unless the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of the indebtedness, and makes any direct or indirect finance, carrying, credit or service charges whatever to the debtor in connection with such insurance charge. Under such circumstances, the creditor has loaned the premium or insurance charge to the debtor and the premium on the insurance charge is deemed collected for the insurer as soon as it is added to the indebtedness, in which event the creditor must remit and the insurer must collect on a single premium basis only. A creditor may remit and an insurer may collect on the monthly balance basis if the insurance charge or premium is not added to the amount of the loan and does not constitute part of the outstanding indebtedness, or if no direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with the insurance charge or premium.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-040 Rate filings and deviations from prima facie rates. (1) Any filing made pursuant to this regulation shall clearly indicate whether the insurer conceives that the rates in said filing fall within the acceptable rates published here or are higher than those published rates.

(2) Requests for higher rates than those established in this regulation for a debtor or a creditor or a class or classes of debtors or creditors will be approved on a showing made by the insurer satisfactory to the commissioner, that because of the nature of the risk, the mortality or morbidity experience which may reasonably be anticipated, will be significantly higher than the average anticipated experience, upon which the applicable rate standard was based. In passing upon such filing, the insurance commissioner will give consideration to available mortality and morbidity data pertaining to the debtors of a creditor or a class or classes of debtors of a creditor, previous experience, if any, for an actuarially credible period on such creditor's debtors, including the experience of any subsidiary or affiliate of the creditor, available age data, and a reasonable rate of expense. Age data and prior experience of the creditor's program should always be submitted.

(3) Commissions or other payments or allowances to creditors, agents or general agents shall never be considered a justification, or any part of a justification, of a higher rate as being reasonable in relation to benefits.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-050 Refunds. (1) RCW 48.34.110 requires that formulae for the refunding of unearned premiums be filed with and approved by the commissioner. To be approved, a refund formula must provide for a "sum of the digits" (also called the "Rule of 78") refund for single premium straight line decreasing benefit plans, a prorata refund for level benefit plans, or an actuarially acceptable refund of the unearned premiums for other benefit plans. A formula need not provide for a refund or credit if the amount thereof is less than one dollar.

(2) Formulae filed with the commissioner before November 1, 1975, which are not in compliance with this rule are disapproved, and shall not be used with respect to policies or certificates issued or renewed after April 1, 1976.

[Order R-75-4, § 284-34-050, filed 9/25/75; Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-060 Effective date—Implementation. This regulation shall become effective January 1, 1968. No form or rate approved before the date of this regulation issues shall be used in this state after January 1, 1968, except as hereinafter provided, unless it is resubmitted and reapproved by the commissioner.

All existing group credit insurance contracts on forms required to be filed with the commissioner shall be amended to conform to the requirements of this regulation, or be terminated, not later than the anniversary of the date of issue of the policy next following the effective date of this regulation.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-070 Prohibited transactions. (1) The following practices, when engaged in by insurers in connection, either directly or indirectly, with a credit life or credit disability insurance program, whether on a group or an individual basis, are hereby defined to be unfair methods of competition, and unfair and deceptive practices in the conduct of the business of insurance, pursuant to, and subject to the enforcement provisions of RCW 48.30.010:

(a) The offer or grant by an insurer or agent to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract.

(b) Agreement by an insurer to deposit with a bank or financial institution money or securities of the insurer with the design or intent that such deposit shall offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) Deposit by an insurer, with a creditor bank or financial institution, of money or securities without interest or at less rate of interest than is currently being paid

by the creditor bank or financial institution to other depositors of like amounts. This prohibition shall not be construed to prohibit the maintenance by an insurer of such demand deposits or premium deposit accounts as are reasonably necessary for use in the ordinary course of business of the insurer.

(d) Any other practice which is followed by an insurer when such practice involves use of the financial resources of the insurer for the principal benefit of the credit institution.

(2) This rule shall become effective January 1, 1977, and the continuation or use of the practices defined in subsection (1) on and after said date is prohibited: *Provided, however,* That any certificate of deposit outstanding on November 16, 1976, may be continued to its maturity date.

[Order R-76-5, § 284-34-070, filed 11/16/76.]

Chapter 284-36 WAC

DOMESTIC FRATERNAL MUTUAL PROPERTY INSURERS' AGENTS AND DIRECTORS

WAC

284-36-010	Application.
284-36-020	Agent-directors permitted.
284-36-030	Election or service as director prohibited.
284-36-040	Fiduciary responsibilities not affected.

WAC 284-36-010 Application. This regulation, WAC 284-36-010 through 284-36-040, shall apply only as to domestic fraternal mutual property insurers, as defined in RCW 48.36.410, and to any domestic stock insurer while it is a subsidiary of such a fraternal mutual property insurer.

[Order R 75-5, § 284-36-010, filed 10/22/75.]

WAC 284-36-020 Agent-directors permitted. Pursuant to the authority vested in the commissioner under RCW 48.07.130(3) up to one-third (to the nearest whole number) of the members of the board of directors of such an insurer may also be insurance agents of the insurer, and be entitled to receive, and receive from the insurer payment of, commissions or other compensation for insurance business written or serviced by them on the same bases as apply to other agents of the insurer in general. Agent-directors qualified under this provision are excepted from the prohibition contained in RCW 48.07.130(1), to the extent of their activities hereby authorized.

[Order R 75-5, § 284-36-020, filed 10/22/75.]

WAC 284-36-030 Election or service as director prohibited. No individual who is an insurance agent of such an insurer shall be elected or serve as a member of the insurer's board of directors if thereby the number of agent-directors of the insurer would exceed one-third (to the nearest whole number) of the total regular membership of the said board. Temporary vacancies on the

board of directors resulting from death, disability or resignation of a director, shall not be deemed to reduce such total regular membership.

[Order R 75-5, § 284-36-030, filed 10/22/75.]

WAC 284-36-040 Fiduciary responsibilities not affected. Nothing in this regulations shall be deemed to affect the responsibilities of a director as a fiduciary of the insurer, its members or stockholders, or other legal responsibilities of a director.

[Order R 75-5, § 284-36-040, filed 10/22/75.]

Chapter 284-44 WAC

HEALTH CARE SERVICES CONTRACTORS-- AGENTS--CONTRACT FORMATS--STANDARDS

WAC

284-44-010	Title and application.
284-44-030	Contract format required.
284-44-040	Contract standards required.
284-44-045	Benefits for registered nurses' services.
284-44-050	Group certificates to be furnished.
284-44-070	Effective date.
284-44-100	Authority and purpose.
284-44-110	Applicability and scope.
284-44-120	Definitions.
284-44-130	When filing is required.
284-44-140	General contents of all filings.
284-44-150	Experience records.
284-44-160	Evaluating experience data.
284-44-170	Minimum required anticipated loss ratio.
284-44-190	Unique contract forms.
284-44-200	Effective date.
284-44-210	"Filing document" form—Standard contract filing information.
284-44-220	"Filing document" form—Nonstandard contract filing information.
284-44-250	Accounting method.
284-44-300	Purpose and applicability.
284-44-310	Agreement underwritten by insurance.
284-44-320	Agreement guaranteed by a surety company.
284-44-330	Agreement guaranteed by a deposit of cash or securities.
284-44-340	Modification of amount of reimbursement or indemnity.
284-44-350	Records and reporting.
284-44-360	Effective date.
284-44-400	Assessments for examination costs.
284-44-410	Form for reporting number of persons entitled to services.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-44-020	Agents, licensing or appointment required. [Order R-74-1, § 284-44-020, filed 6/4/74, effective 8/1/74.] Repealed by 84-08-001 (Order R 84-1), filed 3/22/84. Statutory Authority: RCW 48.44.050.
284-44-060	Minimum filing requirements. [Order R-74-1, § 284-44-060, filed 6/4/74, effective 8/1/74.] Repealed by 81-15-070 (Order R 81-3), filed 7/21/81, effective 10/1/81. Statutory Authority: RCW 48.44.050.
284-44-180	Contract forms excluded from minimum loss ratio requirements. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-180, filed 7/21/81, effective 10/1/81.] Repealed by 82-12-032 (Order R 82-3), filed 5/26/82. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1.

[Title 284 WAC—p 84]

WAC 284-44-010 Title and application. (1) This regulation, WAC 284-44-010 through 284-44-070, is promulgated pursuant to RCW 48.44.050 and 48.44.020, and may be cited as the "Washington state health care service contractor regulation."

(2) This regulation, chapter 284-44 WAC, shall apply to every health care service contractor (hereinafter referred to as "contractor") registered pursuant to RCW 48.44.015.

[Order R-74-1, § 284-44-010, filed 6/4/74, effective 8/1/74.]

WAC 284-44-030 Contract format required. Every health care service contract issued or renewed after December 31, 1974 shall conform to the following format standards:

(1) The style, arrangement and over-all appearance of the contract shall give no undue prominence to any portion of the text, and every printed portion of the text of the contract and of any endorsements or attached papers shall be plainly printed in type of a style in general use, the size of which shall be uniform and not less than eight-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point. The "text" shall include all printed matter except the name and address of the contractor, name or title of the policy, a brief description if any, and captions and subcaptions.

(2) The exceptions, reductions, and limitations (as those terms are defined in WAC 284-50-030) shall be set forth in the contract either included with the benefit provisions to which they apply, or under an appropriate caption such as "exclusions," "exceptions," or "exceptions and limitations," except that if an exception, reduction, or limitation specifically applies only to a particular benefit under the contract, a statement of such exception, reduction, or limitation shall be included with the benefit provision to which it applies.

(3) Each form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(4) It shall contain no provision purporting to make any portion of the contractor's charter, rules, constitution, articles of incorporation, or bylaws a part of the contract if the effect of such provision would be to incorporate into the contract exceptions, reductions, limitations or additional charges not otherwise set forth in the contract, unless such portion is set forth in full in the contract, or is attached thereto.

[Order R-74-1, § 284-44-030, filed 6/4/74, effective 8/1/74.]

WAC 284-44-040 Contract standards required. Every health care service contract issued or renewed after December 31, 1974, shall conform to the following standards:

(1) A contract shall not unreasonably limit benefits to a specified period of time. For example, a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided, is not acceptable. Contracts may, however, limit major medical benefits, supplemental accident benefits, and diagnostic x-ray and laboratory benefits to a reasonable period of time. Benefits may

also be limited to a reasonable maximum dollar amount, and, in the case of doctor calls, to a reasonable number of calls over a stated period of time.

(2) A contract must provide that reasonable benefits will be restored upon each renewal of the contract or upon a calendar year basis or that such benefits be reasonably continuous. It is not required that a major medical contract with a lifetime maximum benefit be renewed or restored.

(3) A contract shall not contain any provision which gives or purports to give the contractor, its agent, officer, employee, or designee the authority to make a decision relative to the contract, or coverage or claims thereunder, which is final and binding on the subscriber or beneficiary. That is, in the case of controversy arising out of the contract, a subscriber shall not be denied the right to have the controversy determined by legal or arbitration proceedings.

(4) A contract shall not contain any provision which requires a subscriber to purchase a "monthly treatment order." This prohibits provisions that require a subscriber to pay a special charge, distinct from the prepayment fees required of all subscribers and coinsurance deductible amounts, in order to obtain advance authorization for treatment or services.

(5) If a contract restricts treatment to services by the contractor's participants or agents, a reasonable provision shall be included to allow emergency treatment consistent with the scope of the benefits regularly provided by the contract.

(6) If a contract provides maternity benefits, there shall be no waiting period for maternity benefits in advance of a conception occurring while the contract is in force.

(7) No contract shall contain any provision that unreasonably restricts or delays the payment of benefits payable under the contract. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.

(8) Every contract shall provide for a grace period of not less than ten days following the due date for the payment of the subscriber's dues, fees, or premium, during which grace period the contract shall continue in force. If payment is not made within the grace period, the contract may be terminated as of the due date of payment rather than at the end of the grace period.

(9) No contract other than a conversion contract issued pursuant to chapter 284-52 WAC shall contain any provision having the effect of coordinating benefits with other health care service contracts, health maintenance agreements, or disability insurance policies, except that group contracts may provide for coordination of benefits pursuant to chapter 284-51 WAC, and except that any contract may provide for coordination with respect to governmental programs.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-44-040, filed 9/19/84; Order R-74-1, § 284-44-040, filed 6/4/74, effective 8/1/74.]

WAC 284-44-045 Benefits for registered nurses' services. (1) Every health care service contractor agreement which is entered into initially or renewed after the effective date of this rule, and which provides benefits for any health care service to be performed by doctors of medicine, and every certificate issued thereunder, shall contain the following provision, or a provision which is the substantial equivalent of it:

"Benefits under this contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW."

(2) The provisions of subsection (1) shall apply to all health care service agreements, whether they expressly provide for indemnification benefits for services rendered by health care providers who are not "participants" as defined in RCW 48.44.010(4), or whether they provide only for benefits in the form of services rendered by health care providers who are "participants" for the purpose of such contracts.

(3) To comply with RCW 48.44.290, benefits must not be denied to a person covered by a health care service agreement by reason of his choice to obtain health care services from a registered nurse. A unilaterally imposed contract provision which requires or permits an artificial reduction in the level of an indemnification benefit based on such a choice to obtain health care services from a registered nurse will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020 (2)(f). An example of such an impermissible provision would be one which unilaterally sets the level of reimbursement for nurse-provided service at a fixed, less-than-100% percentage of the benefit which would be paid for participant-doctor-provided services, if any, or other doctor-provided services, if the contractor has no participant doctors. An example of a permissible provision would be one which was based on some percentage of the usual, customary, and reasonable (UCR) fee charged by the particular provider of health care service, and which applied the same percentage to the UCR fees of medical doctors and registered nurses alike. The latter provision would be permissible even if it resulted in lower actual dollar amounts for benefits for nurse-provided services than for doctor-provided services, since the difference would result from the disparity of fees actually charged by medical doctors and registered nurses rather than from an arbitrary formula based on assumptions concerning the relative worth of doctor-provided services versus nurse-provided services. A contract provision is not unilaterally imposed and is permissible, if it sets the benefit level in accord with an agreement between the health care service contractor and the particular registered nurse for whose services the benefits are provided.

(4) To comply with RCW 48.44.290, no health care service contractor agreement may contain a provision

which places restrictions or limitations on benefits for nurse-provided health care services which are not also placed on benefits for doctor-provided health care services. An example of an impermissible provision would be one which limited the number of office calls made to a registered nurse to a number less than the limit for office calls made to a medical doctor. A contract provision which places such a limitation or restriction on benefits for nurse-provided health care services will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020 (2)(f).

[Statutory Authority: RCW 48.44.050. 82-02-004 (Order R 81-8), § 284-44-045, filed 12/28/81.]

WAC 284-44-050 Group certificates to be furnished. Every contractor shall issue to the employer, a contract holder, or other person or association in whose name a contract is issued, for delivery to each person covered by a group contract, a certificate setting forth in summary form a statement of the essential features of the contract coverage, and to or for whom the benefits thereunder are payable. If family members are covered, only one certificate need be issued for each family. In the event that contracts are changed or amended, new certificates or a clearly understandable amendment to existing certificates shall be promptly furnished. The style, arrangement, and over-all appearance of the certificate shall not be less favorable than the requirements imposed by WAC 284-44-030. Such "certificate" may be in the form of a comprehensive booklet or brochure. The form of such certificate shall be filed with the insurance commissioner.

[Order R-74-1, § 284-44-050, filed 6/4/74, effective 8/1/74.]

WAC 284-44-070 Effective date. The effective date of this regulation shall be August 1, 1974.

[Order R-74-1, § 284-44-070, filed 6/4/74, effective 8/1/74.]

WAC 284-44-100 Authority and purpose. This regulation, WAC 284-44-100 through 284-44-220, is promulgated under the authority of RCW 48.44.050. Its purpose is to

(1) Provide guidelines for the implementation of RCW 48.44.040 and 48.44.020 (2)(d) as to the filing of contract forms and rate schedules, and

(2) Establish standards for the reasonableness of anticipated loss ratios to implement the authority of the commissioner to disapprove contract forms where the benefits provided are unreasonable in relation to the amount charged.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-100, filed 7/21/81, effective 10/1/81.]

WAC 284-44-110 Applicability and scope. This regulation applies to all health care service contractors registered in this state under chapter 48.44 RCW. It applies to every contract, rider and endorsement form and every rate schedule, and any modification or change thereof, which is required to be filed with the commissioner pursuant to RCW 48.44.040 and 48.44.020(2). It

does not apply to health maintenance organizations registered in this state under chapter 48.46 RCW.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-110, filed 7/21/81, effective 10/1/81.]

WAC 284-44-120 Definitions. For the purpose of this regulation the following terms shall have the meaning stated herein:

(1) "Amount charged" shall mean all sums charged, received, or deposited as consideration for a "contract" or "group contract" or the continuance thereof. An assessment or a membership, contract, survey, inspection, service or similar fee or charge made by the health care service contractor in consideration for a "contract" or "group contract" is deemed part of the "amount charged."

(2) "Certificate" shall mean the statement of coverage document furnished subscribers covered under a "group contract."

(3) "Claim" shall mean the cost of health care services paid to or provided on behalf of a "subscriber" in accordance with the terms of a "contract" or "group contract."

(4) "Contract" shall mean an agreement to provide health care services or pay health care costs for or on behalf of an individual "subscriber" and such eligible dependents as may be included therein.

(5) "Contract form" shall mean the prototype of a "contract" or "group contract" filed with the commissioner by a health care service contractor.

(6) "Earned amount charged" shall mean the "amounts charged" applicable to an accounting period whether received before, during or after such period.

(7) "Expenses" shall mean and include, but not be limited to the following:

- (a) Claims processing costs
- (b) Home office and field overhead
- (c) Acquisition and selling costs
- (d) Taxes
- (e) Contribution to surplus

(f) All other costs except "claim" payments to or on behalf of the "subscriber."

(8) "Franchise plan" shall have the meaning set forth in RCW 48.20.350.

(9) "Group contract" shall mean an agreement issued to an employer, corporation, labor union, association, trust or other organization to provide health care services to employees or members of such entities and/or the dependents of such employees or members.

(10) "Incurred claims" shall mean:

- (a) "Claims" paid during the accounting period, plus
- (b) the changes in reserves for "claims" which have been reported but not paid; plus
- (c) the change in reserves for "claims" which have not been reported but which may reasonably be expected.

(11) "Loss ratio" shall mean the "incurred claims" stated as a percentage of the "earned amount charged."

(12) "Rate schedule" shall mean the schedule of prices for various units of coverage which are used to calculate the "amount charged."

(13) "Subscriber" shall mean a person on whose behalf a "contract" or "certificate" is issued.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-120, filed 7/21/81, effective 10/1/81.]

WAC 284-44-130 When filing is required. (1) Pursuant to RCW 48.44.040 and 48.44.020 (2)(d), every contract, rider or endorsement form and any modifications thereof, and every rate schedule and any change thereof shall be filed with the commissioner

(a) Before being offered for sale to the public,
(b) Before such forms are modified or rate schedules are changed, and

(c) Within thirty days after the end of a three-year period during which a previous filing has remained unchanged for such period, including filings made prior to the effective date of this regulation.

(2) Filings of negotiated contract, rider and endorsement forms, and rate schedules applicable thereto, which are placed into effect at time of negotiation or which have a retroactive effective date shall not be required to be filed in accordance with (1)(a), (b) and (c) of this section but shall be filed within thirty working days after group contract negotiations have been completed. An explanation for the delayed filing shall be given on the filing document set forth in WAC 284-44-220.

(3) If a return copy of the filing is desired it shall be submitted in duplicate. The duplicate copy will be stamped by the commissioner to indicate receipt of the filing and will be returned to the sender if a return self addressed envelope is enclosed with the filing.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-130, filed 7/21/81, effective 10/1/81.]

WAC 284-44-140 General contents of all filings. Each filing required to be made pursuant to WAC 284-44-130 shall include:

(1) The information required on the filing documents set forth in WAC 284-44-210 for nonnegotiated forms and rate schedules or as set forth in WAC 284-44-220 for negotiated forms and rate schedules,

(2) The anticipated loss ratio over the lesser of three years or the period for which the underlying assumptions are expected to remain reasonable,

(3) With respect to revisions of a previously filed contract, rider or endorsement form, the magnitude of any change in the amount charged during the latest three rate periods or the latest three contract years, whichever is greater, and

(4) Certification by an actuary, a corporate officer or other qualified designated individual that the filing is in compliance with the applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-140, filed 7/21/81, effective 10/1/81.]

WAC 284-44-150 Experience records. (1) Every health care service contractor shall maintain for each

contract, rider or endorsement form for each rating period or contract year records of:

- (a) Incurred claims,
- (b) Earned amounts charged,
- (c) Expenses, and
- (d) Contributions to the corporate reserve account.

(2) Such records shall include data for rider and endorsement forms which are used with the contract forms. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under contract forms which provide substantially similar coverage may be combined for recordkeeping purposes.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-150, filed 7/21/81, effective 10/1/81.]

WAC 284-44-160 Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, including:

(1) Statistical credibility of amounts charged and services and benefits paid, such as low exposure, low loss frequency and recoupment;

(2) Experienced and projected trends relative to changes in medical costs and changes in utilization;

(3) The concentration of experience at early contract durations where selection or adverse-selection in morbidity are applicable and where loss ratios are expected to be substantially different at later durations;

(4) The mix of business by risk classification; and

(5) Adverse selection or lapse factors reasonably expected in connection with revisions to contract provisions, services and benefits and amounts charged.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-160, filed 7/21/81, effective 10/1/81.]

WAC 284-44-170 Minimum required anticipated loss ratio. (1) Benefits shall be deemed reasonable in relation to amount charged provided the anticipated loss ratio is at least

- (a) 65% for individual subscriber contract forms,
- (b) 70% for "franchise plan" contract forms, and
- (c) 80% for group contract forms.

(2) With the approval of the commissioner contract, rider and endorsement forms which provide substantially similar coverage may be combined for the purpose of determining the anticipated loss ratio.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-170, filed 7/21/81, effective 10/1/81.]

WAC 284-44-190 Unique contract forms. The requirements of WAC 284-44-140 and of 284-44-170 may be waived or modified upon a finding by the commissioner that a contract, rider or endorsement form contains or involves unique provisions or circumstances such as:

(1) Negotiated, experience rated or merit rated contract, rider or endorsement forms;

(2) Group contract forms designed to cover 25 or fewer subscribers or group contract forms which are designed to generate an unusually small amount charged per subscriber;

(3) Unusual employment, geographic, or other circumstances of the subscribers entailing high acquisition costs or other unusual expenses;

(4) A high risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;

(5) Unusual product features such as long elimination periods, high deductibles and high maximum limits or

(6) Issuance on a basis where the benefits provided and amount charged are determined by an affiliated health care service contractor outside of this state as to which the health care service contractor does not have direct control of the services and benefits offered and the amount charged for such contract form.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-190, filed 7/21/81, effective 10/1/81.]

WAC 284-44-200 Effective date. This regulation, WAC 284-44-100 through 284-44-220, shall become effective on October 1, 1981.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-200, filed 7/21/81, effective 10/1/81.]

WAC 284-44-210 "Filing document" form-- Standard contract filing information.

[CODIFICATION NOTE: The graphic presentation of this table has been varied slightly in order that it would fall within the printing specifications for the Washington Administrative Code.]

STANDARD CONTRACT FILING INFORMATION

(Health Care Contractor):

Contract Form Number

Effective Date Date Submitted

- Individual Contract
Medicare Supplement Contract
Community Rated Contract
Conversion Contract
New Contract (attach contract)
No Change in Contract Past 3 years

If this is a Revision of an Existing Contract, check here (...) and attach appropriate endorsements/riders.

- a) Experience Rate Change
b) Recoupment
c) Benefit Change(s)
d) Reserves

Current Rates
Experience Rate Change
Recoupment
Reserves
Benefit Change(s)
Total New Rates

EXPERIENCE (Provide information for the latest three rate periods or latest three contract years, whichever is greater.)

Table with columns: Current Rate Period, First Prior Rate Period, Second Prior Rate Period. Rows include: Rate Period Experience, Earned Income, Paid Claims, Beginning Incurred Reserve, Ending Incurred Reserve, Incurred Claims, Loss Ratio Percentage, Expenses, Gain/Loss, Contribution to Corporate Surplus.

GENERAL INFORMATION:

- 1. % of premium is charged for administering this contract.
2. a) % is the overall annual trend factor used to project the new rates.
b) Annual trend factor by line of service:

Hospital % Professionals % Dental % Other: %

3. Rate Period Claim Breakdown:

Table with columns: Hospital of total, Professional of total, Dental of total, Other of total. Includes dollar amounts.

\$..... months experience was used to develop the new rates.

From to

5. For what period are the new rates anticipated to remain in effect? From to

6. The anticipated loss ratio over the period the new rates are assumed to remain adequate is%.

7. List the effective date and increase percentage of all rate changes in the past three rate periods.

1) 2) 3)
(date) % (date) % (date) %

8. Comments or additional information

9. I hereby certify that this filing is in compliance with applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

Signed

[Statutory Authority: RCW 48.44.050, 81-15-070 (Order R 81-3), § 284-44-210, filed 7/21/81, effective 10/1/81.]

WAC 284-44-220 "Filing document" form--Non-standard contract filing information.

[CODIFICATION NOTE: The graphic presentation of this table has been varied slightly in order that it would fall within the printing specifications for the Washington Administrative Code.]

NONSTANDARD CONTRACT FILING INFORMATION

(Health Care Contractor):

(Contract Holder):

Effective Date of Contract

Effective Date (of change) Date Submitted

Contract Form Number Contract Number

... New contract (attach contract)

... Revision of Existing Contract (attach appropriate endorsements/riders)

a) ... Experience Rate Change ... %

b) ... Recoupment ... %

c) ... Benefit Change(s) ... %

d) ... Reserves ... %

Current Rates
Experience Rate Change
Recoupment
Reserves
Benefit Change(s)
Total New Rates

EXPERIENCE (Provide information for the latest three rate periods or latest three contract years, whichever is greater.)

(1986 Ed.)

Current First Prior Second Prior
Rate Period Rate Period Rate Period

Rate Period
Experi-
ence From ... to ... From ... to ... From ... to ...

Earned Income

Paid Claims

Beginning
Incurred
Reserve

Ending
Incurred
Reserve

Incurred
Claims

Loss Ratio
Percentage

Expenses

Gain/Loss

Experience
Refund or
Credit

Contribution
to Corporate
Surplus

Comments or additional information:

.....
.....
.....
.....

I hereby certify that this filing is in compliance with applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

Signed

Title

[Statutory Authority: RCW 48.44.050, 81-15-070 (Order R 81-3), § 284-44-220, filed 7/21/81, effective 10/1/81.]

WAC 284-44-250 Accounting method. Beginning January 1, 1983, to aid in the administration of chapter 48.44 RCW, every health care service contractor shall account for its business on the accrual basis, and any annual financial statement filed after December 31, 1983, pursuant to RCW 48.44.095, shall be reported on such accrual basis.

[Statutory Authority: RCW 48.44.050, 82-23-010 (Order R 82-6), § 284-44-250, filed 11/5/82, effective 1/1/83.]

WAC 284-44-300 Purpose and applicability. (1) The purpose of this regulation, WAC 284-44-300 through 284-44-360, is to establish indemnity requirement rules and procedures for the effectuation of RCW 48.44.030 and to aid in the administration thereof.

(2) This regulation applies to every health care service contractor registered pursuant to chapter 48.44 RCW.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-300, filed 11/5/82, effective 1/1/83.]

WAC 284-44-310 Agreement underwritten by insurance. (1) If, pursuant to RCW 48.44.030, the agreement is underwritten by a contract or policy of insurance, such contract or policy shall:

(a) Have a continuous term;

(b) Fully insure the benefits of the persons who have paid for or contracted for covered health care services, which persons shall be designated as beneficiaries, when such services are not performed by the health care service contractor or a participant;

(c) Contain a provision that, in the event of cancellation, the coverage shall continue with respect to services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled without ninety days advance written notice to the insured or insurer by the cancelling party; and

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the insurer of any cancellation.

(2) The original or a true copy of the actual insurance contract or policy shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-310, filed 11/5/82, effective 1/1/83.]

WAC 284-44-320 Agreement guaranteed by a surety company. (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a surety company, such agreement shall:

(a) Be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340;

(b) Contain a provision that the bond will be for the benefit of the persons who have paid for or contracted for the health care services;

(c) Contain a provision that in the event of cancellation, the bond will continue to cover liabilities for services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled or terminated without ninety days advance written notice to the assured or surety company by the cancelling party;

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the surety company of any cancellation of such surety agreement.

[Title 284 WAC—p 90]

(2) The original or a true copy of the actual surety bond shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-320, filed 11/5/82, effective 1/1/83.]

WAC 284-44-330 Agreement guaranteed by a deposit of cash or securities. (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a deposit of cash or securities, such deposit shall be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340.

(2) Securities eligible for such deposit shall be those set forth in RCW 48.13.040, 48.13.050, 48.13.080, 48.13.100, 48.13.200, and 48.13.220. The commissioner may, upon advance approval, allow other securities to be included as deposits pursuant to RCW 48.13.250.

(3) In determining the value to be assigned to securities for compliance with the depository requirements, market value shall be the measurement.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-330, filed 11/5/82, effective 1/1/83.]

WAC 284-44-340 Modification of amount of reimbursement or indemnity. (1) Reduced deposit requirements may be permitted when data satisfactory to the commissioner are provided which indicate an amount less than that set forth in WAC 284-44-320 and 284-44-330 is adequate to cover incurred but unpaid reimbursement or indemnity benefits. In determining a lesser requirement, the commissioner will include in his consideration:

(a) The overall adequacy of the contractor's reserves for future benefits;

(b) The relationship between indemnity claims and claims covered by contractual agreements with providers;

(c) The overall financial stability of the contractor; and

(d) A reasonable projection of any increase or decrease of such benefits.

(2) The commissioner may from time to time require additional indemnification to be furnished when a review of the health care service contractor's affairs demonstrates that existing indemnification is inadequate.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-340, filed 11/5/82, effective 1/1/83.]

WAC 284-44-350 Records and reporting. (1) Each health care service contractor shall maintain records which separately reflect the amount of service benefits and the amount of reimbursement or indemnity benefits. Reasonable approximation based on paid claims data may be used to project incurred indemnity benefits. Such amounts shall be reported to the commissioner on forms prescribed by the commissioner and shall be filed with the annual statement and at such other times as the

commissioner may require. The report shall be accompanied by an inventory and valuation of any securities which are used to satisfy the depository requirement. If the amount of the guarantee is not sufficient to satisfy the requirements, an appropriate additional amount shall be obtained, and shall be deposited with, or evidenced to, the commissioner within thirty days of the filing of the report.

(2) A health care service contractor using either a policy of insurance or a surety bond to provide for indemnification shall notify the insurance commissioner, health care services division, sixty days in advance of termination or cancellation of the contract or policy of insurance or surety bond.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-350, filed 11/5/82, effective 1/1/83.]

WAC 284-44-360 Effective date. (1) This regulation, WAC 284-44-300 through 284-44-360, and 284-44-250 shall take effect January 1, 1983.

(2) If any health care service contractor holding a valid certificate of registration in this state immediately prior to the effective date of this rule is unable to meet the requirements of WAC 284-44-300 through 284-44-350, the commissioner may, upon its request, allow it to continue to transact business for such period of time and under such conditions as he deems appropriate.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-360, filed 11/5/82, effective 1/1/83.]

WAC 284-44-400 Assessments for examination costs. Assessments of health care service contractors pursuant to RCW 48.44.145(4) shall be established in the following manner:

(1) The commissioner will determine the amount expected to cover the costs of examinations of health care service contractors during a particular fiscal year, making due allowance for any amounts remaining from previous assessments carried over into a succeeding biennium.

(2) Each health care service contractor shall furnish to the commissioner, as a part of the annual financial statement required by RCW 48.44.095, the form set forth in WAC 284-44-410 indicating the number of persons entitled to health care services pursuant to an agreement under RCW 48.44.020(1), excluding such persons who are not residents of this state. It is recognized that some group subscribers do not provide a monthly itemization of the number of covered dependents. A health care service contractor which, after reasonable effort, cannot obtain the dependency breakdown shall assume, for purposes of this section and WAC 284-44-410, that each subscriber represents two and three-fourths persons, i.e., the subscriber plus one and three-quarters dependents.

(3) The commissioner will divide the amount determined pursuant to subsection (1) of this section by the number of resident persons entitled to health care services from all health care service contractors as reported in their annual statements pursuant to subsection (2) of this section.

(4) The quotient determined pursuant to subsection (3) of this section will be adjusted to allow a reasonable margin for cost variations and rounded for ease of administration, and the resulting number, which will be the equivalent of one-half cent or less, per eligible person per month, will serve as the multiplier which the commissioner will use in calculating the amount of the assessment for each health care service contractor.

(5) The commissioner will notify each contractor of its assessment, after applying the multiplier obtained pursuant to subsection (4) of this section to the number of persons reported by the contractor pursuant to subsection (2) of this section. Payment of the assessment must be made no later than thirty days after the notice is mailed by the commissioner to the contractor.

(6) The first assessment will be based on the expected costs of examinations during the fiscal year beginning July 1, 1984, and the total number of persons reported pursuant to subsection (2) of this section as entitled to health care services during the twelve-month period ending December 31, 1983. Similarly, future assessments will be for examination costs in particular fiscal years based on the number of persons per month in the prior calendar year.

(7) The commissioner anticipates that only one assessment will be made for each fiscal year. However, if additional funds are needed to cover the costs of examinations, the commissioner may follow the procedures outlined in subsections (1) through (5) of this section to assess the contractors for the necessary additional amounts required. In any case, the portion of the cumulative amount of all assessments attributable to each month used to measure the amount of the assessment will not exceed one-half cent per person entitled to health care services during the month, pursuant to an agreement under RCW 48.44.020(1), excluding such persons who were not residents of this state.

[Statutory Authority: RCW 48.44.050. 84-08-001 (Order R 84-1), § 284-44-400, filed 3/22/84.]

WAC 284-44-410 Form for reporting number of persons entitled to services.

REPORT OF NUMBER OF PERSONS ENTITLED TO HEALTH CARE SERVICES

Organization reporting:

For calendar year:

Pursuant to WAC 284-44-400(2), if a health care service contractor, or WAC 284-46-010(2), if a health maintenance organization, set forth below are the numbers of persons, including dependents, who were entitled to health care services during each month of the year indicated above, excluding therefrom such persons who were not residents of this state:

- January
- February
- March
- April
- May
- June

July
August
September
October
November
December

Date Signed.....
Title.....

[Statutory Authority: RCW 48.44.050. 84-08-001 (Order R 84-1), § 284-44-410, filed 3/22/84.]

Chapter 284-46 WAC
HEALTH MAINTENANCE ORGANIZATIONS

WAC
284-46-010 Assessments for examination costs.
284-46-020 Form for reporting number of persons entitled to services.

WAC 284-46-010 Assessments for examination costs. Assessments of health maintenance organizations pursuant to RCW 48.46.120(4) shall be established in the following manner:

(1) The commissioner will determine the amount expected to cover the costs of examinations of health maintenance organizations during a particular fiscal year, making due allowance for any amounts remaining from previous assessments carried over into a succeeding biennium.

(2) Each health maintenance organization shall furnish to the commissioner, as a part of the annual financial statement required by RCW 48.46.080, the form set forth in WAC 284-46-020 indicating the number of persons entitled to health care services pursuant to an agreement as defined in RCW 48.46.020(5), excluding such persons who are not residents of this state. It is recognized that some group subscribers do not provide a monthly itemization of the number of covered dependents. A health maintenance organization which, after reasonable effort, cannot obtain the dependency breakdown shall assume, for purposes of this section and WAC 284-46-020, that each subscriber represents two and three-fourths persons, i.e., the subscriber plus one and three-quarters dependents.

(3) The commissioner will divide the amount determined pursuant to subsection (1) of this section by the number of resident persons entitled to health care services from all health maintenance organizations as reported in their annual statements pursuant to subsection (2) of this section.

(4) The quotient determined pursuant to subsection (3) of this section will be adjusted to allow a reasonable margin for cost variations and rounded for ease of administration, and the resulting number, which will be the equivalent of one-half cent or less, per eligible person per month, will serve as the multiplier which the commissioner will use in calculating the amount of the assessment for each health maintenance organization.

(5) The commissioner will notify each organization of its assessment, after applying the multiplier obtained

pursuant to subsection (4) of this section to the number of persons reported by the organization pursuant to subsection (2) of this section. Payment of the assessment must be made no later than thirty days after the notice is mailed by the commissioner to the organization.

(6) The first assessment will be based on the expected costs of examinations during the fiscal year beginning July 1, 1984, and the total number of persons reported pursuant to subsection (2) of this section as entitled to health care services during the twelve-month period ending December 31, 1983. Similarly, future assessments will be for examination costs in particular fiscal years based on the number of persons per month in the prior calendar year.

(7) The commissioner anticipates that only one assessment will be made for each fiscal year. However, if additional funds are needed to cover the costs of examinations, the commissioner may follow the procedures outlined in subsections (1) through (5) of this section to assess the organizations for the necessary additional amounts required. In any case, the portion of the cumulative amount of all assessments attributable to each month used to measure the amount of the assessment will not exceed one-half cent per person entitled to health care services during the month, pursuant to an agreement under RCW 48.46.020(5), excluding such persons who were not residents of this state.

[Statutory Authority: RCW 48.46.200. 84-08-002 (Order R 84-2), § 284-46-010, filed 3/22/84.]

WAC 284-46-020 Form for reporting number of persons entitled to services.

REPORT OF NUMBER OF PERSONS ENTITLED TO HEALTH CARE SERVICES

Organization reporting:

For calendar year:

Pursuant to WAC 284-44-400(2), if a health care service contractor, or WAC 284-46-010(2), if a health maintenance organization, set forth below are the numbers of persons, including dependents, who were entitled to health care services during each month of the year indicated above, excluding therefrom such persons who were not residents of this state:

January
February
March
April
May
June
July
August
September
October
November
December

Date Signed.....
Title.....

[Statutory Authority: RCW 48.46.200. 84-08-002 (Order R 84-2), § 284-46-020, filed 3/22/84.]

**Chapter 284-48 WAC
BULLETINS**

WAC

- 284-48-010 License status of creditors under credit group policies—Commissions.
- 284-48-020 Authority of agents v. brokers: (1) Brokers of record, (2) marketing substandard auto, (3) rejected life and disability.

WAC 284-48-010 License status of creditors under credit group policies—Commissions.

To: All insurers writing credit life and credit accident and health insurance and all holders of group contracts of such insurance.

From: Lee I. Kueckelhan, Insurance Commissioner

Subject: (1) License status of creditors under credit group policies. (2) Commissions.

I

License status

An uneven practice has developed in this state with respect to the necessary license status of creditors who hold group master policies of credit life and credit accident and health insurance, insuring the lives and health of those persons buying personal property through credit transactions. Some insurers are insisting that such creditors be licensed for life and disability, and find themselves at a competitive disadvantage with other insurers who apparently are informing the creditors that such licensing is unnecessary.

RCW 48.17.060 provides as follows:

- (1) No person shall in this state act as or hold himself out to be an agent, broker, solicitor, or adjuster unless then licensed therefor by this state.
- (2) No agent, solicitor, or broker shall solicit or take applications for, procure, or place for others any kind of insurance for which he is not then licensed.
- (3) This section shall not apply with respect to any person securing and forwarding information required for the purposes of group insurance covering the unpaid balance, or remaining payments proposed to be made, in connection with the purchase of merchandise or securities, and *where no commission or other compensation is payable on account of such insurance to such person.* (Emphasis supplied.)
- (4) Any person violating this section shall be liable to a fine of not to exceed five hundred dollars and imprisonment for not to exceed six months for each instance of such violation.

It is clearly inherent in subsection (3) that licensing is necessary for such creditors if any "commission or other compensation" is payable to them on account of such insurance.

We are informed that certain insurers are attempting to avoid the licensing provision by referring to the compensation paid to the creditor as something other than commission. The term typically applied is "experience refund." The statute makes it clear that the use of the term "commission" is in no way of controlling importance in its application. It expressly says "commission or other compensation." A true experience refund obviously cannot be promised, computed in amount or percentage, or paid, before the term of coverage to which it relates has expired and the experience has occurred and is known. Any compensation to the creditor on an agreed-upon amount or percentage is in no way an experience refund, and its being so labeled is a nullity without legal effect in the construction of the above statute.

This bulletin is notice to its recipients of the position of this office. Unlicensed creditors receiving compensation as described are put on notice that they must be licensed. Because this office does not in any way impute bad faith to creditors who find themselves in violation, we feel it appropriate to extend to them a reasonable period in which to qualify and become licensed. Therefore, it is our intention to wait until December 31, 1965, before invoking any sanctions with respect to such nonlicensing.

II

Commissions

A fundamental purpose of the model law of credit life and credit accident and health insurance (chapter 48.34 RCW) was the establishment of a reasonable relationship between the benefits under such insurance and the premium paid by the insured. This office, following the decision of the National Association of Insurance Commissioners, had adopted the fifty percent loss ratio as a benchmark in determining if such reasonable relationship exists.

It has now come to our attention that some insurers may be paying commissions, however denominated, on credit life and credit accident and health insurance that approach or even exceed fifty percent of premiums. Such commissions obviously cannot be contemplated in an over-all loss ratio of at least fifty percent, since administrative costs, taxes, and other expenses are obviously also involved. If at least fifty percent loss ratio were in fact contemplated, then the paying of commission approaching fifty percent would threaten solvency.

Therefore, you are advised that any rate of compensation to a licensed creditor which exceeds forty percent of premium on any basis or combination of bases will be considered by this office as prima facie evidence that the rate being charged is excessive.

This office will allow until June 30, 1965, for all master policies of group credit life and credit accident and health insurance then in force to comply with this section.

This office has no ready means of knowing the identities and locations of the various creditors holding master policies of group credit life and credit accident and

health insurance in this state. Therefore, we are hereby asking all authorized insurers that write this form of insurance to bring the contents of this bulletin to the immediate attention of such creditors as may hold their contracts.

DATED at Olympia, Washington, this 23rd day of April, 1965.

LEE I. KUECKELHAN
Insurance Commissioner

[Filed May 7, 1965.]

**WAC 284-48-020 Authority of agents v. brokers:
(1) Brokers of record, (2) marketing substandard auto, (3) rejected life and disability.**

To: All licensed insurance producers.
From: Lee I. Kueckelhan, Insurance Commissioner
Re: Authority of agents v. brokers: (1) Brokers of Record, (2) Marketing substandard auto, (3) Rejected life and disability.

Misunderstandings seem to have developed as respects the statutory authority of certain producer licensees of this office. It is hoped that this bulletin can clear up some of the misunderstandings which, when acted upon, amount to violations of statutes. RCW 48.17.020 provides as follows:

"Broker" means any person who, on behalf of the insured, for compensation as an independent contractor, for commission, or fee, and not being an agent of the insurer, solicits, negotiates, or procures insurance or reinsurance or the renewal or continuance thereof, or in any manner aids therein, for insureds or prospective insureds other than himself.

RCW 48.17.060 provides, among other things, that no one can act as or hold himself out to be a broker unless licensed as such. Violation carries a maximum fine of five hundred dollars and maximum imprisonment for six months. In addition, a person violating these statutes would put his existing licenses, if any, in immediate jeopardy under the provisions of RCW 48.17.530.

It is possible to violate the above statutes in many ways. By way of illustration, and not limitation, we set out three particular factual patterns that have come to our attention where there has been apparent noncompliance:

1. BROKERS OF RECORD

We have learned of persons licensed only as agents receiving appointments as "brokers of record" for buyers of insurance, and even making up specifications and calling for bids on behalf of their "principals" — the prospective insureds. This has come about, apparently, by a misapplication or misinterpretation of our statute relating to sharing commissions (RCW 48.17.490). That statute merely forbids the sharing of commissions with persons not licensed for the same class of business; it

does not and cannot have the effect of automatically making an agent into a broker, and thus render all statutes based on the distinction nugatory.

Only licensed brokers can undertake to represent insureds in seeking insurers for particular lines of insurance in this state. Any document executed by an insured that purports to appoint someone other than a licensed broker as a broker of record on behalf of such insured must be considered void and of no effect. (It is to be noted that referring to such a person as an "agent of record" or "producer of record" or other title cures nothing. The only operative fact is the role played by that person in the insurance transaction. If he purports to act as a representative of the insured in negotiation of insurance with any insurer which has not appointed him he is acting as a broker, and must be licensed as such.)

2. SUBSTANDARD AUTOMOBILE MARKETING

Certain carriers do business in this state by appointing only one agent or general agent (referred to hereafter as the "official agent"), which official agent thereafter accepts applications and premiums sent to him by any number of other agents (referred to hereafter as "unofficial agents") around the state who might need a substandard market. Such unofficial agents have no appointment from the insurer involved, yet they usually (1) have in their offices the rate books, literature, and forms of such insurer, (2) are authorized to quote rates to prospective insureds, and (3) are authorized to collect and forward the premiums of the prospective insureds. The public has every reason to believe that a person with such indicia of authority to act on an insurer's behalf has actual authority to do so. The occasion for harm in such an arrangement is obvious and real. We have had instances in which the unofficial agent has defalcated with premium money, and both the official agent and the company have attempted to turn their backs to the matter as if it didn't concern them. This is not in the public interest.

Again, here, the only plausible statutory support for the marketing arrangement appears to be in RCW 48.17.490, relating to the sharing of commissions. That section in no way authorizes the described method of doing business.

The only class of licensee with authority to take applications for such insurance and to collect premiums therefor, without being appointed by the insurer, is the broker. The broker's bond is, indeed, designed to give the protection otherwise lacking. The most any nonappointed agent can do in such a transaction is to refer such prospective insured either to an appointed agent or to a broker, and then share the commission with that appointed agent or broker if the appointed agent or broker wishes to enter into such a commission-sharing arrangement. The nonappointed agent cannot take an operative part in the insurance transaction, cannot solicit the insurance, cannot quote rates, cannot take applications, cannot collect premiums, cannot in any way give the public reason to believe he has authority to represent the company for which he is not appointed.

Because this particular disfavored arrangement is apparently widespread, and has not heretofore been challenged, we feel it is appropriate to allow a reasonable period of time during which corrective action can be taken by licensees and companies that find themselves in violation. Such corrective action may, in some cases, take the form of agents becoming licensed as brokers. In other cases the insurers may decide to make such de facto agents their appointed agents. Perhaps other companies may simply operate on a referral basis as described above. In any event, it would appear that June 30, 1966, would allow ample time to accomplish whatever changes are required. Cases of violation coming to our attention subsequent to that date will result in appropriate disciplinary action against both the producer and company in violation.

3. REJECTED LIFE AND DISABILITY BUSINESS

A life and disability agent must be separately licensed as to each insurer which he holds himself out to be authorized to represent. Only where each company for which such agent is licensed has (1) rejected a particular risk, and (2) has consented to its placement elsewhere, can such agent place such business with another authorized insurer as to which he is not licensed. This is the clear meaning of RCW 48.17.230, which provides as follows:

A licensed agent appointed by an insurer as to life or disability insurances, may, if with the knowledge and consent of such insurer, place any portion of a life or disability risk which has been rejected by such insurer, with other authorized insurers without being licensed as to such other insurers.

Violation of this statute is grounds for disciplinary action against the agent involved. If the life or disability agent desires to place nonrejected business with companies with which he is not licensed, he too must be licensed as a broker.

(A life or disability risk may be considered "rejected", however, if the insurer refuses to write it at standard rates. The legal effect of the insurer's willingness to write the coverage at an increased rate is a counteroffer, not acceptance of the applicant's previous offer.)

Note: 1. Nothing in the foregoing bulletin is intended to be construed as prohibiting practices permitted or required by operation of (a) the Washington Automobile Assigned Risk Plan, or (b) RCW 48.15.080, which relates to the placement of surplus lines.

2. Applications for broker's licenses may be obtained at our Olympia, Seattle, and Spokane offices.

LEE I. KUECKELHAN
Insurance Commissioner

DATED at Olympia, Washington, May 6, 1966.

[Filed May 18, 1966.]

(1986 Ed.)

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

WAC

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284-50-430	Requirements for replacement.
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-50-450	Purpose and authority. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-05-039 (Order R-78-1), § 284-50-450, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
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[Title 284 WAC—p 95]

- 284-50-455 Information to be furnished, style. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-05-039 (Order R-78-1), § 284-50-455, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
- 284-50-460 Form to be used. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-08-024 (Order R 78-2), § 284-50-460, filed 7/12/78; 78-05-039 (Order R-78-1), § 284-50-460, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
- 284-50-465 Effective date. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-05-039 (Order R-78-1), § 284-50-465, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.

WAC 284-50-010 Title and purpose. (1) This regulation, WAC 284-50-010 through 284-50-230, shall be known and may be cited as the "Washington disability insurance advertising regulation."

(2) The purpose of this regulation is to assure truthful and adequate disclosure of all material and relevant information in the advertising of disability insurance (as defined in RCW 48.11.030), health care service contractors' agreements (as defined in RCW 48.44.020), and health maintenance agreements (as defined in RCW 48.46.020). This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of disability insurance and health care agreements in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy or agreement of such insurance offered through various advertising media. RCW 48.30.040, 48.44.110 and 48.46.130 prohibit false, deceptive or misleading advertising in the conduct of the business of insurance and in the conduct of the business of a health care service contractor and a health maintenance organization. Because those statutes establish only general standards, this regulation establishes specific standards for advertisements relating to individual, group, blanket, and franchise disability, insurance and individual and group health care service contractors' agreements and health maintenance agreements.

[Order R-76-2, § 284-50-010, filed 3/4/76; Order R-73-1, § 284-50-010, filed 2/28/73, effective 4/1/73.]

WAC 284-50-020 Applicability. (1) These rules shall apply to every "advertisement," as that term is hereinafter defined, in WAC 284-50-030, subsections (1), (7), (8) and (9), unless otherwise specified in these rules, intended for presentation distribution, or dissemination in this state when such presentation, distribution, or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, or solicitor as those terms are defined in the insurance code of this state and these rules.

(2) Every insurer shall establish and at all times maintain a system of control over the content, form, and

method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer for whom such advertisements are prepared.

[Order R-76-2, § 284-50-020, filed 3/4/76; Order R-73-1, § 284-50-020, filed 2/28/73, effective 4/1/73.]

WAC 284-50-030 Definitions. (1) An advertisement for the purpose of these rules shall include:

(a) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards, and similar displays; and

(b) Descriptive literature and sales aids of all kinds issued by an insurer, agent, or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(c) Prepared sales talks, presentations, and material for use by agents, brokers, and solicitors.

(2) "Policy" for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides disability benefits, or medical, surgical, or hospital expense benefits, whether on an indemnity, reimbursement, service, or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium, and double indemnity benefits included in life insurance and annuity contracts.

(3) "Insurer" for the purposes of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health care service contractor, health maintenance organization, and any other legal entity which is defined as an "insurer" in the insurance code of this state and is engaged in the advertisement of a policy as "policy" is defined in this regulation.

(4) "Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

(5) "Reduction" for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

(6) "Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(7) "Institutional advertisement" for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.

(8) "Invitation to inquire" for the purpose of these rules shall mean an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the

loss for which the benefit is payable, and which may contain:

(a) The dollar amount of benefit payable, and/or

(b) The period of time during which the benefit is payable; provided the advertisement does not refer to cost. An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."

(9) "Invitation to contract" for the purpose of these rules shall mean an advertisement which is neither an invitation to inquire nor an institutional advertisement.

[Order R-76-2, § 284-50-030, filed 3/4/76; Order R-73-1, § 284-50-030, filed 2/28/73, effective 4/1/73.]

WAC 284-50-040 Method of disclosure of required information. All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statement to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

[Order R-73-1, § 284-50-040, filed 2/28/73, effective 4/1/73.]

WAC 284-50-050 Form and content of advertisements. (1) The format and content of an advertisement to which these rules apply shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the insurance commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

(2) Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

[Order R-73-1, § 284-50-050, filed 2/28/73, effective 4/1/73.]

WAC 284-50-060 Deceptive words, phrases, or illustrations prohibited. (1) No advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder," or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions, and reductions shall fairly and accurately describe the negative features of such limitations, exceptions, and reductions of the policy offered.

(4) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency, or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(6) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

(8) An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan," or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

(9) The phrase "tax free" shall not be used in or as a heading, caption, or title in any advertisement and shall not be unduly or deceptively emphasized, but it may be

used in connection with a reasonably complete explanation of the Internal Revenue Service rules applicable to the particular benefits afforded by the policy or policies advertised.

[Order R-73-1, § 284-50-060, filed 2/28/73, effective 4/1/73.]

WAC 284-50-070 Exceptions, reductions, and limitations to be disclosed. (1) When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

(2) When a policy contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding subsection (1) shall disclose the existence of such periods.

(3) An advertisement shall not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to deceptively describe or unfairly minimize the applicability of any exceptions and reductions contained in the policy advertised.

(4) When a policy contains a provision permitted by RCW 48.20.192, 48.20.202, or 48.20.212 (Optional standard provisions No. 15, 16, and 17), an advertisement which is subject to the requirements of WAC 284-50-070(1) shall disclose clearly the effect of such provisions.

[Order R-76-2, § 284-50-070, filed 3/4/76; Order R-73-1, § 284-50-070, filed 2/28/73, effective 4/1/73.]

WAC 284-50-080 Preexisting conditions. (1) An advertisement which is subject to the requirements of WAC 284-50-070 shall, in negative terms, disclose the extent to which any loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

(2) When a policy does not cover losses resulting from preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question requiring a response by the applicant or a statement in prominent type, all in

capital letters, which reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question substantially as follows:

"Do you understand that this policy will not pay benefits during the first ----- year(s) after the issue date for a disease or physical condition which you now have or have had in the past?" YES

Or a statement in prominent type, all capitalized, substantially as follows:

"I UNDERSTAND THAT THE POLICY APPLIED FOR WILL NOT PAY BENEFITS FOR ANY LOSS INCURRED DURING THE FIRST ----- YEAR(S) AFTER THE ISSUE DATE ON ACCOUNT OF DISEASE OR PHYSICAL CONDITION WHICH I NOW HAVE OR HAVE HAD IN THE PAST."

[Order R-76-2, § 284-50-080, filed 3/4/76; Order R-73-1, § 284-50-080, filed 2/28/73, effective 4/1/73.]

WAC 284-50-090 Disclosure of provisions relating to renewability, cancellability, and termination. When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

[Order R-76-2, § 284-50-090, filed 3/4/76; Order R-73-1, § 284-50-090, filed 2/28/73, effective 4/1/73.]

WAC 284-50-100 Testimonials or endorsements by third parties. (1) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.

(2) If the person making a testimonial, an endorsement, or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement, or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for television or radio performance. The payment of substantial amounts, directly or indirectly for "travel and entertainment" for filming or recording of television or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation.

This subsection (2) does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

(3) An advertisement shall not state or imply that any insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

(4) When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

[Order R-76-2, § 284-50-100, filed 3/4/76; Order R-73-1, § 284-50-100, filed 2/28/73, effective 4/1/73.]

WAC 284-50-110 Use of statistics. (1) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

(2) An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for an uncommon claim for the policy advertised is misleading and shall not be used.

(3) The source of any statistics used in an advertisement shall be identified in such advertisement.

[Order R-73-1, § 284-50-110, filed 2/28/73, effective 4/1/73.]

WAC 284-50-120 Identification of plan or number of policies. (1) When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

(2) When an advertisement which is an invitation to contract refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

[Order R-76-2, § 284-50-120, filed 3/4/76; Order R-73-1, § 284-50-120, filed 2/28/73, effective 4/1/73.]

(1986 Ed.)

WAC 284-50-130 Disparaging comparisons and statements. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services, or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

[Order R-73-1, § 284-50-130, filed 2/28/73, effective 4/1/73.]

WAC 284-50-140 Jurisdictional licensing and status of insurer. (1) An advertisement which reasonably is expected to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(2) An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States government.

[Order R-73-1, § 284-50-140, filed 2/28/73, effective 4/1/73.]

WAC 284-50-150 Identity of insurer. (1) The full legal name (and, where required by RCW 48.30.050, the home office) of the actual insurer shall be shown in each advertisement. The form number or numbers of any specific policy or policies advertised shall be stated in each advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device in a manner which would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

(2) No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to combination of words, symbols, or physical materials, used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

[Order R-76-2, § 284-50-150, filed 3/4/76; Order R-73-1, § 284-50-150, filed 2/28/73, effective 4/1/73.]

WAC 284-50-160 Group or quasi-group implications. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

[Order R-73-1, § 284-50-160, filed 2/28/73, effective 4/1/73.]

WAC 284-50-170 Introductory, initial, or special offers. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial, or

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special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising disability insurance or health care service contractors' agreements.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines, and periodicals, by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This rule is inapplicable to solicitations of employees or members of a particular group or association which solicitations are being made under specific provisions of the insurance code for group, blanket, or franchise insurance.

(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

(4) The phrase "a particular insurance product" in subsection (2) of this rule means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for the concurrent or overlapping enrollment periods.

(5) Special awards, such as a "safe driver's award" shall not be used in connection with advertisements of disability insurance.

[Order R-73-1, § 284-50-170, filed 2/28/73, effective 4/1/73.]

WAC 284-50-180 Reduced initial premium rates. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which over-emphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial

reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

[Order R-73-1, § 284-50-180, filed 2/28/73, effective 4/1/73.]

WAC 284-50-190 Statements about an insurer. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age, or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

[Order R-73-1, § 284-50-190, filed 2/28/73, effective 4/1/73.]

WAC 284-50-200 Advertising file to be maintained. Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of its individual policies and typical printed, published, or prepared advertisements of its blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by the insurance commissioner. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

[Order R-73-1, § 284-50-200, filed 2/28/73, effective 4/1/73.]

WAC 284-50-210 Violation defined as unfair practice. A violation of these rules, WAC 284-50-010 through 284-50-230, is hereby defined to be an unfair method of competition and an unfair or deceptive act or practice in the conduct of the business of insurance, pursuant to RCW 48.30.010.

[Order R-73-1, § 284-50-210, filed 2/28/73, effective 4/1/73.]

WAC 284-50-220 Severability provision. If any section or portion of a section of these rules, or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

[Order R-73-1, § 284-50-220, filed 2/28/73, effective 4/1/73.]

WAC 284-50-230 Effective date. The effective date of this regulation, WAC 284-50-010 through 284-50-230, shall be April 1, 1973.

[Order R-73-1, § 284-50-230, filed 2/28/73, effective 4/1/73.]

WAC 284-50-300 Purpose. The purpose of this regulation, WAC 285-50-300 through 284-50-435, is to implement RCW 48.20.450 through 48.20.470 so as to provide reasonable standardization and simplification

of terms and coverages of individual disability insurance policies in order to facilitate public understanding and comparison and to eliminate provisions contained in individual disability insurance policies which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

[Order R-76-4, § 284-50-300, filed 10/29/76, effective 3/1/77.]

WAC 284-50-305 Applicability and scope. This regulation shall apply to all individual disability insurance policies delivered or issued for delivery in this state on and after the effective date hereof, except it shall not apply to individual policies issued pursuant to a conversion privilege under a policy of group or individual insurance when such group or individual policy includes provisions which are inconsistent with the requirements of this regulation, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted. This regulation shall not apply to medicare supplement insurance policies, as such policies are defined in the Medicare Supplemental Health Insurance Act, chapter 153, Laws of 1981.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-305, filed 12/9/81; Order R-76-4, § 284-50-305, filed 10/29/76, effective 3/1/77.]

WAC 284-50-310 Effective date. This regulation shall be effective on March 1, 1977, and shall be applicable to all individual disability insurance policies (except those specifically excluded from the scope of this regulation) delivered or issued for delivery in this state on and after such date: *Provided, however,* That policies which have been approved prior to January 1, 1977, and which are not in compliance with this regulation may be issued until May 1, 1977, unless approval is specifically withdrawn pursuant to RCW 48.18.110.

[Order R-76-4, § 284-50-310, filed 10/29/76, effective 3/1/77.]

WAC 284-50-315 Policy definitions. Except as provided hereinafter, no individual disability insurance policy delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth in this section unless such definitions comply with the requirements of this section.

(1) "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements due to the same or related causes when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

(2) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

(a) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(i) Be an institution operated pursuant to law; and

(ii) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(iii) Provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term "hospital" may state that such term shall not be inclusive of:

(i) Convalescent homes, convalescent, rest or nursing facilities; or

(ii) Facilities primarily affording custodial, educational or rehabilitative care; or

(iii) Facilities for the aged, drug addicts or alcoholics; or

(iv) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on emergency basis where a legal liability exists for charges made to the individual for such services.

(3) "Convalescent nursing homes," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

(a) A definition of such home or facility shall not be more restrictive than one requiring that it:

(i) Be operated pursuant to law;

(ii) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(iii) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(iv) Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(v) Maintains a daily medical record of each patient.

(b) The definition of such home or facility may provide that such term shall not be inclusive of:

(i) Any home, facility or part thereof used primarily for rest;

(ii) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(iii) A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(4) "Accident," "accidental injury," "accidental means," shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injuries, sustained by

the insured person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided under any worker's compensation, employer's liability or similar law, motor vehicle no fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

(5) "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of any insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed 30 days (or 90 days in a cancer only policy) from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

(6) "Preexisting condition" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five year period preceding the effective date of the coverage of the insured person.

(7) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(8) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(9) "Total disability" is subject to the following:

(a) A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit.

(b) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(i) Perform "any occupation whatsoever," "any occupational duty" or "any and every duty of his occupation," or

(ii) Engage in any training or rehabilitation program.

(c) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

(10) "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(11) "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

(12) "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I of Public Laws 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the ["Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof" or words of similar import.

(13) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

[Order R-76-4, § 284-50-315, filed 10/29/76, effective 3/1/77.]

WAC 284-50-320 Prohibited policy provisions. (1) Except as provided in WAC 284-50-315(5), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not

to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than 6 months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder, and the premium for such optional insurance shall be clearly and separately stated in the premium notice.

(3) No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy.

(4) No policy shall provide a return of premium benefit except as permitted by this rule. For purposes of this rule, a return of premium benefit refers only to that benefit which is equal to a stated portion of the premiums paid for the benefit and the basic coverage decreased by claims paid to the insured under the basic coverage. A disability income policy may contain a return of premium benefit if it meets the following conditions:

(a) Such return of premium benefit shall not be reduced by an amount greater than the aggregate of any claims paid under the policy; and

(b) Such benefit shall be provided by rider or the insurer shall provide a similar policy without such benefit to which the insured may convert; and

(c) The premiums for the disability income and return of premium benefits shall be shown separately on the schedule page of the policy; and

(d) The policy shall guarantee that it is renewable; and

(e) Submission of the benefit form for approval shall be accompanied by a demonstration that the premium and reserve structure is such that adverse deviations from the assumptions thereunder are minimized; and

(f) The insurer provides the commissioner with its assurance that it will promptly notify the insured at such time as the return of premium benefit is not payable to the insured because of the aggregate of claims paid under the policy, together with instructions as to the insured's right and manner of converting to the similar policy or to cancel the rider.

(5) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the

federal government for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(6) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except with respect to the following:

(a) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(b) Mental or emotional disorders, alcoholism and drug addiction;

(c) Pregnancy, except for complications of pregnancy, other than for policies defined in WAC 284-50-355;

(d) Illness, treatment or medical condition arising out of:

(i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

(ii) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(iii) Aviation;

(iv) With respect to short-term nonrenewable policies, interscholastic sports;

(e) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

(f) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain;

(g) Treatment (except emergency treatment for which legal liability exists to the insured for the costs thereof) provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(h) Dental care or treatment;

(i) Eye glasses, hearing aids and examination for the prescription or fitting thereof;

(j) Rest cures, custodial care, transportation and routine physical examinations;

(k) Territorial limitations;

(l) Specified disease and specified accident policies issued in accord with WAC 284-50-365.

(7) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra-hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, and use of endorsements is governed by RCW 48.20.015.

(8) Except as otherwise provided in WAC 284-50-330(2) and 284-50-380(5), the terms "Medicare supplement," "Medigap" and words of similar import shall

not be used unless the policy is issued in compliance with The Medicare Supplemental Health Insurance Act, chapter 153, Laws of 1981, and chapter 284-55 WAC.

(9) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with RCW 48.18.110.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-320, filed 12/9/81; Order R-76-4, § 284-50-320, filed 10/29/76, effective 3/1/77.]

WAC 284-50-325 Minimum standards for benefits.

Minimum standards for benefits are prescribed for the categories of coverage noted in WAC 284-50-330 through 284-50-370. No individual disability insurance policy shall be delivered or issued for delivery in this state which does not meet the required minimum standards for its specified category. Nothing in this section shall preclude the issuance of any policy combining two or more categories of coverage.

[Order R-76-4, § 284-50-325, filed 10/29/76, effective 3/1/77.]

WAC 284-50-330 General rules as to minimum standards.

(1) A "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of WAC 284-50-375(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: *Provided, however*, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: *Provided, however*, any accident and

health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60, if at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

(3) In a family policy covering both husband and wife the age of the younger spouse may be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

(4) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(5) If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

(6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility with a period of less than fourteen days after discharge from the hospital.

(8) In accord with RCW 48.20.420, coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap, on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children, and who is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of such date the company receive due proof of such incapacity and dependency in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within no less than ninety days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

(14) All Medicare supplement policies providing in-hospital benefits only shall include in their provided benefits the initial Part A Medicare deductible as established from time to time by the Social Security Administration. Premiums may be reduced or raised to correspond with changes in the covered deductible.

(15) Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

[Order R-76-4, § 284-50-330, filed 10/29/76, effective 3/1/77.]

WAC 284-50-335 Basic hospital expense coverage. "Basic hospital expense coverage" is a policy of disability insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of 80% of the charges for semi-private room accommodations or \$50 per day;

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during the period of confinement in an amount not less than either 80% of the charges incurred up to at least \$1,000 or ten times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(a) Hospital services on the day surgery is performed, and accidental injury, in an amount not less than \$50; and

(b) Hospital services rendered within 72 hours after accidental injury, in an amount not less than \$50; and

(c) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than \$100 if rendered to an in-patient of the hospital.

(1986 Ed.)

(4) Benefits provided under subsections (1) and (2) of this section may be provided subject to a combined deductible amount not in excess of \$100.

[Order R-76-4, § 284-50-335, filed 10/29/76, effective 3/1/77.]

WAC 284-50-340 Basic medical-surgical expense coverage. "Basic medical-surgical expense coverage" is a policy of disability insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1974 California relative value schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$500 for any one procedure; or

(b) Not less than 80% of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a person licensed to perform such service other than the physician (or his assistant) performing the surgical services:

(a) In an amount not less than 80% of the reasonable charges; or

(b) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or \$5 per day for not less than 21 days during one period of confinement.

[Order R-76-4, § 284-50-340, filed 10/29/76, effective 3/1/77.]

WAC 284-50-345 Hospital confinement indemnity coverage. "Hospital confinement indemnity coverage" is a policy of disability insurance which principally provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$10 per day and not less than 31 days during any one period of confinement for each person insured under the policy. Additional benefits may be provided in such policy.

[Order R-76-4, § 284-50-345, filed 10/29/76, effective 3/1/77.]

WAC 284-50-350 Major medical expense coverage. (1) "Major medical expense coverage" is a disability insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$10,000; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such

deductible may be increased by the amount of the benefit provided by such underlying insurance, provided the policy containing such deductible meets the criteria of subsection (3) of this rule.

(2) The coverage for each covered person shall be for at least:

(a) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than \$50 daily (or in lieu thereof the average daily cost of semiprivate room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(b) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than the greater of \$1,500 or 15 times the daily room and board rate if specified in dollar amounts;

(c) Surgical services, prior to application of the copayment percentage, to a maximum of not less than \$600 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

(d) Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(e) In-hospital medical services, prior to application of the copayment percentage, as defined in WAC 284-50-340(3).

(f) Out of hospital care, prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(g) Not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than \$1,000:

(i) In-hospital private duty graduate registered nurse services;

(ii) Convalescent nursing home care;

(iii) Diagnosis and treatment by a radiologist or physio-therapist;

(iv) Rental of special medical equipment, as defined by the insurer in the policy;

(v) Artificial limbs or eyes, casts, splints, trusses or braces;

(vi) Treatment for functional nervous disorders, and mental and emotional disorders;

(vii) Out-of-hospital prescription drugs and medications.

(3) The "variable deductible" permitted by subsection (1) of this rule will not be approved unless the following conditions are met:

(a) The policy containing such deductible shall be either guaranteed renewable as defined in WAC 284-50-

330 or be a policy which would otherwise be so guaranteed renewable except that the insurer has reserved the right to terminate all such policies in this state.

(b) The policy containing such deductible shall provide that the policyholder shall have the right to increase the stated or specified deductible on any policy anniversary date or upon the establishment of a benefit period, as defined in the policy.

(c) An insurer intending to market such policies in this state shall provide the commissioner, as part of its filing of policy forms, the following information and assurances:

(i) The outline of coverage used in connection with the policy shall contain a clear and prominent explanation of the effect of the variable deductible with respect to other coverages;

(ii) In the event a claim situation arises where the operation of the deductible provision would result in payment to the insured of an amount less than the total covered expenses for which the insured has not been reimbursed under other policies, the variable deductible feature of the deductible provision will be disregarded to the extent necessary to provide payment for such nonreimbursed expenses, subject to the variable deductible policy's coinsurance percentage;

(iii) An annual notice will be given to the policyholder recommending a review of the policy and the deductible feature in light of any change in the policyholder's other coverage which might affect the policy. A copy of such notice shall be filed with the commissioner prior to use.

[Order R-76-4, § 284-50-350, filed 10/29/76, effective 3/1/77.]

WAC 284-50-355 Disability income protection coverage. (1) "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

(a) Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to age 62.

(b) Contains an elimination period no greater than:

(i) Ninety days in the case of coverage providing a benefit of one year or less;

(ii) One hundred eighty days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(iii) Three hundred sixty-five days in all other cases during the continuance of disability resulting from sickness or injury.

(c) Has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be one month.

(2) No disability income protection policy shall contain any provision permitting a reduction in benefits because of an increase in Social Security benefits.

(3) This section does not apply to those policies providing business buyout coverage.

[Order R-76-4, § 284-50-355, filed 10/29/76, effective 3/1/77.]

WAC 284-50-360 Accident only coverage. "Accident only coverage" is a policy of accident insurance which provides coverage, singly or combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

[Order R-76-4, § 284-50-360, filed 10/29/76, effective 3/1/77.]

WAC 284-50-365 Specified disease and specified accident coverage. (1) "Specified disease coverage" is a policy which meets one of the following definitions:

(a) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of \$250 and an overall aggregate benefit limit of no less than \$5,000 and a benefit period of not less than two years for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a legally qualified physician or surgeon;

(iii) Private duty services of a registered nurse (R.N.);

(iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;

(v) Professional ambulance for local service to or from a local hospital;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

(viii) The rental of an iron lung or similar mechanical apparatus;

(ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

(x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$25,000 payable at the rate of not less than \$50 a day while confined in a hospital and a benefit period of not less than 500 days.

(2) "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than \$1,000 for accidental death; \$1,000 for double dismemberment and \$500 for single dismemberment.

[Order R-76-4, § 284-50-365, filed 10/29/76, effective 3/1/77.]

(1986 Ed.)

WAC 284-50-370 Limited benefit health insurance coverage. "Limited benefit health insurance coverage" is any policy which provides benefits that are less than the minimum standards for benefits required under WAC 284-50-335 through 284-50-365, and which the commissioner approves as being in the public interest. Such policies may be delivered or issued for delivery in this state only if the outline of coverage required by WAC 284-50-425 is completed and delivered as required by WAC 284-50-380.

[Order R-76-4, § 284-50-370, filed 10/29/76, effective 3/1/77.]

WAC 284-50-375 Required disclosure provisions, general rules. (1) Each individual disability insurance policy shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear or bear a prominent reference thereto on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to by the insured, except if the increased benefits or coverage is required by law.

(3) Where a separate additional premium is charged for benefits provided in connection with a rider or endorsement, such premium charge shall be set forth in the policy.

(4) A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(5) If a policy contains any limitations with respect to preexisting conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

(6) All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only policy and it does not pay benefits for loss from sickness."

(7) All policies, except single premium nonrenewable policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to

have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

(8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

(9) If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion (including those with respect to the reimposition of a time limit on certain defenses provision), and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

[Order R-76-4, § 284-50-375, filed 10/29/76, effective 3/1/77.]

WAC 284-50-380 Outline of coverage requirements for individual coverages. (1) No individual disability insurance policy subject to this regulation shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in WAC 284-50-385 through 284-50-425 is completed as to such policy and:

(a) Is either delivered with the policy; or
 (b) Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

(2) If an outline of coverage was delivered at the time of application and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy must accompany the policy when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is *not* identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued." In addition, the insurer shall comply with the provisions set forth in RCW 48.20.015.

(3) The appropriate outline of coverage for policies providing hospital coverage which only meets the standards of WAC 284-50-335 shall be that statement contained in WAC 284-50-385. The appropriate outline of coverage for policies providing coverage which meets the standards of both WAC 284-50-335 and 284-50-340 shall be the statement contained in WAC 284-50-395. The appropriate outline of coverage for policies providing coverage which meets the standards of both WAC 284-50-335 and 284-50-350 or 284-50-340 and 284-50-350 or 284-50-335, 284-50-340, and 284-50-350 shall be the statement contained in WAC 284-50-405.

(4) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

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(5) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity (WAC 284-50-345), Specified disease (WAC 284-50-365), or Limited benefit health insurance coverages (WAC 284-50-370) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of WAC 284-50-400, 284-50-420 and 284-50-425, the following language which shall be printed or stamped on or attached to the first page of the outline of coverage: "THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* available from the company." Such notice shall be in no less than twelve point type.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-50-380, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-380, filed 12/9/81; Order R-76-4, § 284-50-380, filed 10/29/76, effective 3/1/77.]

WAC 284-50-385 Basic hospital expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-335.

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE —
 OUTLINE OF COVERAGE

(1) **Read your policy carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Basic hospital expense coverage** — Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or *unlimited* hospital expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services; and
- (d) Other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(1986 Ed.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-385, filed 10/29/76, effective 3/1/77.]

WAC 284-50-390 Basic medical-surgical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-340.

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Basic medical-surgical expense coverage** – Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained *in this policy*, in the following order:

- (a) Surgical services;
- (b) Anesthesia services;
- (c) In-hospital medical services; and
- (d) Other benefits, if any.

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-390, filed 10/29/76, effective 3/1/77.]

WAC 284-50-395 Basic hospital and medical surgical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-335 and 284-50-340.

(1986 Ed.)

(COMPANY NAME)

BASIC HOSPITAL AND MEDICAL SURGICAL EXPENSE
COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Basic hospital and medical surgical expense coverage** – Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for *unlimited* hospital or medical-surgical expenses.

(3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained *in this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-395, filed 10/29/76, effective 3/1/77.]

WAC 284-50-400 Hospital confinement indemnity coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-345.

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control.

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The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Hospital confinement indemnity coverage** – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during period of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) (A brief *specific* description of the benefits contained in *this policy*, in the following order:

- (a) Daily benefit payable during hospital confinement; and
- (b) Duration of benefit described in (a).
- (c) Any benefits provided in addition to the daily hospital benefit.

(Note: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-400, filed 10/29/76, effective 3/1/77.]

WAC 284-50-405 Major medical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-350.

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Major medical expense coverage** – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Surgical services;
- (d) Anesthesia services;
- (e) In-hospital medical services;
- (f) Out of hospital care;
- (g) Maximum dollar amount for covered charges; and
- (h) Other benefits, if any.

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-405, filed 10/29/76, effective 3/1/77.]

WAC 284-50-410 Disability income protection coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-355.

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Disability income protection coverage** – Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*:

Note: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-410, filed 10/29/76, effective 3/1/77.]

WAC 284-50-415 Accident only coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-360.

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Accident only coverage** – Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident *ONLY*, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*:

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with WAC 284-50-325(13) of this regulation.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-415, filed 10/29/76, effective 3/1/77.]

WAC 284-50-420 Specified disease or specified accident coverage, outline of coverage. An outline of coverage in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-365.

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **(Specified disease) (specified accident) coverage** – Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits *ONLY*

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when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*:

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with WAC 284-50-325(13).

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-420, filed 10/29/76, effective 3/1/77.]

WAC 284-50-425 Limited benefit health coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies which do not meet the minimum standards of WAC 284-50-335 through 284-50-365.

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) **Limited benefit health coverage** – Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*.)

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (13) of WAC 284-50-330.

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-425, filed 10/29/76, effective 3/1/77.]

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WAC 284-50-430 Requirements for replacement.

(1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other disability insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection (3) of this section. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in subsection (4) of this section. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(3) The notice required by subsection (2) of this section for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicants' Signature)

(4) The notice required by subsection (2) of this section, for a direct response insurer, shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) . Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(5) The required notice may be modified if preexisting conditions are covered under the new policy.

[Order R-76-4, § 284-50-430, filed 10/29/76, effective 3/1/77.]

WAC 284-50-435 Separability. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

[Order R-76-4, § 284-50-435, filed 10/29/76, effective 3/1/77.]

Chapter 284-51 WAC

STANDARDS FOR COORDINATION OF BENEFITS

WAC

284-51-010	Purpose and scope.
284-51-020	Required provisions for coordination of benefits.
284-51-030	Benefits subject to coordination.
284-51-040	"Plan" defined.
284-51-050	Allowable expense.
284-51-060	Claim determination period.
284-51-070	Order of benefit determination.
284-51-075	Order of benefit determination.
284-51-080	Determination of length of coverage.
284-51-090	Coordination procedures.
284-51-100	Time limit.
284-51-110	Small claim waivers.
284-51-120	Facility of payment.
284-51-130	Right of recovery.
284-51-140	Right to receive and release necessary information.
284-51-150	Disclosure of coordination.
284-51-160	Conformity of contracts.
284-51-170	Effective date.
284-51-180	Appendix A, form for "effect on benefits" provision.
284-51-185	Appendix B, form for "effect on benefits" provision.

WAC 284-51-010 Purpose and scope. (1) This regulation, WAC 284-51-010 through 284-51-180, is adopted pursuant to RCW 48.21.200 to establish standard coordination of benefit provisions, and uniform guidelines for their interpretation and administration, for group disability insurance policies (as defined in RCW 48.21.010), health care service contractor group agreements and health maintenance organization group agreements (all of which are hereinafter referred to as "group contracts"), whose hospital, medical, or surgical benefits may be reduced because of other existing coverages. This regulation applies to group contracts delivered or issued for delivery in Washington state. Except where the context otherwise requires, the definitions given in the Washington Insurance Code, Title 48 RCW, govern the construction of this regulation.

(2) This regulation does not require the use of coordination of benefit provisions in group contracts, however, if a group contract contains any provision for the reduction of benefits otherwise payable because of other insurance, it shall be consistent with and no less favorable than the requirements of this regulation, except that a plan of coverage designed to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

(3) For purposes of this regulation, the word "insurer" includes health care service contractors and health maintenance organizations.

(4) Pursuant to RCW 48.21.200(1) and WAC 284-44-040(9), no group disability insurance policy which provides benefits for hospital, medical or surgical expenses and no group health care service contract may contain any provision permitting a reduction or refusal to pay benefits otherwise payable thereunder solely on

account of the existence of similar benefits provided under any individual disability insurance policy (including "franchise plan" insurance) or any individual health care service contract.

(5) For purposes of this regulation, the words "medical benefits" shall be broadly construed and shall include, but not be limited to dental, optical, prescription drug and audio benefits.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-010, filed 6/18/81, effective 1/1/82.]

WAC 284-51-020 Required provisions for coordination of benefits. (1) A group contract which provides for coordination of hospital, medical, or surgical benefits shall contain the required contractual provisions set forth in WAC 284-51-030 through 284-51-140, and 284-51-180, or provisions which are not less favorable to the insured or the insured's beneficiary. Such provisions shall be preceded individually by the caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or sub-captions as the commissioner may approve. Such provisions collectively constitute the "coordination of benefits provision," which is referred to therein as "this provision."

(2) A blanket disability insurance policy, as defined in RCW 48.21.040, is not within the scope of this regulation, thus it may include an "excess" or "nonduplication of benefits" provision.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-020, filed 6/18/81, effective 1/1/82.]

WAC 284-51-030 Benefits subject to coordination. (1) A group contract which provides for coordination of all benefits thereunder shall contain a provision as follows: "BENEFITS SUBJECT TO THIS PROVISION: All of the benefits provided under this policy are subject to this provision."

(2) If one or more of the policy benefits are to be exempt from reduction under the coordination provision, appropriate changes shall be made in the wording set forth in subsection (1). For example: "Only the major medical expense benefits provided under this policy are subject to this provision."

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-030, filed 6/18/81, effective 1/1/82.]

WAC 284-51-040 "Plan" defined. (1) A group contract which provides for coordination of benefits shall contain a provision stating what benefits from that policy and other sources are to be recognized under the coordination provision. Each such source shall be defined as a "Plan."

(2) The definition of a "Plan" may include such sources of benefits or services as:

(a) Group or blanket disability insurance policies and health care service contractor and health maintenance organization group agreements, issued by insurers,

health care service contractors and health maintenance organizations;

(b) Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans;

(c) Governmental programs; and

(d) Coverage required or provided by any statute.

(3) This provision shall include the following wording or its equivalent: "The term 'plan' shall be construed separately with respect to each policy, agreement or other arrangement for benefits or services, and separately with respect to the respective portions of any such policy, agreement or other arrangement which do and which do not reserve the right to take the benefits or services of other policies, agreements or other arrangements into consideration in determining its benefits."

(4) If not all of the group contract's benefits are subject to coordination, this provision shall include the following wording or its equivalent: "'This Plan' means that portion of this policy which provides the benefits that are subject to this provision." Any benefits provided under the group contract that are not subject to this provision constitute another Plan.

(5) The definition of a "Plan" may not include individual or family disability insurance policies permitted by chapter 48.20 RCW; nongroup health care service contractor agreements permitted under chapter 48.44 RCW; nongroup health maintenance organization agreements permitted under chapter 48.46 RCW.

(6) The definition of a "Plan" may not include group hospital indemnity benefits (that is, benefits paid on other than an expense incurred basis) of \$200 per day or less. It may, however, include reimbursement-type benefits where the insured has the right to elect indemnity-type benefits in lieu of the reimbursement benefits at the time of claim. The amount of group hospital indemnity benefits which exceeds \$200 per day may be included in the definition of "Plan."

(7) The definition of a "plan" may not include coverage on preschool, grammar school, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school" basis.

(8) The definition of a "Plan" may include automobile insurance policies required by statute to provide medical benefits.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-040, filed 6/18/81, effective 1/1/82.]

WAC 284-51-050 Allowable expense. (1) A group contract which provides for coordination of benefits shall contain a provision stating what expenses are to be recognized under the coordination provision, as follows: "ALLOWABLE EXPENSE: 'Allowable expense' means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of

each service rendered shall be considered as both an allowable expense and a benefit paid."

(2) The inclusion of Medicare or similar governmental benefits in the definition of a plan will not require the definition of allowable expense to recognize governmental benefits other than hospital, medical and surgical benefits.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-050, filed 6/18/81, effective 1/1/82.]

WAC 284-51-060 Claim determination period. A group contract which provides for coordination of benefits shall contain a provision stating the period to be used in applying the coordination provision, as follows: "CLAIM DETERMINATION PERIOD: 'Claim determination period' means calendar year."

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-060, filed 6/18/81, effective 1/1/82.]

WAC 284-51-070 Order of benefit determination.

(1) When a claim under a plan with a coordination of benefits provision involves another plan which also has a coordination of benefits provision, the following rules will be applied by the insurers involved to decide the order in which the benefits payable under the respective plans will be determined:

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent. However, to the extent the benefits of a plan which covers the person are provided by a plan for retired persons, such plan may provide that its benefits shall be determined after any other plan covering such person, in which case such provision shall be controlling.

(b) The benefits of a plan which covers the person on whose expense claim is based as a dependent of a male person shall be determined before the benefits of a plan which covers such person as a dependent of a female person, except that in the case of a person for whom claim is made as a dependent child,

(i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

(ii) When parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; or

(iii) Notwithstanding items (i) and (ii), if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care

expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

(2) If the policy provides more than one benefit, the policy shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the policy. Suggested language for such provision is included in Appendix A, WAC 284-51-180.

(3) A group contract which provides for coordination of benefits shall contain a provision entitled "**Effect on Benefits**," stating the manner in which benefits are reduced by coordination, which provision shall be substantially as set forth in Appendix A, WAC 284-51-180.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-070, filed 6/18/81, effective 1/1/82.]

WAC 284-51-075 Order of benefit determination.

(1) When a claim under a plan with a coordination of benefits provision involves another plan which also has a coordination of benefits provision, the following rules will be applied by the insurers involved to decide the order in which the benefits payable under the respective plans will be determined:

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.

(b) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this subsection regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this subsection shall not apply, and the rule set forth in the plan which does not have the provisions of this subsection shall determine the order of benefits. In the case of a person for whom claim is made as a dependent child, however,

(i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

(ii) When parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; or

(iii) Notwithstanding items (i) and (ii) of this subdivision, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(c) When (a) and (b) of this subsection do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:

(i) The benefits of a plan covering the person on whose expenses claim is based as a laid off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid off or retired employee, or dependent of such person;

(ii) If either plan does not have a provision regarding laid off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (i) of this subsection shall not apply.

(d) If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter time.

(2) If the policy provides more than one benefit, the policy shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the policy. Suggested language for such provision is included in Appendix B, WAC 284-51-185.

(3) A group contract which provides for coordination of benefits shall contain a provision entitled "*Effect on Benefits*," stating the manner in which benefits are reduced by coordination, which provision shall be substantially as set forth in Appendix B, WAC 284-51-185.

(4) This section takes effect on January 1, 1987. The provisions of this section shall apply to all policy and contract forms subject to this section that are issued on or after this effective date, and all policy and contract forms that were issued prior to said effective date shall be brought into compliance with the requirements of this section by the later of the next anniversary date or renewal date of the group policy or contract, or the expiration of any applicable collectively bargained contract pursuant to which they are written.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-075, filed 11/4/86, effective 1/1/87.]

WAC 284-51-080 Determination of length of coverage. For the purpose of determining length of coverage under WAC 284-51-070 (1)(c), the following rules shall apply:

(1) In determining the length of time a person in a given group has been covered under a given plan, two successive plans covering the group shall be considered one continuous plan if the person was eligible for the coverage under the second plan within 24 hours after the first plan terminated. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to another does not of itself constitute the start of a new plan for purposes of WAC 284-51-070 (1)(c).

(2) If a person's effective date of coverage under a plan is subsequent to the date the carrier first contracted to provide the plan for the group concerned, the carrier shall assume for purposes of WAC 284-51-070 (1)(c), in the absence of specific information to the contrary, that the person's length of time covered under the plan is measured from his effective date of coverage. If a person's effective date of coverage under a plan is the same as the date the carrier first contracted to provide the plan for the group concerned, the carrier shall request the group to furnish the date the person first became covered under the earliest of any prior plans the group may have had. If such date is not furnished, the date the person first became a member of the group shall be used as the date from which to determine the length of time his coverage under the plan has been in force.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-080, filed 6/18/81, effective 1/1/82.]

WAC 284-51-090 Coordination procedures. Insurers shall use the following claims administration procedures to expedite the claim payments where coordination of benefits is involved:

(1) There shall be continuing education of claim personnel. Accurate and prompt completion of such forms as the health insurance council's duplicate coverage inquiry form (DUP-1) by the inquiring carrier and the responding carrier should be stressed. This education effort should also be encouraged through local claim associations.

(2) Claim personnel shall make every reasonable effort, including use of the telephone, to speed up exchange of coordination of benefits information.

(3) Insurers shall consider building a local data file with at least basic information on group health plans for major employers in the local area.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-090, filed 6/18/81, effective 1/1/82.]

WAC 284-51-100 Time limit. No insurer shall unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision. Each insurer shall establish a time limit after which payment should be made. When payment of a claim is necessarily

delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage shall be conducted concurrently, so as to create no further delay in the ultimate payment of benefits. If an insurer is required by the time limit to make payment as the primary plan because it then has insufficient information to make it a secondary plan, it may exercise its rights under its "right of recovery" provision to recover any excess payments made thereby.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-100, filed 6/18/81, effective 1/1/82.]

WAC 284-51-110 Small claim waivers. In appropriate cases, insurers are encouraged to waive the investigation of possible other plan coverage on claims less than \$50, but if additional liability is incurred which raises the claim above \$50, the entire liability may be included in the coordination of benefits computation.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-110, filed 6/18/81, effective 1/1/82.]

WAC 284-51-120 Facility of payment. A group contract which provides for coordination of benefits shall contain a provision substantially as follows: FACILITY OF PAYMENT: Whenever payments which should have been made under this plan in accordance with this provision have been made under any other plan, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over to any plan making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be considered benefits paid under this plan and, to the extent of such payments, the insurer shall be fully discharged from liability under this plan."

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-120, filed 6/18/81, effective 1/1/82.]

WAC 284-51-130 Right of recovery. A group contract which provides for coordination of benefits shall contain a provision substantially as follows: RIGHT OF RECOVERY: Whenever payments have been made by the insurer with respect to allowable expenses in total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the insurer shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any other organizations or other plans."

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-130, filed 6/18/81, effective 1/1/82.]

WAC 284-51-140 Right to receive and release necessary information. A group contract which provides for coordination of benefits may contain a provision substantially as follows: "RIGHT TO RECEIVE AND RELEASE

NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing this provision and any provision of similar purpose in any other plan, the insurer may, with such consent of the insured person as may be necessary, release to or obtain from any other insurer, organization or person any information, with respect to any person, which the insurer considers necessary for such purpose. Any person claiming benefits under this plan shall furnish to the insurer the information necessary for such purpose."

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-140, filed 6/18/81, effective 1/1/82.]

WAC 284-51-150 Disclosure of coordination. (1) Each certificate of coverage under a group contract which provides for coordination of benefits must contain, at least in summary form, a description of the coordination provision.

(2) Each certificate of coverage shall contain a statement substantially as follows: "If you have other coverage besides ours, we recommend that you submit your claim to us and to each other insurer at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid."

(3) In addition, each insurer shall urge its group clients to take reasonable steps so that those insured by the group policy are exposed to reasonably concise explanations, with as little technical terminology as is consistent with accuracy, of the purpose and operation of the coordination of benefits provision. Such educational effort may, for example, take the form of articles in company magazines or newspapers, speeches before labor organizations or other employee groups, brochures in pay envelopes, notices on bulletin boards and materials used by employers in counseling employees.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-150, filed 6/18/81, effective 1/1/82.]

WAC 284-51-160 Conformity of contracts. The prohibition of coordination provisions' reducing total benefits below 100 percent of allowable expenses became effective for group contracts as of September 8, 1975, pursuant to RCW 48.21.200. Any group contract in effect as of the effective date of this regulation, including any group contract containing an "excess" or "nonduplication" provision, which is not in compliance with this regulation, shall be brought into compliance no later than on the next anniversary date, renewal date or the expiration date of the applicable collectively bargained contract, if any, whichever date is latest.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-160, filed 6/18/81, effective 1/1/82.]

WAC 284-51-170 Effective date. This regulation, WAC 284-51-010 through 284-51-180, shall take effect January 1, 1982.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-170, filed 6/18/81, effective 1/1/82.]

(1986 Ed.)

WAC 284-51-180 Appendix A, form for "effect on benefits" provision. Effect on benefits:

(1) This provision shall apply in determining the benefits for a person covered under this plan for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of:

(a) The benefits that would be payable under this plan in the absence of this provision, and

(b) The benefits that would be payable under all other plans in the absence thereof of provisions of similar purpose to this provision would exceed such allowable expenses.

(2) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision for the allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other plans, except as provided in item (3) of this section, shall not exceed the total of such allowable expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) Another plan which is involved in item (2) of this section and which contains a provision coordinating its benefits with those of this plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and

(b) The rules set forth in item (4) of this section would require this plan to determine its benefits before such other plan then the benefits of such other plan will be ignored for the purposes of determining the benefits under this plan.

(4) For the purpose of item (3) of this section, the rules establishing the order of benefit determination are:

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent. However, if a plan is one providing benefits for retired persons and it provides that its benefits shall be determined after any other plan covering a retired person, such provision shall be controlling.

(b) The benefits of a plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a plan which covers such person as a dependent of a female person, except that in the case of a person for whom claim is made as a dependent child,

(i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; and

(ii) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent

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with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding items (i) and (ii) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

(5) (Note: This item (5) may be omitted if the plan provides only one benefit. If the contract provides more than one benefit, it shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the contract. The following wording is illustrative of a policy in which all benefits are affected.)

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this plan.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200, 81-14-001 (Order R 81-2), § 284-51-180, filed 6/18/81, effective 1/1/82.]

WAC 284-51-185 Appendix B, form for "effect on benefits" provision. Effect on benefits:

(1) This provision shall apply in determining the benefits for a person covered under this plan for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of:

(a) The benefits that would be payable under this plan in the absence of this provision, and

(b) The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

(2) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision for the allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other plans, except as provided in subsection (3) of this section, shall not exceed the total of such allowable expenses. Benefits payable

under another plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) Another plan which is involved in subsection (2) of this section and which contains a provision coordinating its benefits with those of this plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and

(b) The rules set forth in subsection (4) of this section would require this plan to determine its benefits before such other plan then the benefits of such other plan will be ignored for the purposes of determining the benefits under this plan.

(4) For the purpose of subsection (3) of this section, the rules establishing the order of benefit determination are:

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.

(b) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this subsection regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this subsection shall not apply, and the rule set forth in the plan which does not have the provisions of this subsection shall determine the order of benefits. In the case of a person for whom claim is made as a dependent child, however,

(i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

(ii) When parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; or

(iii) Notwithstanding items (i) and (ii) of this subsection, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(c) When (a) and (b) of this subsection do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:

(i) The benefits of a plan covering the person on whose expenses claim is based as a laid off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid off or retired employee, or dependent of such person; and

(ii) If either plan does not have a provision regarding laid off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (i) of this subsection shall not apply.

(d) If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter time.

(5) (Note: This subsection may be omitted if the plan provides only one benefit. If the contract provides more than one benefit, it shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the contract. The following wording is illustrative of a policy in which all benefits are affected.)

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this plan.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-185, filed 11/4/86, effective 1/1/87.]

Chapter 284-52 WAC CONVERSION REGULATION

WAC	Purpose.
284-52-010	Mandated conversion plans minimum standards.
284-52-020	Other provisions applicable to mandated conversion plans.
284-52-030	Basic medical plan.
284-52-040	Major medical plan.
284-52-050	Comprehensive medical plan.
284-52-060	Exclusions.
284-52-070	

WAC 284-52-010 Purpose. (1) The purpose of this chapter is to establish rules pertaining to mandated conversion plans, and their specific standards and minimum benefits, to effectuate the provisions of RCW 48.21.260, 48.21.270, 48.44.370, 48.44.380, 48.46.450, and 48.46.460 (sections 3, 4, 6, 7, 9 and 10, chapter 190, Laws of 1984).

(2) Other conversion plans in addition to those required by this chapter may also be offered.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-010, filed 9/19/84.]

WAC 284-52-020 Mandated conversion plans minimum standards. (1) Every insurer and every health care service contractor which issues group hospital or medical benefit plans shall make available to covered persons a choice of three conversion benefit plans which meet the requirements of WAC 284-52-040, 284-52-050, and 284-52-060, and every health maintenance organization which issues group hospital or medical benefit plans shall make available a conversion benefit plan which meets the requirements of WAC 284-52-060.

(2) Chapter 190, Laws of 1984, permits a denial of conversion coverage "to a person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care." For such denial provision to apply, such other coverage must not contain operable exclusions for preexisting conditions or waiting periods greater than those remaining under the terminated plan.

(3) Such conversion benefit plans:

(a) May provide that their benefits will be excess to any group hospital or medical plan, governmental program, or automobile medical, automobile no-fault, automobile uninsured and/or underinsured motorist or similar coverage issued to or on behalf of the covered person.

(b) Shall provide that deductible amounts will be determined on a calendar year basis.

(c) Shall provide that expenses incurred or the cost of services rendered and applied toward the annual deductible amount during the last three months of such calendar year shall be applied toward the deductible amount in the ensuing calendar year.

(d) May be rated based upon attained age.

(e) Which provide coverage for dependent children, may require evidence of insurability for newly acquired dependents except that newborn infants shall be covered from the moment of birth without evidence of insurability provided application therefor and payment of applicable rates, if any, are made within sixty days of birth.

(f) Shall permit the covered person to pay the premium monthly.

(g) Shall provide that an insured, subscriber or enrollee may continue to renew the conversion coverage until such person fails to pay a necessary premium or fee, becomes eligible for Medicare, or is covered under another group plan providing benefits for hospital and medical care, but only after preexisting conditions are covered and waiting periods have been satisfied under such plan.

(h) Which are written to cover all members of a family under one contract, shall contain a provision to assure that each member, in the event that he or she ceases to be a qualified family member for purposes of coverage, as, for example, by attaining a particular age, or through a marriage or a divorce, or by reason of death of the principal covered person, shall have the right to continue the coverage without a physical examination, statement of health, or other proof of insurability.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-020, filed 9/19/84.]

WAC 284-52-030 Other provisions applicable to mandated conversion plans. Except as otherwise required or permitted by this chapter, mandated conversion plans shall:

(1) Use a format no less favorable to the covered individual than those set forth in RCW 48.20.012, with respect to insurers, or WAC 284-44-030, with respect to health care service contractors and health maintenance organizations;

(2) Contain a provision providing for the return of the contract for a refund of payment, consistent with RCW 48.20.013, 48.44.230 or 48.46.260, as appropriate;

(3) Contain provisions consistent with and no less favorable to the covered individual than the following laws and regulations thereunder:

(a) With respect to insurers, the requirements and standard provisions set forth in chapter 48.20 RCW;

(b) With respect to health care service contractors, the requirements of chapter 48.44 RCW and WAC 284-44-040, except that lifetime maximum benefits under a conversion plan are not required to be renewed or restored;

(c) With respect to health maintenance organizations, the requirements of chapter 48.46 RCW;

(4) Be administered by the carrier in full compliance with any applicable laws which prohibit denials of payments for services performed by certain licensed providers of service.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-030, filed 9/19/84.]

WAC 284-52-040 Basic medical plan. A basic medical plan shall have an annual deductible amount of no less than five hundred dollars or more than one thousand dollars per person and shall provide at least the following benefits:

(1) A lifetime maximum amount of benefits of seventy-five thousand dollars per person.

(2) Daily hospital room and board expenses in an amount not less than one hundred eighty dollars per day for at least seventy days per calendar or contract year.

(3) Ancillary hospital expenses up to a maximum of eighteen hundred dollars per calendar or contract year.

(4) Surgeons' fees at the usual and customary charge up to a maximum of at least fifteen hundred dollars per surgical procedure.

(5) Usual and customary assistant surgeons' fees.

(6) Usual and customary anesthesiologists' and anesthesiologists' fees.

(7) Inpatient and outpatient physician services at the usual and customary charge.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-040, filed 9/19/84.]

WAC 284-52-050 Major medical plan. A major medical plan shall have an annual deductible amount of no less than one thousand dollars or more than five thousand dollars per person and shall provide at least the following benefits:

(1) A lifetime maximum amount of benefits of two hundred fifty thousand dollars.

(2) Payment of at least seventy-five percent of the usual and customary charges for the following:

(a) Daily hospital room and board expenses not less than the semi-private room rate or less than one hundred twenty days per calendar or contract year.

(b) Ancillary hospital expenses.

(c) Surgeons' fees.

(d) Assistant surgeons' fees.

(e) Anesthesiologists' and anesthesiologists' fees.

(f) Inpatient and outpatient physician services.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-050, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-050, filed 9/19/84.]

WAC 284-52-060 Comprehensive medical plan. Except as provided in subsection (3) of this section, a comprehensive medical plan shall have an annual deductible amount of five hundred dollars per person and shall provide at least the following benefits:

(1) A lifetime maximum amount of benefits of five hundred thousand dollars per person.

(2) Payment of at least eighty percent of the usual and customary charges for the following:

(a) Daily hospital room and board expenses not less than the semi-private room rate nor less than one hundred eighty days per calendar or contract year.

(b) Ancillary hospital expenses.

(c) Surgeons' fees.

(d) Assistant surgeons' fees.

(e) Anesthesiologists' and anesthesiologists' fees.

(f) Inpatient and outpatient physician services.

(3) A health maintenance organization's comprehensive medical plan may provide for no deductible amount or a deductible in any amount not exceeding five hundred dollars.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-060, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-060, filed 9/19/84.]

WAC 284-52-070 Exclusions. No policy or contract set forth in WAC 284-52-040, 284-52-050, and 284-52-060 may exclude coverage by type of illness, injury, accident, treatment, or medical condition, except with respect to the following:

(1) Mental or emotional disorders, alcoholism and drug addiction.

(2) Pregnancy, except for complications of pregnancy.

(3) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto.

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury.

(c) Aviation.

(4) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows covered surgery resulting from trauma, infection or other diseases of the involved

part, reconstructive breast surgery covered pursuant to RCW 48.20.395, 48.21.230, 48.44.330 and 48.46.280, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

(5) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain.

(6) Treatment (except emergency treatment for which legal liability exists to the covered person for the costs thereof) provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal worker's compensation, employer's liability or occupational disease law; service rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(7) Dental care or treatment.

(8) Eye glasses, hearing aids, and examination for the prescription or fitting thereof.

(9) Rest cures, custodial care, transportation, and routine physical examinations.

(10) Territorial limitations.

(11) Other exclusions commonly used by the particular carrier in group contracts providing hospital or medical benefits to employee groups.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-070, filed 9/19/84.]

Chapter 284-53 WAC

STANDARDS FOR GROUP ALCOHOLISM COVERAGE

WAC

284-53-010 Standards for group alcoholism coverage.

WAC 284-53-010 Standards for group alcoholism coverage. Contractual provisions for alcoholism benefits required by RCW 48.21.180, 48.44.240, or 48.46.350 shall meet the following standards and administrative requirements.

(1) The coverage for alcoholism treatment shall provide payment toward reasonable charges for any medically necessary treatment and supporting services provided to covered individuals by an "approved treatment facility" approved pursuant to RCW 70.96A.020(2), which may include medical evaluations, psychiatric evaluations, room and board (inpatient only), psychotherapy (individual and group), counseling (individual and group), behavior therapy, recreation therapy, family therapy (individual and group) for the patient and covered persons, prescription drugs prescribed by an approved treatment facility, and supplies prescribed by an approved treatment facility. The coverage shall provide such payment whether the treatment or services are provided on an inpatient (resident) or an outpatient (nonresident) basis, except to the extent that inpatient or outpatient coverage is not provided to the individual insured for other common illnesses or disease. Inpatient

coverage shall include detoxification if detoxification is not included in other contract coverage.

(2) Except to the extent prohibited by this section, the coverage may be limited by provisions of the contract that are applicable to other benefits or services including, but not limited to, provisions relating to deductibles, coinsurance and copayments. However, coverage shall not be denied by reason of contract provisions which are not pertinent to the treatment of alcoholism, such as provisions requiring a treatment facility to have surgical facilities or approval by the joint commission on accreditation of hospitals, that there be a physician in attendance, or that the exact date of onset be known.

(3) The minimum benefits for alcoholism treatment, supporting services and detoxification shall be an amount which is the lesser of five thousand dollars, exclusive of deductibles, coinsurance and copayments, in any consecutive twenty-four-month period or an amount equal to the benefit limit in the contract applicable to the individual insured which would normally be applied to treatment of any common major illness or disease other than alcoholism. The benefits may be limited to a lifetime maximum of not less than ten thousand dollars exclusive of deductibles, coinsurance and copayments, notwithstanding WAC 284-44-040(2). For purposes of determining the limitations allowed by this subsection, with regard to all benefits except the lifetime maximum a carrier may take credit for any benefits paid by any carrier on behalf of a covered individual for alcoholism treatment and supporting services received in an immediately preceding twenty-four month period. For purposes of determining the lifetime maximum allowed by this subsection, calculation must be made on either a per contract or per carrier basis except that when one group contract holder has utilized one or more carriers or plans then a carrier may take credit for amounts paid on behalf of a covered individual from the effective date of this section onward under all past and current carriers and plans with respect to that group contract holder.

(4) Contract provisions subject to this rule:

(a) Shall not impose waiting periods or preexisting condition limitations on alcoholism coverage, except that a carrier may impose a waiting period or preexisting condition limitation for alcoholism treatment and supporting services to the extent that a waiting period or preexisting condition limitation is imposed for other common illnesses or disease.

(b) Shall not provide for the application of comparative statistical measures which are lacking in statistical reliability. Because of the limited number of approved treatment facilities in this state and the diversity of methodologies and fee structures, a measure based on the application of usual, customary and reasonable charges for overall alcoholism treatment and supporting services is not currently acceptable but comparison of costs for specific components of such treatment and supporting services may be acceptable.

(c) Shall not deny reasonable benefits for actual treatment and services rendered solely because a course of treatment was interrupted or was not completed.

(d) May limit coverage to specific facilities but only if the carrier provides one or more reasonably available and conveniently located approved treatment facilities under RCW 70.96A.020(2) which alone or in combination offer both inpatient and outpatient care. This right to limit coverage to specific facilities will permit a carrier to limit diagnosis and treatment to that rendered by itself or by a facility to which it makes referrals, but, in either case, only if the facility is an approved treatment facility under RCW 70.96A.020(2).

(e) May require prenotification in all reasonable situations; may also require a second opinion if such second opinion is required under the contract generally for other common illnesses and disease. Prenotification with respect to detoxification in most cases would not be reasonable.

(5) In situations where an insured is under court order to undergo an alcoholism assessment or treatment, or in situations related to deferral of prosecution, deferral of sentencing or suspended sentencing, or in situations pertaining to motor vehicle driving rights and the Washington state department of licensing, the carrier may require the insured to furnish at the patient's expense no less than ten and no more than thirty working days before treatment is to begin, an initial assessment of the need for alcoholism treatment and a treatment plan, made by an individual of the patient's choice who is a qualified alcoholism counselor employed by an approved treatment facility under RCW 70.96A.020(2) or licensed under chapter 18.57 or 18.71 RCW to enable the carrier to make its own evaluation of medical necessity prior to scheduled treatment.

(6) Except as provided in this section, contractual provisions subject to this section and the administration of such provisions shall not use definitions, predetermination procedures or other prior approval requirements, or other provisions, requirements or procedures, which unreasonably restrict access to treatment, continuity of care or payment of claims.

(7) This section applies to provisions for alcoholism benefits contained in contracts delivered or issued for delivery or renewed in this state on or after January 1, 1987.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-18-027 (Order R 86-2), § 284-53-010, filed 8/27/86, effective 1/1/87.]

Chapter 284-55 WAC

MEDICARE SUPPLEMENTAL HEALTH INSURANCE REGULATION

WAC

284-55-010	Purpose.
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284-55-070	Requirements for application forms, replacement.
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284-55-090	Form for "replacement notice" by direct response insurer.
284-55-100	Return of certificate for refund, unfair practice.
284-55-110	Loss ratio requirements.

WAC 284-55-010 Purpose. The purpose of this regulation is to effectuate the provisions of RCW 48.20.450, 48.20.460 and 48.20.470, and to supplement the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act, by establishing minimum standards for benefits and specific standards for Medicare supplement insurance, by prescribing the "outline of coverage" to be used in the sale of Medicare supplemental insurance, by establishing other disclosure requirements, by prohibiting the use of certain provisions in Medicare supplement insurance policies, by defining and prohibiting certain practices as unfair acts and practices, and establishing loss ratio requirements.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-010, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-010, filed 12/9/81.]

WAC 284-55-020 Applicability and scope. (1) Except as otherwise specifically provided, this regulation shall apply to every group and individual policy of disability insurance and to every subscriber contract of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization, which relates its benefits to Medicare, or which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. Such policy or contract is referred to in this regulation as "Medicare supplemental insurance" or "Medicare supplement insurance policy."

(2) This regulation shall not apply to:

(a) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(b) A policy or contract of any professional, trade, or occupational association for its members or former members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or have been actively engaged in the same profession, trade or occupation;

(ii) Has been maintained in good faith for purposes other than obtaining insurance; and

(iii) Has been in existence for at least two years prior to the date of initial offering of such policy or plan to its members;

(c) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of

group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation;

(d) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation, or

(e) Health maintenance organization contracts specified in section 16, of chapter 153, Laws of 1981, to the extent they may be in conflict with this regulation.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-020, filed 12/9/81.]

WAC 284-55-030 Definitions. For purposes of this regulation:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement insurance policy or subscriber contract, the person who seeks to contract for insurance benefits, and

(b) In the case of a group Medicare supplement insurance policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group Medicare supplement insurance policy, which policy has been delivered or issued for delivery in this state.

(3) "Insurer" includes fraternal benefit societies, health care service contractors and health maintenance organizations.

(4) "Direct response insurer" means an insurer who, as to a particular transaction, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-030, filed 12/9/81.]

WAC 284-55-035 Policy definitions and terms. No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless such policy or contract contains definitions or terms which conform to the requirements of this section.

(1) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(2) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

(a) A definition of such home or facility shall not be more restrictive than one requiring that it:

(i) Be operated pursuant to law;

(ii) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(iii) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(iv) Provide continuous twenty-four hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(v) Maintains a daily medical record of each patient.

(b) The definition of such home or facility may provide that such term shall not be inclusive of:

(i) Any home, facility or part thereof used primarily for rest;

(ii) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(iii) A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(3) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the joint commission on accreditation of hospitals.

(a) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(i) Be an institution operated pursuant to law; and

(ii) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

(iii) Provide twenty-four hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term "hospital" may state that such term shall not be inclusive of:

(i) Convalescent homes, convalescent, rest, or nursing facilities; or

(ii) Facilities primarily affording custodial, educational, or rehabilitative care; or

(iii) Facilities for the aged, drug addicts, or alcoholics; or

(iv) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(4) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(5) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(6) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1, 82-12-032 (Order R 82-3), § 284-55-035, filed 5/26/82.]

WAC 284-55-040 Prohibited policy provisions. (1) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy unless such policy or contract meets the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act.

(2) No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment, or medical condition, except as follows:

(a) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(b) Mental or emotional disorders, alcoholism and drug addiction;

(c) Illness, treatment, or medical condition arising out of:

(i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

(ii) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury;

(iii) Aviation;

(d) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;

(e) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of, or in the vertebral column;

(f) Treatment provided in a governmental hospital; benefits provided under Medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories, or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(g) Dental care or treatment;

(h) Eye glasses, hearing aids, and examination for the prescription or fitting thereof;

(i) Rest cures, custodial care, transportation, and routine physical examinations;

(j) Territorial limitations:

Provided, That Medicare supplement insurance policies may not contain, when issued, limitations or exclusions of the type enumerated in (a), (e), (i) or (j) of this subsection that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

(3) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement insurance policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(4) Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Any provision to the contrary is prohibited.

(5) No Medicare supplement insurance policy shall restrict, exclude or limit benefits for a sickness through use of a probationary, or similar, provision.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1, 82-12-032 (Order R 82-3), § 284-55-040, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-040, filed 12/9/81.]

WAC 284-55-045 Minimum benefit standards. Except as permitted by WAC 284-55-040(2), no insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy which does not meet the following

minimum benefit standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital reserve days;

(3) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days; and

(4) Coverage of twenty percent of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of two hundred dollars of such expenses and to a maximum benefit of at least five thousand dollars per calendar year.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-045, filed 5/26/82.]

WAC 284-55-050 Outline of coverage required. An agent or insurer initiating a sale of an individual or group Medicare supplement insurance policy in this state shall complete and sign a disclosure form, and deliver the completed form to the applicant not later than the time of application for the policy. The disclosure form to be used shall be the "outline of coverage," which is set forth in WAC 284-55-060. Except for direct response insurers, an insurer shall obtain an acknowledgment of receipt of such outline from the applicant.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-050, filed 12/9/81.]

WAC 284-55-060 Form for "outline of coverage."

(COMPANY NAME)
 OUTLINE OF MEDICARE
 SUPPLEMENT COVERAGE

(1) Read your policy carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare supplement coverage – Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3)(a) (for agents:)

Neither (Insert company's name) nor its agents are connected with Medicare.

(b) (for direct responses:)

(Insert company's name) is not connected with Medicare.

(4) (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but \$		
	61st to 90th day	All but \$		
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabili- tation services.	91st to 150th day	All but \$ a day		
	Beyond 150 days	Nothing		

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
POSTHOSPITAL				
SKILLED NURSING CARE . . .	First 20 days	100% of costs		
In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge.	Additional 80 days	All but \$ a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE				
	Physician's services, inpatient and outpatient Medicare services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge (after \$ deductible)		

(5) (Statement that the policy does or does not cover the following:)

- (a) Private duty nursing,
- (b) Skilled nursing home care costs (beyond what is covered by Medicare),
- (c) Custodial nursing home care costs,
- (d) Intermediate nursing home care costs,
- (e) Home health care above number of visits covered by Medicare,
- (f) Physician charges (above Medicare's reasonable charge),
- (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),
- (h) Care received outside of U.S.A.,
- (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for, or the cost of, eyeglasses or hearing aids.

(6) (An explanation of such terms as "usual and customary," "reasonable and customary," or words of similar import, if used in the policy; a description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:)

- (a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)
- (b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)

(7) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.)

(8) (The amount of premium for this policy.)

.....
(Insurer's Name)
By _____ Date _____
.....
(Agent's or Officer's Signature)

(Drafting note. The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.)

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-060, filed 12/9/81.]

WAC 284-55-065 Required disclosure provisions and buyer's guide. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

(2) Where riders or endorsements are used at the time a policy is issued and separate additional premium is charged therefor, such premium charge shall be set forth in the policy.

(3) Insurers issuing accident and sickness policies, certificates, or subscriber contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for Medicare by reason of age must provide to all applicants a Medicare supplement "buyer's guide."

(4) The "buyer's guide" required to be provided is the pamphlet *Guide to Health Insurance for People with Medicare*, developed jointly by the National Association of Insurance Commissioners and Health Care Financing Administration of the United States Department of Health and Human Services, or any reproduction or official revision of that pamphlet. Specimen copies may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. The guide is identified as Department of Health and Human Services/Health Care Financing Administration Form Number HCFA-02110.

(5) Delivery of the "buyer's guide" must be made whether or not such policies, certificates, or subscriber contracts are advertised, solicited, or issued as Medicare supplement policies. Except in the case of direct response insurers, delivery of the "buyer's guide" must be made to the applicant at the time of application and acknowledgement of receipt of the "buyer's guide" must be obtained by the insurer. Direct response insurers must deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-065, filed 5/26/82.]

WAC 284-55-067 Notice regarding policies or subscriber contracts which are not Medicare supplement policies. Any accident and sickness insurance policy or subscriber contract, other than a Medicare supplement policy; disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in WAC 284-55-020 (2)(c) and (d), issued for delivery in this state to persons eligible for Medicare by reason of age, shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare supplement policy. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. Such notice shall be in no less than twelve point type and shall contain the following language: "THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the company."

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-067, filed 5/26/82.]

(1986 Ed.)

WAC 284-55-070 Requirements for application forms, replacement. (1) Application forms shall include a question designed to elicit information as to whether a Medicare supplement policy or certificate is intended to replace any other health care service contract, health maintenance organization contract, disability insurance policy or certificate presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) Upon determining that a sale will involve replacement, the insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage.

(3) The notice required by subsection (2) of this section for an insurer, other than a direct response insurer, shall be provided in substantially the form set forth in WAC 284-55-080.

(4) The notice required by subsection (2) of this section for a direct response insurer shall be in substantially the form set forth in WAC 284-55-090.

(5) The application form shall also contain questions as to whether, as of the date of the application, the applicant

(a) Has any other health care service contract, health maintenance organization contract, disability insurance policy or certificate in force, and

(b) Is eligible for state medical assistance coupons (Medicaid).

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-070, filed 12/9/81.]

WAC 284-55-080 Form for "replacement notice."

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

[Title 284 WAC—p 127]

Drafting note. This subsection may be modified if pre-existing conditions are covered under the new policy.

- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

.....
(Date)

.....
(Applicant's Signature)

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-080, filed 12/9/81.]

WAC 284-55-090 Form for "replacement notice" by direct response insurer.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy.

This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

- (3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

.....
(Company Name)

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-090, filed 12/9/81.]

WAC 284-55-100 Return of certificate for refund, unfair practice. It shall be an unfair act and practice for an insurer to issue a certificate that does not have prominently displayed on its first page a notice stating in substance that the person to whom the certificate is issued shall be permitted to return the certificate within 30 days after its delivery to the purchaser and to have the premium refunded if, after examination of the certificate, the purchaser is not satisfied with it for any reason. If a purchaser does return the certificate, pursuant to such notice, to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no certificate had been issued.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-100, filed 12/9/81.]

WAC 284-55-110 Loss ratio requirements. The provisions of this section shall be used in determining whether the loss ratios required by RCW 48.66.100 are met.

(1) With respect to a health care service contractor, compliance with the provisions of WAC 284-44-100 through 284-44-220 shall be required and those provisions shall be controlling. Commencing with reports for the accounting periods beginning on or after January 1, 1983, the minimum anticipated loss ratio requirements set forth in WAC 284-44-170 shall be applicable to Medicare supplement contracts. Such loss ratio requirements are more stringent than those imposed by RCW 48.66.100, are more appropriate and are necessary for the protection of the public interest.

(2) With respect to a health maintenance organization, the loss ratio shall be deemed to have been met if its "expense costs" are 40% or less of the "premium" charged individual subscribers or 25% or less of the

"premium" charged subscribers covered under a group contract, with contracts issued as a result of solicitation of individuals through the mail or mass media advertising, including both print and broadcast advertising, being treated for this purpose as individual contracts: *Provided*, That commencing with reports for the accounting periods beginning on or after January 1, 1983, the loss ratio shall be deemed to have been met only if its "expense costs" are thirty-five percent or less of the "premium" charged individual subscribers or twenty percent or less of the "premium" charged subscribers covered under a group contract, with contracts issued as a result of solicitation of individuals through the mail or mass media advertising, including both print and broadcast advertising, being treated for this purpose as individual contracts. Such loss ratio requirements are more stringent than those imposed by RCW 48.66.100, are more appropriate and are necessary for the protection of the public interest.

(3) With respect to any other insurer, a loss ratio shall be the "incurred claims" stated as a percentage of the "earned premiums."

(4) For purposes of this section, the following definitions shall apply:

(a) "Incurred claims" shall mean:

(i) "Claims" paid during the accounting period, plus

(ii) The changes in reserves for "claims" which have been reported but not paid, plus

(iii) The change in reserves for "claims" which have not been reported but which may reasonably be expected.

(iv) The change in policy reserves as defined for the insurer's statutory annual statement.

(b) "Earned premium" shall mean the "premium" applicable to an accounting period whether received before, during or after such period.

(c) "Claims" shall mean the costs of benefits paid to or provided on behalf of the persons on whose behalf a contract or certificate is issued, not including "expense costs."

(d) "Expense costs" shall mean:

(i) Claims processing costs,

(ii) Home office and field overhead,

(iii) Acquisition and selling costs,

(iv) Taxes,

(v) Contributions to surplus or profit, and

(vi) All other costs, except benefit payments to or on behalf of the covered persons.

(e) "Premium" shall mean all sums charged, received, or deposited as consideration for a Medicare supplement insurance policy or the continuance thereof. An assessment or a membership, contract, survey, inspection, service or other similar fee or charge made by the insurer in consideration for such contract is deemed part of the "premium."

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-110, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-110, filed 12/9/81.]

Chapter 284-58 WAC

REGULATIONS PERTAINING TO FORM FILINGS

WAC

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284-58-270	Certification form to be used for property and casualty insurance.
284-58-280	Form to be used for certification of property or casualty insurance form filings.

WAC 284-58-010 Title and purpose. (1) This chapter, WAC 284-58-010 through 284-58-280, shall be known and may be cited as the Washington state form filing requirements.

(2) The purpose of this chapter is to establish the necessary contents of a form filing, including the documents to be used in connection with a form filing, to designate the types of policy forms which may not be filed by certification pursuant to RCW 48.18.100(2), and, with respect to disability insurance, to establish the filing requirements with respect to manuals of classification, manual of rules and rates, and modifications thereof.

(3) The fees for filing both forms and rates, and the definitions of such filings for purposes of determining the proper filing fees, are set forth in WAC 284-14-010.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-010, filed 11/5/82.]

WAC 284-58-020 Scope and general contents. (1) This regulation applies to all insurers and to all forms required to be filed with the commissioner pursuant to RCW 48.18.100, and to all manuals of classification, manuals of rules and rates and modifications thereof required to be filed with respect to disability insurance pursuant to RCW 48.19.010(2).

(2) RCW 48.18.100 establishes two basic types of form filings. The first type contemplates the approval of the commissioner. The second type contemplates a filing containing a certification, which permits the insurer to use the form without approval, immediately after the filing. The first, or approval, type of filing requires the commissioner to act within fifteen days (or thirty days, if extended pursuant to RCW 48.18.100(3)), and, if the form has not been either approved or disapproved during such time period, the form is deemed approved and may be used by the insurer. In either case, the commissioner may subsequently withdraw approval or stop the use of a form for cause.

(3) This chapter is divided into the following parts:

(a) The general contents of a life or disability insurance form filing and the reporting documents to be used are set forth in WAC 284-58-030 through 284-58-060.

(b) Designations of the types of life and disability insurance forms which may and may not be filed by the "certification" procedure are found in WAC 284-58-070 through 284-58-180.

(c) Procedures and forms for the certification of life and disability insurance forms and rates begin with WAC 284-58-190.

(d) The general contents of a form filing for property and casualty or kinds of insurance other than life and disability, required to be made pursuant to RCW 48.18.100, are set forth in WAC 284-58-250.

(e) Designation of the types of forms for insurances other than life and disability which may not be filed by the "certification" procedure is set forth in WAC 284-58-260.

(f) The form to be used for the certification of forms for insurances other than life and disability is set forth in WAC 284-58-280.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-020, filed 11/5/82.]

WAC 284-58-030 General contents of all life and disability form and disability rate filings. Each life or disability insurance form filing submitted to the commissioner, whether for approval or by certification, shall contain the following materials arranged in this order:

(1) The appropriate filing fee as prescribed by WAC 284-14-010, and the filing transmittal information required by WAC 284-14-020 separately attached to each form being filed;

(2) One filing report as required by WAC 284-58-040 and, if applicable, a certification prepared pursuant to WAC 284-58-190 or 284-58-210, as appropriate;

(3) The printed form or forms, completed in John Doe fashion if appropriate;

(4) Rates, manuals of classification, manuals of rules and rates and modifications thereof, if appropriate;

(5) Actuarial memorandum of nonforfeiture values, if appropriate;

(6) Actuarial demonstration of anticipated loss ratio, if appropriate; and

(7) Any additional required enclosure.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-030, filed 11/5/82.]

WAC 284-58-040 Life and disability filing report documents. Filing report documents have been established to facilitate and expedite the forms review process with respect to life and disability insurance and must be used with every form filing. A cover letter will not be necessary except with respect to an exceptional filing. The filing report document to be used for life and disability form filings is set forth in WAC 284-58-050. The filing report document to be used for disability insurance rates is set forth in WAC 284-58-060.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-040, filed 11/5/82.]

WAC 284-58-050 Document to be used in filing life and disability forms.

STATE OF WASHINGTON
FILING REPORT - LIFE AND DISABILITY FORMS

(This report must accompany each filing of life and disability forms submitted to the Washington State Insurance Commissioner.)

- 1. Company Name:
- 2. Date of Submission:
- 3. Company Mailing Address:
- 4. Check if the form(s) will be used for Blanket (), Franchise (), or Mass-marketing purposes ().
- 5. This filing is made for () Approval by the Commissioner or () As a Certified Filing — Certificate attached

- 6. Type of Filing:

Form or Group of Similar Forms*	Form #	Forms to be replaced. Give form numbers
() Policy	.....	.....
() Application	.....	.....
() Rider	.....	.....
() Endorsement	.....	.....
() Amendment	.....	.....
() Other	.....	.....

*An example of a group of similar forms would be a set of decreasing term forms, but not including any renewable term or permanent plans with policy provisions different from those of a decreasing term form.

7. Date(s) of Domiciliary Form(s) Approval: -----, -----, -----, -----

8. What line of insurance is involved?

- () Group
() Blanket
() Individual
() Franchise
() Mass Marketed Individual Forms
() Other, please explain in a cover letter

9. If an individual policy form is being filed, what type of product is involved?

- () Universal Life
() Indeterminate Premium Life
() Adjustable - Optional Increases in Face
() Fixed Benefit, Fixed Level Premium Life
() Graded Benefit or Graded Premium Life
() Deposit Term or Deposit Permanent
() Reentry Term
() Reversion Privilege Term
() Retired Lives Reserve
() Flexible Premium Annuity
() Savings Annuity
() Reversionary Annuity
() Fixed Premium Annuity
() Accident Only
() Health
() Monthly Income Disability
() Medicare Supplement
() Credit
() Separate Account Insurance Forms
() Other, please explain in a cover letter

10. () Check here if there are any unusual features or provisions in this filing. Examples include variable premiums and coverages, limited markets or unusual underwriting. If checked, explain fully in a cover letter.

11. () Check here if this filing contains any provisions previously disapproved by this office. If checked, describe fully in a cover letter.

12. List other health insurance forms of the same generic type presently marketed. If such other forms are of nearly identical benefits, explain the need for this form in a cover letter.

13. () Check here if the form is filed as a result of a change in a Washington statute or regulation. Please give citation:

14. () Check here if the forms filed are substantially identical to other forms recently approved in Washington. State the form numbers and indicate the provisions which differ. -----, -----, -----, -----, -----

15. () Check here if this form is to be issued to a trust. (The certificate issued to the participant must be filed.)

16. Signature of designated representative with whom this submission may be discussed

Name printed or typed with title

Telephone number

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-050, filed 11/5/82.]

WAC 284-58-060 Document to be used in filing disability rates.

STATE OF WASHINGTON
FILING REPORT - DISABILITY RATES

(This report must accompany each filing of disability insurance rates submitted to the Washington State Insurance Commissioner.)

1. Company Name: 2. Date of Submission:

3. Company Mailing Address:

4. Line of disability insurance involved?

- () Group
() Blanket Insurance
() Individual
() Franchise
() Mass Marketed Individual Forms

5. Type of disability insurance product involved:

- () Accident Only
() Health with Substantial Inside Limits
() Health Insurance without Substantial Inside Limits
() Monthly Income Disability
() Medicare Supplement
() Credit

6. Type of Filing:

Rates to be used with insurance form or group of similar forms*

- () Initial Filing of Rates
() Rate Increase/Decrease.....
() Automatic Medicare Rate Increase
() Rate Deviation Credit Insurance
() Other

*An example of a group of similar forms would be those grouped together for morbidity experience studies or for pricing purposes where similar experience is expected, such as a group of major medical policies with different deductible amounts.

- 7. This filing is made for () Approval by the Commissioner or () As a Certified Filing — Certificate attached
- 8. Date(s) of Domiciliary Form(s) and Rate Approval(s): -----, -----
- 9. Give the approval date of the form(s) and the effective date(s) of any rate increase(s) in the state of Washington.
Form Numbers: -----, -----, -----, -----, -----, -----
Previous rate increases -----, -----, -----, -----, -----
- 10. What is the scope and reason for the rate increase? (Enclose actuarial justification and demonstration.)
- 11. Does the filing apply to: () new business, () to in force business, () both? State reasons therefor.
- 12. To what degree is it anticipated that this rate increase will result in additional lapses and worsened morbidity experience.
- 13. () Check here if there are any unusual features or provisions to this filing requiring special rate considerations. If checked, explain fully in a cover letter.
- 14. () Check here if this filing contains any rates previously disapproved by this Office. If checked, describe fully in a cover letter.
- 15. List other health insurance forms of the same generic type presently marketed. Explain in a cover letter if such forms were grouped together with form(s) of this filing for pricing or experience study purposes, but are now kept separate.
- 16. () Check here if the rates are filed as a result of a change in a Washington statute or regulation concerning policy benefits or rate structure. Please give the citation:
- 17. () Check here if the rates filed are for forms similar to other forms recently approved in Washington. Please list the form numbers: -----, -----, -----, -----
- 18.
Signature of designated representative with whom this filing may be discussed
.....
Name printed or typed with title
.....
Telephone number

WAC 284-58-070 General designation of life and disability forms which may not be filed by certification. The following categories of life and disability forms may never be filed through the certification process, but must be filed for approval:

- (1) Forms of a type not previously reviewed and approved in the state of Washington for the particular filing company, as, for example, when a company enters a new segment of the insurance market such as a life insurer first entering the group or credit insurance market.
- (2) Any form containing unusual features or provisions. Examples include variable premiums and coverages, limited markets or unusual underwriting.
- (3) Any form containing any provision previously disapproved by this state.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-070, filed 11/5/82.]

WAC 284-58-080 Individual disability insurance forms, certification not permitted. No individual disability insurance forms may be filed by the certification process. All must be filed for approval.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-080, filed 11/5/82.]

WAC 284-58-090 Group disability insurance forms, certification not permitted. The following types of group disability insurance forms may not be filed by certification process, but must be filed for approval:

- (1) Medicare supplement insurance forms.
- (2) Forms to be used with association groups as defined in RCW 48.24.045.
- (3) Forms to be used with debtor groups as defined in RCW 48.24.040.
- (4) Excess risk or loss insurance.
- (5) Any other form not listed in WAC 284-58-100.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-090, filed 11/5/82.]

WAC 284-58-100 Group disability insurance forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of group disability insurance forms and rates may be filed through the certification process:

- (1) Forms to be used with employee groups as defined in RCW 48.21.010.
- (2) Forms to be used with dependents' groups as defined in RCW 48.24.030.
- (3) Forms to be used with health care groups as defined in RCW 48.21.030.
- (4) Forms to be used with credit union groups as defined in RCW 48.24.035.
- (5) Forms to be used with labor union groups as defined in RCW 48.24.050.
- (6) Forms to be used with public employee associations as defined in RCW 48.24.060.
- (7) Forms to be used with trustee groups as defined in RCW 48.24.070.
- (8) Forms to be used with agent groups as defined in RCW 48.24.080.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-060, filed 11/5/82.]

(9) Forms to be used with financial institution groups as defined in RCW 48.24.095.

(10) Forms to be used with a one case filing.

(11) Manuals of classification, manuals of rules and rates, and any modifications thereof filed pursuant to RCW 48.19.010(2).

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-100, filed 11/5/82.]

WAC 284-58-110 Blanket disability insurance forms, certification not permitted. The following types of blanket disability insurance forms may not be filed by the certification process, but must be filed for approval:

- (1) Forms submitted under RCW 48.21.040 (1)(f).
- (2) Any other form not listed in WAC 284-58-120.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-110, filed 11/5/82.]

WAC 284-58-120 Blanket disability insurance forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of blanket disability insurance forms and rates may be filed through the certification process:

(1) Forms to be used with common carrier groups, volunteer organizations, nonprofit welfare organizations, exceptional work hazards employees, and student and faculty groups, as defined in RCW 48.21.040 (1)(a) through (e).

(2) Forms to be used with a one case filing.

(3) Manuals of classification, manuals of rules and rates, and any modifications thereof filed pursuant to RCW 48.19.010(2).

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-120, filed 11/5/82.]

WAC 284-58-130 Individual life insurance and annuity forms, certification not permitted. The following types of individual life insurance and individual annuity forms may not be filed by the certification process, but must be filed for approval:

(1) Variable insurance forms used with a separate account.

(2) Universal life forms.

(3) Indeterminate premium forms.

(4) Lower premiums for nonsmokers and other groups of better risks when such premiums are not guaranteed for the full premium paying period.

(5) Refiling of cash values pursuant to section 14(4)(j), chapter 9, Laws of 1982 1st ex. sess.

(6) Deposit term insurance forms.

(7) Deposit permanent insurance forms.

(8) Retired lives reserves.

(9) Reentry term.

(10) Graded premium forms.

(11) Modified benefit forms.

(12) Flexible premium or single premium annuity with excess interest or similar provisions.

(13) Savings annuity.

(14) Reversionary annuity.

(15) Any annuity policy or rider form with a policy loan provision.

(16) All charitable annuity forms.

(17) All funeral insurance forms.

(18) All coupon policy forms.

(19) All industrial insurance forms.

(20) Accidental death benefit riders.

(21) Waiver of premium disability riders.

(22) Any other form not listed in WAC 284-58-140.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-130, filed 11/5/82.]

WAC 284-58-140 Individual life insurance and annuity forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of individual life insurance and individual annuity forms may be filed through the certification process:

(1) Level benefit, level premium, limited pay or single premium whole life contracts.

(2) Level benefit, level premium, limited pay single premium joint whole life contracts.

(3) Level premium endowment forms which endow for the face amount.

(4) Single premium endowment forms which endow for the face amount.

(5) Retirement income, income endowment, or life income to age 65 or other retirement age.

(6) Family plans consisting of level premium, level benefit term or permanent insurance.

(7) Level premium, level benefit term insurance whether renewable or convertible or not.

(8) Level premium decreasing term insurance with or without nonforfeiture values.

(9) Fixed premium or single premium deferred or immediate annuities.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-140, filed 11/5/82.]

WAC 284-58-150 Group life insurance and annuity contract forms, certification not permitted. The following types of group life insurance and group annuity forms may not be filed by the certification process, but must be filed for approval:

(1) Variable insurance forms used with a separate account.

(2) Forms to be used with debtor insurance groups as defined in RCW 48.24.040.

(3) Forms to be used with association groups as defined in RCW 48.24.045.

(4) Excess risk or loss insurance.

(5) Any other form not listed in WAC 284-58-160.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-150, filed 11/5/82.]

WAC 284-58-160 Group life insurance and annuity forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of group life insurance and group annuity forms may be filed through the certification process:

(1) Forms to be used with employee groups as defined in RCW 48.24.020.

(2) Forms to be used with dependent groups as defined in RCW 48.24.030.

(3) Forms to be used with credit union groups as defined in RCW 48.24.035.

(4) Forms to be used with labor union groups as defined in RCW 48.24.050.

(5) Forms to be used with public employee association groups as defined in RCW 48.24.060.

(6) Forms to be used with trustee groups as defined in RCW 48.24.070.

(7) Forms to be used with agent groups as defined in RCW 48.24.080.

(8) Forms to be used with financial institution groups as defined in RCW 48.24.095.

(9) Forms to be used with qualified pension plans.

(10) Forms to be used with nonqualified pension plans.

(11) Forms to be used with a one case filing.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-160, filed 11/5/82.]

WAC 284-58-170 Credit insurance forms, certification not permitted. No credit insurance forms may be filed by the certification process. All must be filed for approval.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-170, filed 11/5/82.]

WAC 284-58-180 Fraternal benefit society forms. All fraternal benefit society forms may be filed by the certification process.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-180, filed 11/5/82.]

WAC 284-58-190 Certification form to be used for disability insurance form filings. If an insurer elects to file a disability form or rate through the certification process, as permitted by this chapter, it shall complete the certification form set forth in WAC 284-58-200, which must be reproduced on paper no larger than 8-1/2 inches by 11 inches without modification, attach the certification form to the filing report document and submit the same, together with the other contents required by WAC 284-58-030, to the commissioner.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-190, filed 11/5/82.]

WAC 284-58-200 Form to be used for certification of disability insurance form or rate filings.

STATE OF WASHINGTON

CERTIFICATION

DISABILITY INSURANCE FORM(S) AND RATE FILING

Company Name:

Form number and generic description of form to which this certification applies:

I hereby certify that to the best of my knowledge and judgment this form and rate filing is in compliance with the applicable laws and regulations of the state of

Washington, that the benefits are reasonable in relation to the premiums, that formulas for loading and contingency margins are applied consistently and equitably to all the forms, benefits, issue ages, years of issue and other classifications employed including successive generic forms and generations of policyholders, that the calculations were based on my best estimate of the future experience including the need for contingency reserves and that the future experience has been projected only within a time period over which the premiums may reasonably be expected to remain adequate. The manual rates and classifications are attached, as are loss ratio calculations for groups to which the manual rates will apply. I certify that to the best of my knowledge the form does not contain or incorporate by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract and that all of the conditions pertaining to the insurance are explicitly stated in the contract.

(Signature)

-
Check one () Chief Executive Officer
() Actuary and Member of American Academy of Actuaries

Please type or print name of person, and title, whose signature appears above.

.....
Date:
Telephone No.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-200, filed 11/5/82.]

WAC 284-58-210 Certification form to be used for life insurance and annuity form filings. If an insurer elects to file a life insurance or annuity form through the certification process, as permitted by this regulation, it shall complete a certification form the contents of which are set forth in WAC 284-58-220, which must be reproduced on paper no larger than 8-1/2 inches by 11 inches without modification, attach the certification form to the filing report document and submit the same, together with the other contents required by WAC 284-58-030, to the commissioner.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-210, filed 11/5/82.]

WAC 284-58-220 Form to be used for certification of life insurance or annuity form filings.

STATE OF WASHINGTON

CERTIFICATION

LIFE INSURANCE AND ANNUITY FORM FILINGS

Company Name:

Form number and generic description of form to which this certification applies:

I have prepared or supervised the preparation of the actuarial formula for this policy. The actuarial demonstrations are attached. I certify that the nonforfeiture benefits for this form, for every age and face amount combination are in compliance with the applicable laws and regulations of the state of Washington. I certify that to the best of my knowledge and judgment, this form is in compliance with the applicable laws and regulations of the state of Washington, and the form does not contain or incorporate any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract and that all of the conditions pertaining to the insurance are explicitly stated in the contract.

(Signature)

- Check one () Chief Executive Officer
() Actuary and Member of American Academy of Actuaries

Please type or print name of person, and title, whose signature appears above.

Date:
Telephone No.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-220, filed 11/5/82.]

WAC 284-58-250 General contents of a form filing for property and casualty insurance and kinds of insurance other than life and disability. Each form filing for property and casualty insurance or kinds of insurance other than life and disability, whether for approval or by certification, shall contain the following:

- (1) A completed filing transmittal information form as prescribed in WAC 284-14-020. (If the form being filed is a revision or replacement of an existing form, include or attach a summary of the change being made.)
(2) If applicable, a completed certification form as prescribed in WAC 284-58-270.
(3) The printed form or forms, in duplicate.
(4) The appropriate filing fee as prescribed by WAC 284-14-010.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-250, filed 11/5/82.]

WAC 284-58-260 Designation of forms for insurances other than life and disability which may not be filed by certification. (1) Except as provided in subsection (2) of this section, every property or casualty insurance policy form and endorsement pertaining to the following types of insurance must be filed for approval and may not be filed through the certification process.

- (a) Fire and allied lines;
(b) Farmowners multiple peril;
(c) Homeowners multiple peril;
(d) Commercial multiple peril;

- (e) Inland marine;
(f) Professional liability;
(g) Earthquake;
(h) Private passenger automobile;
(i) Commercial automobile;
(j) General liability;
(k) Glass;
(l) Crime coverage;
(m) Boiler and machinery; and
(n) Credit.

(2) Whenever a policy form or endorsement identified in subsection (1) of this section has been filed by a rating organization with, and approved by, the commissioner, a form with identical substantive wording may be filed by an individual insurance company by the certification process.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-260, filed 11/5/82.]

WAC 284-58-270 Certification form to be used for property and casualty insurance. If an insurer elects to file a property or casualty insurance form, or a form for a kind of insurance other than life and disability, through the certification process, as permitted by this chapter, it shall complete a certification form, the contents of which shall be as set forth in WAC 284-58-280, and submit such certification form, together with the other contents required by WAC 284-58-250, to the commissioner.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-270, filed 11/5/82.]

WAC 284-58-280 Form to be used for certification of property or casualty insurance form filings.

CERTIFICATION OF FORM (for other than life or disability insurance)

To the Washington State Insurance Commissioner

Pursuant to RCW 48.18.100 and WAC 284-58-270, I certify to the best of my knowledge and belief that each insurance policy form annexed hereto and filed herewith is in compliance with Title 48 RCW and Title 284 WAC.

(Type or print company's name:)

(Signature)

- Check one () Chief Executive Officer
() Actuary and Member of American Academy of Actuaries

Please type or print name of person, and title, whose signature appears above.

Date:
Telephone No.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-280, filed 11/5/82.]

Chapter 284-60 WAC
DISABILITY INSURANCE LOSS RATIOS

WAC	
284-60-010	Scope.
284-60-020	Purpose.
284-60-030	Definitions.
284-60-040	Grouping of policy forms for purposes of rate making and requests for rate increase.
284-60-050	Loss ratio requirements for individual disability insurance forms.
284-60-060	Loss ratio requirement for group and blanket disability insurance policy forms and manual rates.
284-60-070	Experience records.
284-60-080	Evaluating experience data.
284-60-090	Special circumstances.
284-60-100	Effective date.

WAC 284-60-010 Scope. (1) This regulation, WAC 284-60-010 through 284-60-100, applies to all insurers and to every disability insurance policy form filed for approval in this state after August 31, 1983, except:

- (a) Additional indemnity and premium waiver forms for use only in conjunction with life insurance policies;
- (b) Medicare supplement policy forms which are regulated by chapter 284-55 WAC;
- (c) Credit insurance policy forms issued pursuant to chapter 48.34 RCW;
- (d) Group policy forms other than:
 - (i) Specified disease policy forms,
 - (ii) Policy forms, other than loss of income forms, as to which all or substantially all, of the premium is paid by the individuals insured thereunder,
 - (iii) Policy forms, other than loss of income forms, for issue to single employers insuring less than one hundred employees;
- (e) Policy forms filed by health care service contractors or health maintenance organizations;
- (f) Policy forms initially approved before September 1, 1983, including subsequent requests for rate increases and modifications of rate manuals.

(2) Approvals of policy forms of the types subject to this regulation approved before September 1, 1983, and which are not in compliance with the provisions of this regulation on January 1, 1985, are hereby withdrawn as of January 1, 1985, and such forms shall not thereafter be used for new issues.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-010, filed 6/23/83, effective 9/1/83.]

WAC 284-60-020 Purpose. The purpose of this regulation is to:

- (1) Establish loss ratio standards for the purpose of implementing the authority of the commissioner to disapprove and to withdraw approval of disability policy forms which are not returning or are not expected to return a reasonable proportion of the premiums in the form of benefits, pursuant to RCW 48.18.110(2), 48.19.010(2), 48.70.030 and 48.70.040.
- (2) Define certain practices in the use of policy forms and in the making of disability insurance rates to be unfair, deceptive and discriminatory practices, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-020, filed 6/23/83, effective 9/1/83.]

WAC 284-60-030 Definitions. (1) The "expected loss ratio" is a prospective calculation and shall be calculated as the projected "benefits incurred" divided by the projected "premiums earned" and shall be based on the actuary's best projections of the future experience within the "calculating period."

(2) The "actual loss ratio" is a retrospective calculation and shall be calculated as the "benefits incurred" divided by the "premiums earned," both measured from the beginning of the "calculating period" to the date of the loss ratio calculations.

(3) The "overall loss ratio" shall be calculated as the "benefits incurred" divided by the "premiums earned" over the entire "calculating period" and may involve both retrospective and prospective data.

(4) The "calculating period" shall be the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with his best estimate of future experience and during which the actuary does not expect to request a rate increase.

(5) The "benefits incurred" shall be the "claims incurred" plus any increase (or less any decrease) in the "reserves."

(6) The "claims incurred" shall mean:

- (a) Claims paid during the accounting period; plus
- (b) The change in the liability for claims which have been reported but not paid; plus
- (c) The change in the liability for claims which have not been reported but which may reasonably be expected.

The "claims incurred" shall not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

(7) The "reserves," as referred to in this regulation, shall include:

- (a) Active life disability reserves;
- (b) Additional reserves whether for a specific liability purpose or not;
- (c) Contingency reserves;
- (d) Reserves for select morbidity experience; and
- (e) Increased reserves which may be required by the commissioner.

(8) The "premiums earned" shall mean the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

(9) Renewal provisions are defined as follows:

- (a) "Guaranteed renewable"—Renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.
- (b) "Noncancellable"—Renewal cannot be declined nor can rates be revised by the insurance company.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-030, filed 6/23/83, effective 9/1/83.]

WAC 284-60-040 Grouping of policy forms for purposes of rate making and requests for rate increase.

(1) The actuary responsible for setting premium rates shall group similar policy forms, including forms no longer being marketed, in the pricing calculations. Such grouping shall rely on the judgment of the pricing actuary and be satisfactory to the commissioner. Among the factors which shall be considered are similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between policyholders. Such grouping shall enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.18.480.

(2) The insureds under similar policy forms are grouped at the time of rate making in accord with RCW 48.18.480 because they are expected to have substantially like insuring, risk and exposure factors and expense elements. The morbidity and mortality experience of these insureds will, as a group, deteriorate over time. It is hereby defined to be an unfair and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to withdraw a form from its assigned grouping by reason only of the deteriorating health of the people insured thereunder.

(3) One or more of the policy forms grouped for rate making purposes may, by random chance, experience significantly higher or more frequent claims than the other forms. It is hereby defined to be an unfair and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to deviate from the assigned grouping of policy forms for pricing purposes at the time of requesting a rate increase unless the actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive policy forms of similar benefits are sometimes introduced by the insurers for the purpose of keeping up with trends in hospital costs, new developments in medical practice, additional supplemental benefits offered by competitors, and other reasons. While this is commendable, policyholders who can not qualify for the new improved policies, or to whom the new benefits are not offered, are left insured and isolated as a high risk group under the prior form and soon become subject to massive rate increases. It is hereby defined to be an unfair and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to fail to combine successive generic policy forms and to fail to combine policy forms of similar benefits covering generations of policyholders in the calculation of premium rates and loss ratios.

[Statutory Authority: RCW 48.02.060, 83-14-002 (Order R 83-1), § 284-60-040, filed 6/23/83, effective 9/1/83.]

WAC 284-60-050 Loss ratio requirements for individual disability insurance forms. The following standards and requirements apply to individual disability insurance forms:

(1) Benefits shall be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the insurer and satisfactory to the commissioner.

(2) The calculating period may vary with the benefit and renewal provisions. The company may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period shall accompany the filing.

(3) Policy forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, shall use a relatively short calculating period reflecting the uncertainties of estimating the risks involved. Policy forms based on more dependable statistics may employ a longer calculating period. The calculating period may be the lifetime of the contract for guaranteed renewable and noncancellable policy forms if such forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverages, inside benefit limits, or the inherent nature of the benefits. The calculating period may be as short as one year for coverages which are based on statistics of minimal reliability or which are highly exposed to inflation.

(4) A request for a rate increase to be effective at the end of the calculating period shall include a comparison of the actual to the expected loss ratios, shall employ any accumulation of reserves in the determination of rates for the new calculating period, and shall account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

(5) A request for a rate increase submitted during the calculating period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

(6) The commissioner may approve a series of two or three smaller rate increases in lieu of one large increase. These should be calculated to reduce lapses and anti-selection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or for a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

(7) Companies shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

[Statutory Authority: RCW 48.02.060, 83-14-002 (Order R 83-1), § 284-60-050, filed 6/23/83, effective 9/1/83.]

WAC 284-60-060 Loss ratio requirement for group and blanket disability insurance policy forms and manual rates. The following standards and requirements apply to group and blanket disability insurance policy forms and manual rates:

(1) Specified disease group insurance shall generate at least a seventy-five percent loss ratio regardless of the size of the group.

(2) Group disability insurance, other than specified disease insurance, as to which the insureds pay all or substantially all of the premium shall generate loss ratios no lower than those set forth in the following table.

Number of Certificate Holders at Issue, Renewal or Rerating	Minimum Overall Loss Ratio
9 or less	60%
10 to 24	65%
25 to 49	70%
50 to 99	75%
100 or more	80%

(3) Group disability policy forms, other than for specified disease insurance, for issue to single employers insuring less than one hundred lives shall generate loss ratios no lower than those set forth in subsection (2) of this section for groups of the same size.

(4) The calculating period may vary with the benefit and premium provisions. The company may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations.

(5) A request for a rate increase submitted at the end of the calculating period shall include a comparison of the actual to the expected loss ratios and shall employ any accumulation of reserves in the determination of rates for the selected calculating period and account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

(6) A request for a rate increase submitted during the calculating period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to or support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

(7) The commissioner may approve a series of two or three smaller rate increases in lieu of one larger increase. These should be calculated to reduce the lapses and antiselection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

(8) Companies shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-060, filed 6/23/83, effective 9/1/83.]

WAC 284-60-070 Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each policy year for each policy, rider, endorsement and similar form which were combined for purposes of premium calculations, including the reserves. Records shall also be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of policy year experience based on calendar year data.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-070, filed 6/23/83, effective 9/1/83.]

WAC 284-60-080 Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration shall be given to all relevant factors including:

(1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;

(2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, economic cycles affecting disability income experience, inflation in expense charges and others;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later policy durations;

(4) The mix of business by risk classification;

(5) The expected lapses and antiselection at the time of rate increases.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-080, filed 6/23/83, effective 9/1/83.]

WAC 284-60-090 Special circumstances. Loss ratios other than those indicated in WAC 284-60-050 and 284-60-060 may be approved with satisfactory actuarial demonstrations. Examples of coverages where the commissioner may grant special considerations are:

(1) Short term nonrenewable policy forms such as airline trip or student accident.

(2) Policy forms exposed to high risk of claim fluctuation because of the low loss frequency, or the catastrophic or experimental nature of the coverage.

(3) Individual guaranteed renewable and noncancellable policy forms, but the loss ratio shall not be less than those set forth in the following table in lieu of those specified in WAC 284-60-050. In the calculation of loss ratios for such policies the reserves, except those required by RCW 48.12.030 (3)(a), shall be excluded from consideration as benefits incurred.

	Guaranteed Renewable	Noncancellable
Medical Expense	55%	50%
Loss of Income and Other	50%	45%

(4) Cases where higher than usual expenses are expected because of peculiar administrative or geographic circumstances.

(5) Freestanding group or blanket contracts for benefits which are normally written in conjunction with other benefits.

[Statutory Authority: RCW 48.02.060, 83-14-002 (Order R 83-1), § 284-60-090, filed 6/23/83, effective 9/1/83.]

WAC 284-60-100 Effective date. This regulation shall become effective on September 1, 1983, and shall apply to all policy, rider, endorsement, and similar forms and rate schedule filings subject to this regulation submitted on or after said date.

[Statutory Authority: RCW 48.02.060, 83-14-002 (Order R 83-1), § 284-60-100, filed 6/23/83, effective 9/1/83.]

Chapter 284-78 WAC

JOINT UNDERWRITING ASSOCIATION FOR DAY CARE INSURANCE

WAC

284-78-010	Purpose.
284-78-020	Definitions.
284-78-030	The association.
284-78-040	Activation of association.
284-78-050	Administration.
284-78-060	General powers and duties of the board.
284-78-070	Assessments.
284-78-080	Statistics, records, and reports.
284-78-090	Eligibility of licensees for coverage.
284-78-100	Standard policy coverage—Premiums.
284-78-110	Renewal of policies.
284-78-120	Cancellation of policies.
284-78-130	Right of appeal.
284-78-140	Cooperation of producers.
284-78-150	Commissions.
284-78-160	Additional notice required.
284-78-170	Termination of association.
284-78-180	Effective date.

WAC 284-78-010 Purpose. The purpose of this chapter is to establish a joint underwriting association pursuant to chapter 141, Laws of 1986, to provide liability insurance for day care services.

[Statutory Authority: RCW 48.02.060 (3)(a), 86-18-043 (Order R 86-3), § 284-78-010, filed 8/29/86.]

WAC 284-78-020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Insurer" means any insurance company that, on or after July 1, 1986, possesses a certificate of authority to write property and casualty insurance within this state on a direct basis.

(2) "Day care insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of negligence or malpractice in rendering professional service by any licensee.

(3) "Association" means the joint underwriting association established pursuant to the provisions of chapter 141, Laws of 1986.

(4) "Licensee" means any person or facility licensed to provide day care services pursuant to chapter 74.15 RCW.

(5) "Commissioner" means the insurance commissioner of the state of Washington.

(6) "Service insurer" means any insurance company designated by the association and approved by the commissioner to issue policies pursuant to this chapter.

(7) "Board" means the governing board of the association.

[Statutory Authority: RCW 48.02.060 (3)(a), 86-18-043 (Order R 86-3), § 284-78-020, filed 8/29/86.]

WAC 284-78-030 The association. (1) A nonprofit joint underwriting association for day care insurance is hereby established. Membership in the association shall be mandatory for all insurers that on or after July 1, 1986, possess a certificate of authority to write property and casualty insurance within this state on a direct basis. Every such insurer shall be and remain a member of the association and fulfill all its membership obligations as a condition of its authority to continue to transact property and casualty insurance business in this state.

(2) The association shall remain inactive, except for the actions of the board enumerated in WAC 284-78-050 through 284-78-080, until it is activated by the commissioner as provided in WAC 284-78-040.

[Statutory Authority: RCW 48.02.060 (3)(a), 86-18-043 (Order R 86-3), § 284-78-030, filed 8/29/86.]

WAC 284-78-040 Activation of association. If the commissioner finds that any licensee is unable to obtain day care insurance with liability limits of at least one hundred thousand dollars per occurrence from the voluntary insurance market, or through any market assistance plan organized pursuant to section 906, chapter 305, Laws of 1986, the commissioner may notify the board in writing of such finding and may direct the board to activate the association and commence writing day care insurance within thirty days of receipt of the notice in accordance with the provisions of these regulations.

[Statutory Authority: RCW 48.02.060 (3)(a), 86-18-043 (Order R 86-3), § 284-78-040, filed 8/29/86.]

WAC 284-78-050 Administration. (1) The association shall be administered by a governing board, subject to the supervision of the commissioner, and operated by a manager appointed by the board.

(2) The board shall consist of nine members. Five board members shall be insurers, one of which shall be appointed by the commissioner from each of the following: American Insurance Association, Alliance of American Insurers, National Association of Independent Insurers, all other stock insurers, and all other nonstock insurers. A sixth board member shall be the insurer designated as the service insurer for the association (or, if there is more than one service insurer, the sixth board member shall be such service insurer as the commissioner designates as the board member). The other three board members shall be licensees who are appointed by

the commissioner to so serve, none of whom shall be interested, directly or indirectly, in any insurer except as a policyholder. Board members shall serve for a period of one year or until their successors are appointed. Not more than one insurer in a group under the same management or ownership shall serve on the board at the same time. At least one of the six insurers on the board shall be a domestic insurer. All members of the board shall serve at the pleasure of the commissioner.

(3) Each person serving on the board or any subcommittee thereof, each member insurer of the association, and each officer and employee of the association shall be indemnified by the association against all costs and expenses actually and necessarily incurred by him, her, or it in connection with the defense of any action, suit, or proceeding in which he, she, or it is made a party by reason of his, her, or its being or having been a member of the board, or a member or officer or employee of the association, except in relation to matters as to which he, she, or it has been judged in such action, suit, or proceeding to be liable by reason of wilful misconduct in the performance of his, her, or its duties as a member of such board, or member, officer, or employee of the association. This indemnification shall not be exclusive of other rights as to which such member, or officer, or employee may be entitled as a matter of law.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-050, filed 8/29/86.]

WAC 284-78-060 General powers and duties of the board. (1) Within thirty days after the appointment of its members by the commissioner, the board shall prepare and adopt articles of association consistent with this chapter, subject to approval by the commissioner. In a timely manner thereafter, the board shall take all actions necessary to prepare the association to receive applications and issue policies, when and if the commissioner activates the association as provided in WAC 284-78-040. These actions shall include the preparation of all necessary policy forms and rating information to be filed with the commissioner for approval and all necessary operating manuals and procedures to be followed.

(2) The board shall meet as often as may be required to perform the general duties of the administration of the association or on the call of the commissioner. Three insurer members of the board shall constitute a quorum.

(3) The board may appoint a manager, who shall serve at the pleasure of the board, to perform any duties necessary or incidental to the proper administration of the association, including the hiring of necessary staff.

(4) The board shall annually furnish to all insurer members of the association and to the commissioner a written report of operations.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-060, filed 8/29/86.]

WAC 284-78-070 Assessments. (1) The board may calculate, levy, and collect assessments from member insurers whenever necessary for the orderly operation of the association.

(2) After its formation, the board may calculate, levy, and collect from member insurers a start-up assessment to pay initial expenses of the association and to establish any necessary reserves. The start-up assessment shall not exceed one million dollars. For ease of administration, the share of the start-up assessment levied upon and collected from each member insurer shall be the same for each member insurer, regardless of size and regardless of whether it is actively writing business in this state.

(3) Any assessment subsequent to the initial start-up assessment shall be used to offset losses and/or expenses in excess of income received by the association. These assessments may be made as often as the board determines is necessary. To the extent such an assessment exceeds one million dollars, each member insurer shall be assessed a proportionate share relating to premium volume. The first one million dollars of such an assessment shall be levied and collected in equal amounts from each member insurer.

(4) Any member insurer failing to remit its assessment when due is subject to revocation of its certificate of authority to write property and casualty insurance in this state.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-070, filed 8/29/86.]

WAC 284-78-080 Statistics, records, and reports.

(1) The association shall maintain separate statistics on business written and shall make the following quarterly report to the commissioner:

(a) Number of applications received by the association;

(b) Number of applications accepted by the association and the total and average premiums charged, including the high and low premiums;

(c) Number of risks declined;

(d) Number of risks conditionally declined and the number ultimately accepted after having been conditionally declined; and

(e) Number of risks cancelled.

(2) In addition to statistics, the association shall maintain complete and separate records of all business transactions, including copies of all policies and endorsements issued by the association, and records of reasons provided for each declination of coverage or cancellation of coverage, including the results of any on-site inspections, or investigations of applicants or insureds or their employees.

(3) Regular reports of the association's operations shall be submitted to all members of the board, such reports to include, but not necessarily to be limited to, premiums written and earned, losses, including loss adjustment expense, paid and incurred, all other expenses incurred, outstanding liabilities, and, at least once a year, the proposed annual budget of the association for the next fiscal year.

(4) The books of account, records, reports, and other documents of the associations shall be open to the commissioner for examination at all reasonable times.

(5) The books of account, records, reports, and other documents of the association shall be open to inspection by members only at such times and under such conditions as the board shall determine.

(6) The books of account of any and all servicing insurers may be audited by a firm of independent auditors designated by the board.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-080, filed 8/29/86.]

WAC 284-78-090 Eligibility of licensees for coverage. Any licensee that is unable to obtain day care insurance with liability limits of at least one hundred thousand dollars per occurrence from the voluntary insurance market or from any market assistance plan organized pursuant to section 906, chapter 305, Laws of 1986, is eligible to apply for coverage through the association. The association's service insurer shall promptly process such application and, if the licensee is judged to be an acceptable insurable risk, offer coverage to the licensee. In view of the purpose of chapter 141, Laws of 1986, every licensee will be presumed to be an acceptable insurable risk for the association. To refuse coverage to any licensee meeting the other eligibility requirements of this section, the association must have the prior written approval of the commissioner. The commissioner will grant such approval only if the association demonstrates that extraordinary circumstances justify refusing coverage to such individual licensee.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-090, filed 8/29/86.]

WAC 284-78-100 Standard policy coverage—Premiums. (1) All policies issued by the association shall have liability limits of at least one hundred thousand dollars per occurrence and shall be issued for a term of one year.

(2) Premiums shall be based on the association's rate filings approved by the commissioner in accordance with chapter 48.19 RCW. Such rate filings shall provide for modification of rates for licensees according to the type, size, and past loss experience of each licensee, and any other differences among licensees that can be demonstrated to have a probable effect upon losses.

(3) A policy shall be offered which provides liability coverage with respect to child abuse, whether a sexual nature or not. In the discretion of the association, such policy may exclude from coverage an individual who directly commits or participates in the actual abuse, but it may not exclude from coverage other persons who may be liable only vicariously for such abuse. In addition, the association may offer coverage with a broader exclusion with respect to coverage for child abuse.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-100, filed 8/29/86.]

WAC 284-78-110 Renewal of policies. (1) Policies written by the association will not automatically renew. To obtain continuing coverage by the association, a licensee must again satisfy initial eligibility requirements

under WAC 284-78-090 at the end of the expiring policy term.

(2) The association shall notify covered licensees at least forty-five days prior to the expiration of a policy term of the need to submit a new application for coverage to the association to continue coverage.

(3) If the association fails to provide the required notice, the existing policy shall continue in force until the association has provided the required notice. In such case, premium shall be charged the licensee on a pro rata basis for coverage during the extended coverage period.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-110, filed 8/29/86.]

WAC 284-78-120 Cancellation of policies. (1) No policy or binder issued pursuant to this chapter shall be cancelled except:

(a) For nonpayment of premium, in which case cancellation of the policy shall be effected by providing ten days written notice in advance of the date of cancellation. Payment to the association of all premiums due, prior to the effective date of the cancellation, shall continue coverage as if no cancellation notice had been issued; or

(b) With the prior written approval of the commissioner upon the request of the board, for cause which would have been grounds for refusal of coverage under WAC 284-78-090.

(2) Notice of cancellation, accompanied by the actual reason therefor, shall be sent to the named insured.

(3) Any cancellation notice sent to the named insured shall be accompanied by a statement that the named insured has a right of appeal to the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-120, filed 8/29/86.]

WAC 284-78-130 Right of appeal. (1) Any applicant or insured, currently licensed pursuant to chapter 74.15 RCW, shall have a right of appeal to the commissioner, including the right to appear personally before the commissioner or his or her designee, if requested by the person seeking appeal, from any decision by the board to deny, cancel, or nonrenew coverage.

(2) Appeals to the commissioner under this provision shall be handled in accordance with chapters 48.04 and 34.04 RCW.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-130, filed 8/29/86.]

WAC 284-78-140 Cooperation of producers. All licensed insurance agents and brokers shall provide full cooperation in carrying out the aims and the operation of the association.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-140, filed 8/29/86.]

WAC 284-78-150 Commissions. The association shall pay commissions as established by the board on policies issued pursuant to this chapter to the licensed agent or broker designated by the applicant.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-150, filed 8/29/86.]

WAC 284-78-160 Additional notice required. Any notice of cancellation or nonrenewal of day care insurance given by an insurer to a licensee potentially eligible for coverage through the association shall include or be accompanied by an explanation of the licensee's right and procedure to obtain insurance through the association.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-160, filed 8/29/86.]

WAC 284-78-170 Termination of association. The association shall have perpetual existence, subject to repeal or modification of this chapter.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-170, filed 8/29/86.]

WAC 284-78-180 Effective date. This chapter is effective July 1, 1986.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-180, filed 8/29/86.]

Chapter 284-84 WAC

FIXED PREMIUM UNIVERSAL LIFE INSURANCE

WAC

284-84-010	Scope.
284-84-020	Definitions.
284-84-030	Commissioner's reserve valuation method.
284-84-040	Alternate minimum reserves.
284-84-050	Reserves, adjusting and testing.
284-84-060	Minimum cash surrender values for fixed premium universal life insurance policies.
284-84-070	Mandatory policy provisions.
284-84-080	Disclosure requirements.
284-84-090	Periodic disclosure to policyowner.
284-84-100	Unfair practices.
284-84-110	Filing requirements.

WAC 284-84-010 Scope. (1) This chapter applies to all insurers and to every individual fixed premium universal life insurance policy form, as defined in this regulation, whether solicited on an individual or mass-marketing basis, filed for approval after August 31, 1986.

(2) The approval of individual fixed premium universal life insurance policy forms approved, whether affirmatively approved or deemed approved, prior to September 1, 1986, and which are not in compliance with the provisions of this regulation on January 1, 1987, is hereby withdrawn as of January 1, 1987, and such forms shall not thereafter be delivered or issued for delivery in this state.

(3) This chapter defines unfair practices and disclosure requirements in connection with the separate accumulation of policy values granted in a rider and attached to, granted in a separate policy provision or incorporated in fixed premium universal life insurance policy forms. This chapter does not define minimum nonforfeiture

provisions for the separate accumulation of funds or policy values attached to, separately granted or incorporated in fixed premium universal life insurance policy forms.

(4) This chapter does not apply to universal life insurance policies where the interest credits are linked to an external referent.

(5) This chapter does not apply to policy forms defined under chapter 48.18A RCW.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-010, filed 12/20/85.]

WAC 284-84-020 Definitions. As used in this regulation:

(1) "Universal life insurance policy" means any individual life insurance policy having provisions for separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

(2) "Flexible premium universal life insurance policy" means a universal life insurance policy which permits the policyowner to vary the amount or timing of one or more premium payments or the amount of insurance, independently of each other.

(3) "Fixed premium universal life insurance policy" means a universal life insurance policy other than a flexible premium universal life insurance policy. These policies typically schedule a guaranteed maximum premium at the beginning of each policy year for the premium paying period.

(4) "Cash surrender value" means the amount available in cash to the policyowner upon surrender of the policy, in the absence of any indebtedness.

(5) "Net cash surrender value" means the cash surrender value less any indebtedness under the policy.

(6) "Policy value" means the amount, developed within the main structure of the policy or provided in a separate policy provision, to which separately identified interest credits and mortality, morbidity, expense or other charges are made under a fixed premium universal life insurance policy. The policy owner may or may not have a right to the entire policy value because of built in surrender charges imposed by the insurer.

(7) "Substandard class of insureds" is one whose mortality rates are assumed to be higher than the mortality rates employed with standard issues according to the insurer's classification of risks.

(8) "Death benefit corridor" defines a minimum policy benefit payable in addition to its cash value in the event of the death of the insured.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-020, filed 12/20/85.]

WAC 284-84-030 Commissioner's reserve valuation method. The minimum valuation standard for universal life insurance policies shall be the commissioner's reserve

valuation method, as hereinafter described for such policies, and the tables and interest rates hereinafter specified. The terminal reserve for the basic policy and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less (C) and less (D), where:

(1) Reserves by the net level premium method shall be equal to $((A)-(B))r$ where:

(a) (A) is the present value of all future guaranteed benefits at the date of valuation.

(b) (B) is the quantity ${}^{PVFB} \cdot \ddot{a}_{x+t} / \ddot{a}_x$, where PVFB is the present value of all benefits guaranteed at issue assuming future guaranteed maturity premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer.

(c) \ddot{a}_x and \ddot{a}_{x+t} are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and $x+t$, respectively, and continuing until the highest attained age at which a premium may be paid under the policy. (x) is defined as the issue age and (t) is defined as the duration of the policy.

(d) The guaranteed maturity premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees.

(e) The guaranteed maturity premium for fixed premium policies shall be adjusted for death benefit corridors provided by the policy.

(f) r is equal to one.

(g) The guaranteed maturity fund at any duration is that amount which, together with future guaranteed maturity premiums, will mature the policy based on all policy guarantees at issue.

(2) (C) is the quantity $((a)-(b)) \cdot \ddot{a}_{x+t} \cdot r / \ddot{a}_x$, where (a)-(b) is as described in RCW 48.74.040(1) for the plan of insurance defined at issue by the guaranteed maturity premiums and all guarantees contained in the policy or declared by the insurer. The definition of \ddot{a}_{x+t} and \ddot{a}_x is set forth in subsection (1)(c) of this section.

(3) (D) is the sum of any additional quantities analogous to (C) which arise because of structural changes in the policy, with each such quantity being determined on a basis consistent with that of (C) using the maturity date in effect at the time of the change.

(a) Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyowner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(b) In effecting structural changes, consistent methods are prescribed when calculating reserves. Several such methods are possible, but perhaps the simplest such method would be that of maintaining proportionality between the guaranteed maturity fund and guaranteed maturity premium values and the current face amount. In applying this method, guaranteed maturity fund and guaranteed maturity premium values could be calculated per dollar of face amount and simply multiplied by the

new face amount. This would eliminate much of the complexity involved in other methods.

(c) The guaranteed maturity premium, the guaranteed maturity fund and (B) shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the foregoing descriptions.

(4) Future guaranteed benefits are determined by (a) projecting the greater of the guaranteed maturity fund and the policy value, taking into account future guaranteed maturity premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and (b) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

(5) All present values shall be determined using (a) an interest rate (or rates) specified by RCW 48.74.030 for policies issued in the same year; (b) the mortality rates specified by RCW 48.74.030 for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose; and (c) any other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

(6) To the extent that the insurer declares guarantees more favorable than those in the policy (contractual guarantees), such declared guarantees shall be applicable to the determination of future guaranteed benefits.

(7) The mortality and interest bases for calculating present values are those assumptions defined in the Standard Valuation Law for the calculation of minimum policy reserves.

(8) RCW 48.74.030 (1)(g) permits valuation calculations on the basis of substandard mortality. While such provisions have been used infrequently in the past, it is anticipated that substandard mortality will be more frequently utilized in universal life insurance, given its flexible nature, to reflect the mortality classification assigned to the policy by the insurer.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-030, filed 12/20/85.]

WAC 284-84-040 Alternate minimum reserves. (1) If, in any policy year, the guaranteed maturity premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of (a) or (b) of this subsection:

(a) The reserve calculated according to the method, the mortality table, and the rate of interest actually used.

(b) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the guaranteed maturity premium in each policy year for which the valuation net premium exceeds the guaranteed maturity premium.

(2) For universal life insurance reserves on a net level premium basis, the valuation net premium is $PVFB/\ddot{s}_x$ and for reserves on a commissioner's reserve valuation method, the valuation net premium is $PVFB/\ddot{s}_x + ((a)-(b))/\ddot{s}_x$.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-040, filed 12/20/85.]

WAC 284-84-050 Reserves, adjusting and testing.

(1) Reserves, as calculated without regard to this section, may, under some circumstances, be less than the cash surrender value or the policy value. In such instances, the reserves shall be increased to be equal to the largest of the cash surrender value, the reserve for the policy value less the surrender charges or the policy reserve. The policy value, to the extent it is guaranteed in the present and future years, shall be prefunded in accordance with the principles of the commissioner's reserve valuation method. The policy reserve shall be calculated by the commissioner's reserve valuation method for the fixed premium fixed benefit plan with all present values based on the most conservative of the mortality and interest assumptions defined by the policy guarantees for the purpose of defining benefits, or for the purpose of valuation.

(2) For testing to see if the basic policy reserves calculation pursuant to WAC 284-84-030 is sufficient to cover a scale of cash surrender values, some of which exceed the CRVM basic policy reserves calculation in such section, or for testing a scale of gross premium rates, some or all of which may be less than the basic policy reserve valuation net premium, the mortality table and interest rates applicable at the actual date of issue for the calculation of minimum policy reserves may be used. Should such testing indicate the need for increased reserves, the reserves as calculated under the assumptions in WAC 284-84-040 would be carried.

(3) Reserves for policies where the policy value is developed within the structure of their main benefits shall employ the greater of the cash surrender value or the reserve for the policy value less the surrender charges in the testing pursuant to subsection (2) of this section. Alternatively, a separate reserve may be entered on page 3, line 11 of the statutory statement for the excess of the policy value over the guaranteed cash value.

(4) Reserves for policies where the policy value is provided in a separate policy provision shall employ the cash surrender value in the testing of such value pursuant to subsection (2) of this section and reserve for the policy value separately.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-050, filed 12/20/85.]

WAC 284-84-060 Minimum cash surrender values for fixed premium universal life insurance policies. (1) The minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

(a) The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to $((A)-(B)-(C)-(D))$, where:

(i) (A) is the present value of all future guaranteed benefits.

(ii) (B) is the present value of future adjusted premiums. The adjusted premiums are calculated as described in RCW 48.76.050 (1) and (2), or in (4)(a), as applicable. If RCW 48.76.050 (4)(a) is applicable, the nonforfeiture net level premium is equal to the quantity $PVFB/\ddot{s}_x$ where PVFB is the present value of all benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer, and where \ddot{s}_x is the present value of an annuity of one per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy.

(iii) (C) is the present value of any quantities analogous to the nonforfeiture net level premium which arise because of guarantees declared by the insurer after the issue date of the policy. \ddot{s}_x shall be replaced by an annuity beginning on the date as of which the declaration became effective and payable until the end of the period covered by the declaration.

(iv) (D) is the sum of any quantities analogous to (B) which arise because of structural changes in the policy.

(v) Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyowner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(vi) In effecting structural changes, consistent methods are prescribed when calculating nonforfeiture values. Several such methods are possible, but perhaps the simplest such method would be that of maintaining proportionality between the guaranteed maturity fund and guaranteed maturity premium values and the current face amount. In applying this method, guaranteed maturity fund and guaranteed maturity premium values could be calculated per dollar of face amount and simply multiplied by the new face amount. This would eliminate much of the complexity involved in other methods.

(b) Future guaranteed benefits are determined by (i) projecting the policy value, taking into account future premiums, if any, and using all guarantees of interest, mortality, expense deduction, etc., contained in the policy or declared by the insurer; and (ii) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

(c) All present values shall be determined using (i) an interest rate (or rates) specified in chapter 48.76 RCW for policies issued in the same year and (ii) the mortality rates specified for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose.

(2) Minimum paid-up nonforfeiture benefits. If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, it shall be

such that its present value shall be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value shall be based on mortality and interest standards at least as favorable to the policyowner as the mortality and interest standards permitted for paid-up nonforfeiture benefits by chapter 48.76 RCW. In lieu of the paid-up nonforfeiture benefit, the insurer may provide actuarially equivalent alternatives, calculated on a guaranteed or more favorable basis defined in the policy, which provide a greater amount or longer period of death benefits, or, if applicable, a greater amount of earlier payment of endowment benefits. Such alternative paid-up nonforfeiture benefits must be available for election by the policyowner for at least sixty days after the due date of the premium in default.

(3) Nonforfeiture benefits for substandard issues. The cash and nonforfeiture values of a substandard issue shall be calculated according to the same principles and formulas as the standard issues affording equitable treatment of the several classes of insureds.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-060, filed 12/20/85.]

WAC 284-84-070 Mandatory policy provisions. The policy shall, in addition to compliance with RCW 48-23.020, provide or comply with the following:

(1) The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised as to the status of the policy including the rights to the values and benefits. The report shall also specify the conditions, if any, that the policyowner must fulfill in order to obtain these ownerships. The end of the current report period must be no more than three months prior to the date of the mailing of the report. Specific requirements of this report are detailed in WAC 284-84-090.

(2) The policy shall provide for an illustrative report which shall be sent to the policyowner upon request. Minimum requirements of such report are set forth in WAC 284-84-080. The insurer may charge the policyowner a reasonable fee for providing the report. The amount of this fee shall be disclosed on the policy specifications page.

(3) The policy guarantees. The policy shall contain:

(a) A table of guaranteed cash surrender and nonforfeiture values and a description of the basis of their calculation.

(b) All values and data shown in the policy shall be based on the minimum guaranteed interest rate(s) and the maximum guaranteed mortality and expense charges.

(4) The policy shall contain a description of the calculation of cash surrender values deriving from the accumulation of a policy value including the following information:

(a) The guaranteed maximum expense charges and loads;

(b) The guaranteed minimum rate or rates of interest;

(c) The guaranteed maximum mortality charges;

(d) The guaranteed morbidity charges, if any;

(e) Any other guaranteed charges; and

(f) Any surrender or partial withdrawal charges.

(5) Expense charges and loads, interest credits, mortality and morbidity charges, other current charges, current surrender or partial withdrawal charges shall not remain conditional for a period longer than twelve months.

(6) If the policyowner has the right to change the basic coverage, any limitation on the amount or timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the policy shall state whether a new period of contestability and/or suicide is applicable to the additional coverage.

(7) If there is a misstatement of age or sex in the policy, the amount of the death benefit shall be that which would be purchased by the most recent mortality charge at the correct age or sex. The commissioner may approve other methods which are deemed satisfactory.

(8) The scheduled guaranteed premium shall be sufficient to fund the coverage to the termination date, if any, and to provide for the endowment, if any.

(9) If the "current" premiums are not guaranteed, they may be included in the policy if clearly labelled and identified.

(10) If the contract provides for current premiums, then it shall also disclose the duration of the insurance provided if the current premiums are paid at each policy anniversary. This disclosure shall be in close proximity to the amount of the current premium shown on the policy specifications page. The duration shall be calculated using the guaranteed policy assumptions.

(11) The policy specifications page shall contain a statement, in close proximity to the statement of the current interest to be credited the policy value, if any, that the current interest and savings in the mortality or expense charges may not be fully reflected in the policy benefits.

(12) Substandard issues. If a policy is issued to an insured in a substandard premium class, the policy must be identified as a substandard issue on the policy specifications page, along with the guaranteed and current extra premiums and an explanation of how the mortality charge applied to the policy value will be determined.

(13) The policy shall define the class of insureds in terms of each applicable pricing variable and its initial set of "current" premiums as of the date of issue.

(14) The policy shall include a provision whereby changes in the current premium and any charges or credits may only be made with respect to the entire class of insureds.

(15) The brief description on the face page shall contain the words "universal life insurance."

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-070, filed 12/20/85.]

WAC 284-84-080 Disclosure requirements. In connection with any advertising, solicitation, negotiation, or procurement of a fixed premium universal life insurance policy:

(1) Any statement of policy cost factors or benefits shall contain:

(a) The corresponding guaranteed policy cost factors or benefits, clearly identified;

(b) A statement explaining any nonguaranteed nature of the current premiums, interest rates, charges, or other fees applied to the policy, including the insurer's rights to alter any of these factors; and

(c) Any limitations on the crediting of interest, including identification of those portions of the policy value to which a specified interest rate shall be credited.

(2) Any illustration of the policy value shall be accompanied by the corresponding cash surrender value.

(3) Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined.

(4) Any illustration of the policy benefits based upon nonguaranteed interest, mortality, morbidity, expense charges and loads, other current charges, current surrender or partial withdrawal charges shall be accompanied by a prominent statement indicating that these benefits are not guaranteed.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-080, filed 12/20/85.]

WAC 284-84-090 Periodic disclosure to policyowner. The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised of the status of the policy, and any riders attached, including the rights to the values and benefits. The report shall also specify the conditions, if any, that the policyowner must fulfill in order to obtain these ownerships. The end of the current report period shall be no more than three months prior to the date of the mailing of the report.

Such report shall include the following:

(1) The beginning and ending dates of the current report period;

(2) The policy value at the end of the previous report period and at the end of the current report period;

(3) The rate of interest applied to the policy value and the total amounts which have been credited or debited to the policy value during the current report period, identifying each by type (for example, interest, mortality, expense and riders);

(4) The current death benefit at the end of the current report period on each life covered by the policy;

(5) The cash surrender value and the net cash surrender value of the policy as of the end of the current report period; and

(6) The amount of outstanding loans, if any, as of the end of the current report period; and

(7) If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-090, filed 12/20/85.]

WAC 284-84-100 Unfair practices. Pursuant to RCW 48.30.010, it shall be an unfair practice to:

(1) Contrive to set the premiums at the time of repricing so as to reduce, postpone or avoid cash values.

(2) Recoup past losses or distribute past gains when repricing the policies, when defining the current interest to be credited, or when determining mortality, morbidity or expenses to be charged.

(3) Increase the interest credited to present a more competitive rate while at the same time increasing the mortality, morbidity, expense or other charge or to adjust these and other rates in a similar manner, unless justified by actual company experience.

(4) Review less than all pricing assumptions at repricing or setting of the current credits and charges, thereby upsetting the consistent and equitable treatment of the policyholders.

(5) Add additional pricing variables to the definition of a class of insureds after issue, without the prior written approval of the commissioner.

(6) Separate one class of insureds into two or more classes after issue, without the prior written approval of the commissioner.

(7) Adjust premiums, interest credits, expenses and loads other than with respect to an entire class of insureds.

(8) Treat renewing policyholders in a manner inconsistent or inequitably with new policyholders.

(9) Have one class of insureds support, or be supported by, another class.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-100, filed 12/20/85.]

WAC 284-84-110 Filing requirements. (1) The actuarial memorandum which accompanies the policy filing shall list, among other things, the basis or modification of each table of maximum mortality charge to be used by the company; for example, male, female, and nonsmoker, smoker, etc. It shall also include sufficient numerical data and other information employed by the company to identify the standard and substandard classes of insureds.

(2) For substandard issues, the commissioner must be supplied with a sample of the appropriate policy pages completed through each type of rating used by the company; for example, percentage of standard class premium, extra premium, temporary or permanent flat charge per thousand.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-110, filed 12/20/85.]

Chapter 284-90 WAC RULES PERTAINING TO AIDS

WAC

284-90-010	Purpose.
284-90-020	Insuring procedures relating to AIDS.
284-90-030	Policy reserves—Annual financial statements.

WAC 284-90-010 Purpose. (1) The purpose of this chapter is to assure nondiscriminatory treatment of insureds and prospective insureds by establishing minimum standards insurers must meet with respect to

acquired immune deficiency syndrome (AIDS) and its related conditions. Such related conditions include a positive testing for the Human T-Cell Lymphotropic Virus Type III (HTLV-III) antibodies and a diagnosis of AIDS related complex.

(2) The insurance code prohibits unfair discrimination between insureds having like risk and exposure factors. The practical effect of the law is to require grouping of insureds into classes of like risk and exposure and charging a premium commensurate with the risk and exposure. This assures the equitable treatment of each class of insureds in the sense that the premium charge is reasonably related to the risk assumed by the insurer and that no class of insureds supports (or is supported by) another class of insureds. For example: Insureds with a heart condition should not subsidize (or be subsidized by) insureds with AIDS or diabetes; policies issued on a standard basis should not be surcharged to support those issued to insureds suffering from an ailment. To properly classify such prospective insureds, insurers must ask appropriate questions on application forms and may require reasonable testing of prospective insureds.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-21-065 (Order R 86-5), § 284-90-010, filed 10/15/86.]

WAC 284-90-020 Insuring procedures relating to AIDS. (1) AIDS and its related conditions are diseases and must be considered as such under the insurance laws of this state. Underwriting considerations must be consistent with the underwriting considerations applied to other diseases. Prospective insureds must be accepted or rejected or rated standard or substandard on the basis of bona fide and substantiated statistical differences in risk or exposure.

(2) Questions about AIDS and related health conditions on applications for insurance must be in clear and understandable language and must lend themselves to the placement of applicants in the proper class of insureds. Questions which are ambiguous or misleading are prohibited.

(3) When used, the blood testing of insurance applicants must be administered on a nondiscriminatory basis. If a prospective insured is to be declined or rated substandard because of HTLV-III antibodies in the blood, such action must be based on a Western Blot Test or another test of equal or greater accuracy. Testing procedures of lesser accuracy may be used on a nondiscriminatory basis for underwriting purposes, but a prospective insured may not be declined or rated substandard solely on the basis of results from such test(s).

(4) There are several aspects of the disease AIDS which may create unforeseen claim settlement problems under life insurance, loss of time, and medical coverages. The likelihood of the claimant incurring medical expenses from several different symptoms of AIDS or one of its related conditions may make it difficult to determine when the disease first manifested itself. The long incubation period along with the concurrent and aggravating ailments may create problems with the application of the preexisting conditions clause and the

incontestable provision, as well as the rules which determine a new spell of illness. The benefit provision, including any extended benefit provision, will determine the extent of claim payments if the disease manifested itself while the policy was in force but continued after expiration of coverage or termination of the contract. Such matters, and others unique to the disease of AIDS and its related conditions, must be resolved in a manner consistent with the settlement of claims resulting from other diseases.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-21-065 (Order R 86-5), § 284-90-020, filed 10/15/86.]

WAC 284-90-030 Policy reserves--Annual financial statements. The instructions for the annual statement of life and disability insurers, health care service contractors, and health maintenance organizations which must be filed with the insurance commissioner require an actuarial statement setting forth the actuary's opinion relating to policy reserves and other actuarial items. Effective with statements submitted after December 31, 1986, such statements shall take into account the effect on the adequacy of the insurer's reserves of AIDS and its related conditions and any other disease that does or may potentially constitute an epidemic.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-21-065 (Order R 86-5), § 284-90-030, filed 10/15/86.]